American College of Emergency Physicians®

COUNCIL MEETING

September 27-28, 2024

Mandalay Bay Hotel and Convention Center
Las Vegas, NV

Scientific Assembly
LAS VEGAS 24

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved January 2019

Antitrust

Reaffirmed January 2019, June 2013 and October 2007

Revised October 2001 and June 1996

Approved April 1994

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:

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- 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 reimburser.
- 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.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved April 2023

Conflict of Interest

Revised April 2023, January 2017, June 2011, June 2008

Reaffirmed October 2001

Revised September 1997

Originally approved January 1996

All Key Leaders (defined below) of the American College of Emergency Physicians (ACEP) and others acting on behalf of the College have a fiduciary duty to the College, including the duties of loyalty, diligence, and confidentiality. The following groups or individuals are defined as Key Leaders:

1. Officers
2. Board of Directors
3. Past Presidents, Past Speakers, Past Chairs of the Board
4. Councillors, Alternate Councillors
5. Committee Chairs and Members
6. Section and Task Force Chairs
7. Section and Task Force Members who participate in the development of policy and resources on behalf of the College
8. Editors of ACEP-sponsored publications (e.g., *Annals of Emergency Medicine*, *JACEP Open*, *ACEP Now*, various podcasts)
9. ACEP staff leadership, including its Executive Director, Chief Operating Officer, and members of the Senior Management Team

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 College 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 the College. The immediacy and seriousness of various conflicts of interest situations may vary. Of basic importance is the degree to which the interest would tend one toward bias or pre-disposition on an issue or otherwise compromise the interests of the College.

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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 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 agree 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 adherence to this policy regarding conflicts of interest of Section and Task Force Members who participate in the development of policy and resources on behalf of the College shall be the responsibility of the Section and Task Force Chairs.
3. Key Leaders shall annually complete a form designated by the 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 agree to protect the confidentiality of that information.
5. Officers, Board Members, the Executive Director, Chief Operating Officer, and members of the Senior Management Team shall annually agree to clarify their position when speaking on their own behalf as opposed to speaking on behalf of the College, or as an Officer or member of the Board of Directors or members of the Senior Management Team.
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.

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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 acknowledge that their service to the College requires annual completion of a Conflict of Interest Disclosure Form related to certain affiliations and interests that discloses the following:
      a. Name of employer. Positions of employment, including the nature of the business of the employer, the position held, and a description of the daily employment.
      b. Positions of leadership in other organizations, chapters, commissions, groups, coalitions, agencies, and/or entities (eg, Board of Director positions, committees, and/or_spokesperson roles). Include a brief description of the nature and purposes of the organization or entity.
      c. Family members who are non-physicians, currently or formerly employed in an emergency department or urgent care center, providing care to patients, including, but not limited to nurse practitioners, physician assistants, or certified nurse specialists. Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, sibling-in-law, child-in-law, parent-in-law, stepparent, stepchild, guardian, ward, or a member of the individual's household.
      d. Outside relationship with any person(s) or entity from which the College obtains goods and services, or which provides services that compete with the College where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicity traded company; c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.
      e. Financial interests or positions of responsibility in any entity providing goods or services in support of the practice of emergency medicine (eg, 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.
      f. Outside relationship with any health plan, health insurance company, delegated payer, health insurance company administrative service organization, or health insurance company related philanthropic organization or entity where such relationship involves: a) holding any position of responsibility; b) an equity interest (other than a less than 1% interest in a publicity traded company); c) any stipend, contribution, gift, gratuities, lodging, dining or entertainment valued at more than $100.
      g. Industry-sponsored research support within the preceding twenty-four (24) months.
      h. Speaking fees from non-academic entities during the preceding twenty-four (24) months.
      i. 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 regard to the College or its products.
      j. Any other interest the Key Leader believes may create a conflict with the fiduciary duty to the membership of the College or that may create the appearance of a conflict of interest.
   2. Key Leaders shall acknowledge and agree to the following on the Conflict of Interest Disclosure Form:
      a. Fiduciary responsibility to the College to avoid conflict of interest or the appearance of conflict of interest.
      b. Access to confidential information and to protect the confidentiality of that information.
      c. Clarify position when speaking on own behalf as opposed to speaking on behalf of the College.
      d. To abide by the terms and requirements of the ACEP Conflict of Interest Policy.
      e. Recognize the obligation to notify the appropriate individual as required by the Conflict of Interest Policy should a possible conflict of interest arise in responsibilities to the College. To

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abstain from participation in any business of the College that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so, how that conflict may be resolved. If any relevant changes occur that would be reasonably viewed as requiring disclosure, there is a continuing obligation to file an amended Conflict of Interest Disclosure Form.

3. Except as provided in Section 5 below, completed disclosure forms shall be submitted to the President and the Executive Director, or other designee(s), no later than thirty (30) 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.
4. 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 College member may request a copy of a Key Leader's disclosure form upon written request to the ACEP President.
5. Completed disclosure forms required from Section and Task Force Members will be submitted to the relevant Section or Task Force staff liaison, or other designee(s), within thirty (30) days of appointment or assignment.
6. The College may provide to its members and the public the disclosure forms of its Key Leaders and anyone who speaks at the Council meeting.

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 the College 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.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved June 2018

Meeting Conduct Policy

Originally approved
June 2018

Background

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

Prohibited Behavior

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

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

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

Application of Rules

These conduct rules apply to all attendees and participants at any ACEP-sponsored event, as well as ACEP-sponsored meeting social events (for example,

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opening and closing parties at Scientific Assembly). **All who register to participate, attend, speak at, or exhibit at an ACEP event agree to comply with this Policy.**

Reporting Prohibited Behavior

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

Potential Consequences

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

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 Council Meeting

September 27-28, 2024
Pre-Meeting Events Occur Thursday Evening, September 26, 2024
Mandalay Bay Convention Center (MBCC), Oceanside A (Level 2)
Las Vegas, NV

TIMED AGENDA

Friday, September 27, 2024

Continental breakfast available – Oceanside Foyer		***7:30 am***
1. Call to Order A. Meeting Dedication B. Pledge of Allegiance C. National Anthem	Dr. Costello	8:00 am
2. Introductions	Dr. Costello	8:10 am
3. Welcome from NV Chapter President	Dr. Hardwick	8:12 am
4. Tellers, Credentials, & Election Committee A. Credentials Report B. Meeting Etiquette	Dr. Char	8:14 am
5. Changes to the Agenda	Dr. Costello	8:16 am
6. Council Meeting Website Overview	Mr. Joy	8:16 am
7. EMF Council Challenge	Dr. Wilcox	8:21 am
8. NEMPAC Council Challenge	Dr. Jacoby	8:23 am
9. Review and Acceptance of Minutes A. Council Meeting – October 7-8, 2023	Dr. Costello	8:25 am
10. Approval of Steering Committee Actions A. Steering Committee Meeting – January 25, 2024 B. Steering Committee Meeting – April 14, 2024	Dr. Costello	8:26 am
11. Interim Executive Director's Report	Dr. Schneider	8:27 am
12. Call for and Presentation of Emergency Resolutions	Dr. Costello	8:47 am
13. Steering Committee's Report on Late Resolutions A. Reference Committee Assignments of Allowed Late Resolutions B. Disallowed Late Resolutions	Dr. Costello	8:50 am
14. Nominating Committee Report A. Board of Directors 1. Slate of Candidates 2. Call for Floor Nominations B. President-Elect 1. Slate of Candidates 2. Call for Floor Nominations	Dr. Costello	8:55 am

Item	Presenter	Time
15. Candidate Opening Statements	Dr. Costello	
A. Board of Directors Candidates (2 minutes each)		9:05 am
B. President-Elect Candidates (5 minutes each)		9:25 am
16. Reference Committee Assignments	Dr. Costello	9:45 am
BREAK		***9:50 am – 10:00 am***
17. Reference Committee Hearings		10:00 am – 1:00 pm
A – Governance & Membership – *Oceanside B*		
B – Advocacy & Public Policy – *Oceanside C*		
C – Emergency Medicine Practice – *Oceanside D*		
Boxed Lunches Available – Oceanside Foyer		***11:00 am – 12:30 pm***
18. Reference Committee Executive Sessions		1:00 pm – 2:30 pm
A – *Oceanside B*		
B – *Oceanside C*		
C – *Oceanside D*		
BREAK – Return to main Council meeting room – Oceanside A		***1:00 pm – 1:15 pm***
19. Town Hall Meeting – *Oceanside A*	Dr. McCrea	1:15 pm – 2:15 pm
A. A Peak Behind the Curtain: The 2025 RAND Report		
20. Candidate Forum for the President-Elect Candidates – *Oceanside A*		2:20 pm – 2:50 pm
BREAK – Return to Reference Committee meeting rooms *Oceanside B, Oceanside C, Oceanside D*		***2:50 pm – 3:00 pm***
21. Candidate Forum for Board of Directors *Candidates rotate through Reference Committee meeting rooms.*		3:00 pm – 4:45 pm
BREAK – Return to main Council meeting room – Oceanside A		***4:45 pm – 5:00 pm***
22. Speaker's Report	Dr. Costello	5:00 pm
23. In Memoriam	Dr. Costello	5:15 pm
A. Reading and Presentation of Memorial Resolutions *Adopt by observing a moment of silence.*	Dr. McCrea	
24. EMRA Report	Dr. Denley	5:30 pm
25. ABEM Report	Dr. Gorgas	5:35 pm
26. AMA Section Council on Emergency Medicine Report	Dr. Epstein/Dr. Heine	5:45 pm
27. Secretary-Treasurer's Report	Dr. McCabe-Kline	5:50 pm
28. President's Address	Dr. Terry	5:55 pm
RECESS		***6:15 pm***

Candidate Reception ● 6:15 pm – 7:15 pm ● Oceanside E-G (MBCC, Level 2)

Saturday, September 28, 2024

Continental breakfast available – Oceanside Foyer		***7:30 am***
1. Call to Order	Dr. Costello	8:00 am
2. Tellers, Credentials, & Elections Committee Report	Dr. Char	8:00 am
3. Electronic Voting A. Electronic Voting Testing	Dr. Char	8:05 am
4. EMF Report	Dr. Williams	8:30 am
5. NEMPAC Report	Dr. Jacoby	8:35 am
6. Submitting Amendments Electronically	Dr. Costello	8:40 am
7. Reference Committee Reports A. Reference Committee ___ B. Reference Committee ___		8:45 am
8. Awards Luncheon – *Oceanside E-G*		12:00 pm
A. Welcome 1. Recognition of Past Speakers and Past Presidents 2. Recognition of Current and Past Board Members 3. Recognition of Chapter Executives	Dr. Costello	12:40 pm
B. ACEP Awards Announcements	Dr. Terry	
C. Reading and Presentation of Commendation Resolutions *Adopt by acclamation.*	Dr. Costello/Dr. McCrea	
D. Council Award Presentations 1. Council Service Milestone Awards – *5, 10, 15, 20, 25, 30, 35, 40+ Year Councillors* 2. Council Teamwork Award 3. Council Horizon Award 4. Council Champion in Diversity & Inclusion Award 5. Council Curmudgeon Award 6. Council Meritorious Service Award	Dr. Costello/Dr. McCrea	
LUNCHEON ADJOURNS – Return to main Council meeting room – Oceanside A		***1:30 pm***
9. Tellers, Credentials, & Elections Committee Report	Dr. Char	1:40 pm
10. Reference Committee Reports Continue C. Reference Committee ___		1:45 pm
11. President-Elect's Address	Dr. Haddock	4:45 pm
12. Installation of President	Dr. Terry/Dr. Haddock	5:05 pm
13. Tellers, Credentials, & Elections Committee Report	Dr. Char	5:10 pm
14. Elections A. Board of Directors B. President-Elect	Dr. Char	5:10 pm
15. Announcements	Dr. Costello	5:40 pm
ADJOURN		***5:45 pm***

Next Annual Council Meeting ● September 5-6, 2025 (Friday-Saturday) ● Salt Lake City, UT

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 Council Meeting

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18 President-Elect Candidates
- L. Anthony Cirillo, MD, FACEP
- Jeffrey M. Goodloe, MD, FACEP
- Ryan A. Stanton, MD, FACEP

19 Board of Directors Candidates
- Jennifer J. Casaletto, MD, FACEP
- Steven B. Kailes, MD, MPH, FACEP
- C. Ryan Keay, MD, FACEP
- Heidi C. Knowles, MD, FACEP
- Diana B. Nordlund, DO, JD, FACEP
- Bing S. Pao, MD, FACEP

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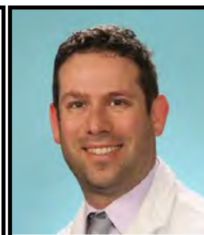
American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 Council Steering Committee

Updated January 2024

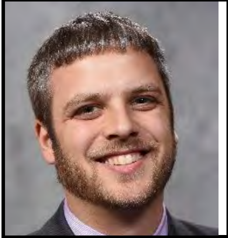
	Melissa W. Costello, MD, FACEP - Speaker Mobile, AL		**Michael J. McCrea, MD, FACEP Vice Speaker** Perrysburg, OH
	Erik Blutinger, MD, MSc, FACEP New York, NY		**Sara Ann Brown, MD, FACEP** Monroeville, IN
	Emily Fitz, MD, FACEP Zionsville, IN		**Deborah Fletcher, MD, FACEP** Shreveport, LA
	Vik Gulati, MD, FACEP San Diego, CA		**Robert Hancock, DO, FACEP** Roanoke, TX
	Amanda Irish, MD, MPH Coralville, IA		**C. Ryan Keay, MD, FACEP** Lynnwood, WA
	Alexander J. Kirk, MD, FACEP Carrollton, TX		**Marc Mendelsohn, MD, FACEP** St. Louis, MO

David Nestler, MD, MS, FACEP

Rochester, MN

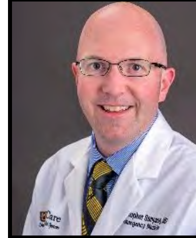
Diana Nordlund, DO, JD, FACEP

Caledonia, MI



Scott Pasichow, MD, MPH, FACEP

Maplewood, NJ



Christopher S. Sampson, MD, FACEP

Columbia, MO

Matthew J. Sanders, DO, FACEP

Springboro, OH

Michaela S. Banks, MD
(EMRA REP to Steering Committee)

New Orleans, LA

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Procedures for Councillor and Alternate Seating

Councillor Credentialing

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

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

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

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

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

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

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

> "Each sponsoring body shall deposit with the secretary of the Council a certificate certifying its councillor(s) and alternate(s). The certificate must be signed the president, secretary, or chairperson of the sponsoring body. No councillor or alternate shall be seated who is not a member of the College. College members not specified in the sponsoring body's certificate may be certified and credentialed at the annual meeting in accordance with the Council Standing Rules.
>
> ACEP Past Presidents, Past Speakers, and Past Chairs of the Board, if not certified as councillors or alternate councillors by a sponsoring body, may participate in the Council in a non-voting capacity. Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions."
>
> Whenever the term "present" is used in these Bylaws with respect to councillor voting, it shall mean credentialed as certified by the chair of the Tellers, Credentials, & Elections Committee."

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

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

Seating of Past Presidents, Past Council Speakers, and Past Chairs of the Board

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

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

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

Voting Cards and Electronic Voting

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

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

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

Seating Exchange Between Credentialed Councillors and Alternates

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

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

3. If a councillor is leaving the floor of the Council, and there will **not** be an alternate replacement, the councillor must return the voting card and keypad (if applicable) to staff at councillor credentialing. Once the councillor returns, the voting card and keypad (if applicable) will be returned to the councillor. If debate is occurring on the Council floor, the councillor should wait until final action has been taken on a particular issue before returning to the seat on the Council floor.

2024 Councillor Seating Chart

SECRETARY PARLIAMENTARIAN SPEAKER VICE SPEAKER

PROJECTION STAFF

422 + 42 Leaders=464

Row	Left	Center	Right	Row
1	AACEM=1 Air Med=1 AAWEP=1 AK=1 AL=5 AR=2	CA=15	AZ=10 Careers=1 Critical Care=1 Cruise Ship=1	1
2	CO=7 CORD=1 Democratic=1 Disaster=1 DE=2 DEI=1	CA=15	DC= 3 Dual=1 EMS=1 EMRA=8 Event Med=1	2
3	EMPMHP=1 FL=14	CA=8 CT=7	Govt Svc=13 Exploring Ret=1	3
4	FL=14 Forensic=1	GA=11 Freestanding=1 Geriatric=1	International=1 KS=2 KY=4 LA=4 ME=3	4
5	HI=2 Informactics=1 ID=3 IN=7	IL=13 IA=2	MI=15	5
6	Locums=1 MD=7 Med Directors=1 Med Human=1	MA=10 Observation=1 Palliative=1 Pain Management=1	MI=7 NH=2 NY=5	6
7	MN=8 MS=3 Peds=1 QPS=1	MO=6 MT=1 NE=2 NV=4	NY=15	7
8	NJ=12 Research=1 Rural=1	NM=5 ND=1 OH=8	NY=11 Tactical=1 Telehealth=1	8
9	NC=12 PR=2	OH=9 OK=3 Social EM=1 Sports Med=1	TN=5 TX=8	9
10	OR=5 PA=9	RI=3 SAEM=1 SC=5 SD=1 UT=4	TX=15	10
11	PA=10 Toxicology=1 Trauma=1 Ultrasound=1	VT=2 Wellness=1 WA=9	WI=6 Wilderness=1 Worforce=1 WV=3 WY=1 YPS=1	11
12	VA=12 Undersea=1	BOD		12
		BOD		

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Past Presidents, Past Council Speakers, and Past Chairs of the Board Seating

Past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor (see seating chart). The 2024 councillor seating chart includes the following:

Alabama	4 councillors + 1 past leader attending not serving as a councillor = 5 seats
Arizona	8 councillors + 2 past leaders attending not serving as councillors = 10 seats
California	33 councillors + 5 past leaders attending not serving as councillors = 38 seats
Colorado	6 councillors + 1 past leader attending not serving as a councillor =7 seats
Connecticut	6 councillors + 1 past leader attending not serving as a councillors = 7 seats
Florida	21 councillors + 7 past leaders attending not serving as a councillors = 28 seats
Georgia	9 councillors + 2 past leader attending not serving as councillor = 11 seats
Government Services	10 councillors + 3 past leaders attending not serving as councillor = 13 seats
Indiana	6 councillors + 1 past leader attending not serving as councillor = 7 seats
Michigan	20 councillors + 2 past leaders attending not serving as councillors = 22 seats
New Jersey	10 councillors +2 past leader attending and not serving as councilor = 12 seats
New Mexico	3 councillors + 2 past leaders attending and not serving as councillor = 5 seats
New York	30 councillors + 1 past leader attending not serving as a councillor = 31 seats
North Carolina	11 councillors + 1 past leaders attending not serving as councillors = 12 seats
Ohio	15 councillors + 2 past leaders attending not serving as councillors = 17 seats
Pennsylvania	18 councillors + 1 past leaders attending not serving as councillors =19 seats
Texas	21 councillors + 2 past leaders attending not serving as a councillor = 23 seats
Virginia	9 councillors + 3 past leaders not serving as a councillor = 12 seats
Washington	7 councillors + 2 past leaders attending not serving as a councillor = 9 seats
West Virginia	2 councillors + 1 past leader attending not serving as a councillor = 3 seats

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2024 COUNCILLORS & ALTERNATE COUNCILLORS

Chapter/Section	Position	Name
AACEM	Councillor	Jane H Brice, MD, FACEP
ALABAMA CHAPTER	Councillor	Stephen William Knight, MD, FACEP
	Councillor	Jaron D Raper, MD, FACEP
	Councillor	Annalise Sorrentino, MD, FACEP
	Councillor	Sean Vanlandingham, MD, FACEP
	Alternate	Muhammad N Husainy, DO, FACEP
ALASKA CHAPTER	Councillor	Camilla Sulak, MD, FACEP
ARIZONA CHAPTER	Councillor	Patricia A Bayless, MD, FACEP
	Councillor	Bradley A Dreifuss, MD, FACEP
	Councillor	Olga Gokova, MD, FACEP
	Councillor	Nicole R Hodgson, MD, FACEP
	Councillor	Paul Andrew Kozak, MD, FACEP
	Councillor	Wendy Ann Lucid, MD, FACEP
	Councillor	Anthony C Wong, MD, FACEP
	Councillor	Dale P Woolridge, MD, PhD, FACEP
	Alternate	Rebecca B Parker, MD, FACEP
ARKANSAS CHAPTER	Councillor	J Shane Hardin, MD, PhD, FACEP
	Councillor	Robert Thomas VanHook, MD, FACEP
	Alternate	Brian L Hohertz, MD, FACEP
	Alternate	Ariel S Noble, MD
CALIFORNIA CHAPTER	Councillor	Nida F Degesys, MD, FACEP
	Councillor	Luigi Di Stefano, MD, FACEP
	Councillor	Adam P Dougherty, MD, FACEP
	Councillor	Nicole Elizabeth Exeni McAmis, MD
	Councillor	Andrew N Fenton, MD, FACEP
	Councillor	Jorge A Fernandez, MD, FACEP
	Councillor	Marc Allan Futernick, MD, FACEP
	Councillor	Michael Gertz, MD, FACEP
	Councillor	Douglas Everett Gibson, MD, FACEP
	Councillor	Alicia Mikolaycik Gonzalez, MD, FACEP
	Councillor	Kamara W Graham, MD, FACEP
	Councillor	Jason Greenspan, MD, FACEP
	Councillor	Vikant Gulati, MD, FACEP
	Councillor	Puneet Gupta, MD, FACEP
	Councillor	Omar Guzman, MD, FACEP
	Councillor	Christopher Libby, MD, MPH, FACEP
	Councillor	Aimee K Moulin, MD, FACEP
	Councillor	Leslie Mukau, MD, FACEP
	Councillor	Taylor S Nichols, MD, FACEP
	Councillor	Valerie C Norton, MD, FACEP
	Councillor	Comfort Arinola Adeola Orebayo , DO
	Councillor	Bing S Pao, MD, FACEP
	Councillor	Chi Lee Perlroth, MD, FACEP

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2024 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Kelly E Quinley, MD
	Councillor	Vivian Reyes, MD, FACEP
	Councillor	Matthew Richard, MD, FACEP
	Councillor	Ellen Marie Shank, MD
	Councillor	Susanne J Spano, MD, FACEP
	Councillor	Thomas Jerome Sugarman, MD, FACEP
	Councillor	Gary William Tamkin, MD, FACEP
	Councillor	David Terca, MD, FACEP
	Councillor	Anna L Yap, MD
	Councillor	Randall J Young, MD, FACEP
	Alternate	Rodney W Borger, MD, FACEP
	Alternate	Fred Dennis, MD, MBA, FACEP
	Alternate	Hannah Gordon, MD, MPH
	Alternate	Michael J Kiemeney, MD, FACEP
	Alternate	Hunter M Pattison, MD
	Alternate	Julie C Phillips, MD, FACEP
	Alternate	Vineet K. Sharma, MD
	Alternate	Wilson Smith, MD
	Alternate	Peter Erik Sokolove, MD, FACEP
	Alternate	Melanie T Stanzer, DO, FACEP
	Alternate	Patrick Um, MD, FACEP
	Alternate	Anna L Webster, MD, FACEP
	Alternate	Bradley Alan Zlotnick, MD, FACEP
COLORADO CHAPTER	Councillor	Jasmeet Singh Dhaliwal, MD, MPH, MBA
	Councillor	Ramnik S Dhaliwal, MD, JD
	Councillor	Laura Edgerley-Gibb, MD, FACEP
	Councillor	Anna Engeln, MD, FACEP
	Councillor	Rachelle M Klammer, MD, FACEP
	Councillor	Rebecca L Kornas, MD, FACEP
	Alternate	Douglas M Hill, DO, FACEP
	Alternate	Carla Elizabeth Murphy, DO, FACEP
	Alternate	Megan Purdy
	Alternate	Parth Shah, DO
	Alternate	Bradley D Shy, MD, FACEP
	Alternate	James D Thompson, MD, FACEP
CONNECTICUT CHAPTER	Councillor	Thomas A Brunell, MD, FACEP
	Councillor	Daniel Freess, MD, FACEP
	Councillor	Carlos Patrick Holden, MD
	Councillor	Elizabeth Schiller, MD, FACEP
	Councillor	Gregory L Shangold, MD, FACEP
	Councillor	Kevin Joseph Sprague, II, MD
CORD	Councillor	Jason Cass Wagner, MD, FACEP
DELAWARE CHAPTER	Councillor	Kathryn Groner, MD, FACEP
	Councillor	John T Powell, MD, MHCDS, FACEP
	Alternate	Anam Habib Chaudhry, DO

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2024 COUNCILLORS & ALTERNATE COUNCILLORS

DISTRICT OF COLUMBIA CHAPTER	Councillor	Stanislaw C Haciski, MD
	Councillor	Natalie Sullivan, MD
	Councillor	Neha Puppala Sullivan, MD
EMERGENCY MEDICINE RESIDENTS' ASSOCIATION	Councillor	Michaela Skylar Banks, MD
	Councillor	Blake Denley, MD
	Councillor	Kenneth Taeyoung Kim, MD
	Councillor	Aaron R Kuzel, DO
	Councillor	Derek Martinez, DO
	Councillor	Jessica Adkins Murphy, MD
	Councillor	David Wilson, MD
	Councillor	Angela Wu, MD
	Alternate	Jacob Mark Altholz, MD
	Alternate	James Blum, MD
	Alternate	Alexander Hua, MD
	Alternate	Lucinda Meldrum Millsom, MBBS
	Alternate	Joe-Ann Moser, MD
	Alternate	Nicholas William Rizer, MD
	Alternate	Morgan Danielle Sweere, MD
	Alternate	Pauline Wiltz, DO
FLORIDA CHAPTER	Councillor	Thomas P Bentley, MD, FACEP
	Councillor	Andrew I Bern, MD, FACEP
	Councillor	Ricki A Brown, MD
	Councillor	Blake Buchanan, MD
	Councillor	Elizabeth A Calhoun, MD
	Councillor	Damian E Caraballo, MD, FACEP
	Councillor	Edward A Descallar, MD, FACEP
	Councillor	Anton Gomez, DO
	Councillor	Gabriel Gomez, DO
	Councillor	Shayne M Gue, MD, FACEP
	Councillor	Brandy Milstead Hollingsworth, MD
	Councillor	Saundra A Jackson, MD, FACEP
	Councillor	Steven B Kailes, MD, FACEP
	Councillor	Mike Lozano, Jr, MD, MSHI, FACEP
	Councillor	Ryan T McKenna, DO, FACEP
	Councillor	Ashley Norse, MD, FACEP
	Councillor	Ana Iris Pineda, MD, FACEP
	Councillor	Jeremy K Selley, DO, FACOEP
	Councillor	Todd L Slesinger, MD, FACEP
	Councillor	Zachary C Terwilliger, MD
	Councillor	Stephen C Viel, MD, MBA, FACEP
	Alternate	Stuart James Bumgarner, MD
	Alternate	Lara N Goldstein, MD
	Alternate	Harold Gomez Acevedo, MD, FACEP
	Alternate	Ian David Storch, MD, FACEP
	Alternate	Cristina Zeretzke, MD, FACEP

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GEORGIA CHAPTER	Councillor	Matthew R Astin, MD, FACEP
	Councillor	Brett H Cannon, MD JD MBA, FACEP
	Councillor	James Joseph Dugal, MD(E), FACEP
	Councillor	Matthew Taylor Keadey, MD, FACEP
	Councillor	Jeffrey F Linzer, Sr, MD, FACEP
	Councillor	DW "Chip" Pettigrew, III, MD, FACEP
	Councillor	James L Smith, Jr, MD, FACEP
	Councillor	Johnny L Sy, DO, FACEP
	Councillor	Matthew J Watson, MD, FACEP
	Alternate	Shamie Das, MD, MBA, MPH, FACEP
	Alternate	Mark A Griffiths, MD, FACEP
	Alternate	Brendan Hawthorn, MD, FACEP
	Alternate	Benjamin Lefkove, MD, FACEP
	Alternate	Alison Ruch, MD, FACEP
	Alternate	Matthew Rudy, MD, FACEP
	Alternate	Carmen D. Sulton, MD, FACEP
	Alternate	Kathryn West, MD, FACEP
	Alternate	John L Wood, MD, FACEP
GOVT SERVICES CHAPTER	Councillor	Christine A DeForest, DO, FACEP
	Councillor	Roderick Fontenette, MD, FACEP
	Councillor	Christina Kim, DO
	Councillor	Katrina N Landa, MD, FACEP
	Councillor	David S McClellan, MD, FACEP
	Councillor	Torree M McGowan, MD, FACEP
	Councillor	Katey Della Giustina Osborne, MD
	Councillor	Paul James Diggins Roszko, MD, FACEP
	Councillor	Justine K Stremick, MD, FACEP
	Councillor	Sean Stuart, DO, FACEP
	Alternate	Linda L Lawrence, MD, CPE, FACEP
	Alternate	Mike Ramirez, MD
	Alternate	Gillian Schmitz, MD, FACEP
	Alternate	Robert Eduard Suter, DO, MHA, FACEP
HAWAII CHAPTER	Councillor	Mark Baker, MD, FACEP
	Councillor	John M Gallagher, MD, FACEP
IDAHO CHAPTER	Councillor	Ken John Gramyk, MD, FACEP
	Councillor	Darin J Lee, MD
	Councillor	Travis Marshall, MD, FACEP
	Alternate	Heather S Hammerstedt, MD, FACEP
	Alternate	Travis Aaron Newby, DO, FACEP
ILLINOIS CHAPTER	Councillor	Amit D Arwindekar, MD, FACEP
	Councillor	Kristen M Donaldson, MD, MPH, FACEP
	Councillor	Elisabeth M Giblin, MD
	Councillor	Cai Glushak, MD, FACEP
	Councillor	Katarzyna Maria Gore, MD, FACEP

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2024 COUNCILLORS & ALTERNATE COUNCILLORS

Chapter	Role	Name
	Councillor	John W Hafner, MD, FACEP
	Councillor	Adnan Hussain, MD, FACEP
	Councillor	Jason A Kegg, MD, FACEP
	Councillor	Janet Lin, MD, FACEP
	Councillor	Monika Pitzele, MD, PhD, FACEP
	Councillor	Yanina Purim-Shem-Tov, MD, MS, FACEP, FACEP
	Councillor	Willard W Sharp, MD, FACEP
	Councillor	Deborah E Weber, MD, FACEP
	Alternate	Richard Lee Austin, Jr, MD, FACEP
	Alternate	Kelly Jester Geldmacher, MD, FACEP
	Alternate	Jolie C Holschen, MD, FACEP
	Alternate	William Weber, MD, MPH, FACEP
INDIANA CHAPTER	Councillor	Michael D Bishop, MD, FACEP
	Councillor	Sara Ann Brown, MD, FACEP
	Councillor	Timothy A Burrell, MD, MBA, FACEP
	Councillor	Kyle D English, MD, FACEP
	Councillor	Emily M Fitz, MD, FACEP
	Councillor	Eric B Yazel, MD, FACEP
	Alternate	Daniel W Elliott, MD, FACEP
	Alternate	Daniel S Udrea, MD
IOWA CHAPTER	Councillor	Ryan M Dowden, MD, FACEP
	Councillor	Rachael Sokol, DO, FACEP
	Alternate	Thomas E Benzoni, DO, FACEP
	Alternate	Nicholas Holden Kluesner, MD, FACEP
	Alternate	Cory Wittrock, MD, FACEP
KANSAS CHAPTER	Councillor	John F McMaster, MD, FACEP
	Councillor	Matthew S Sinnwell, MD, FACEP
	Alternate	Howard Chang, MD, FACEP
	Alternate	Joshua J Davis, MD
	Alternate	Trevor S Mattox, MD
	Alternate	Jeffrey G Norvell, MD, MBA, RDMS, FACEP
	Alternate	Jesse Tran, DO, FACEP
KENTUCKY CHAPTER	Councillor	Christopher W Pergrem, MD, FACEP
	Councillor	Isaac Shaw, MD, FAAEM
	Councillor	Hugh W Shoff, MD MS, FACEP
	Councillor	Beth Spurlin, MD, PhD, MBA
LOUISIANA CHAPTER	Councillor	James B Aiken, MD, FACEP
	Councillor	Jamie Kuo, MD, MHLA, FACEP
	Councillor	Phillip Luke LeBas, MD, FACEP
	Councillor	Michael D Smith, MD MBA CPE, FACEP
	Alternate	Deborah D Fletcher, MD, FACEP
	Alternate	Jordan N Vaughn , MD
MAINE CHAPTER	Councillor	Garreth C Debiegun, MD, FACEP

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2024 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Brandon E Giberson, DO, FACEP
	Councillor	James B Mullen, III, MD, FACEP
	Alternate	Nathan G Donaldson, DO, FACEP
	Alternate	Andrew Ehrhard, MD, FACEP
	Alternate	Kelly Ann Meehan-Coussee, MD, FACEP
	Alternate	Laurel Parker, MD, FACEP
	Alternate	Jessica Stevens, MD, MPH
	Alternate	Sheldon H Stevenson, DO, FACEP
MARYLAND CHAPTER	Councillor	Michael C Bond, MD, FACEP
	Councillor	Karen Dixon, MD, FACEP
	Councillor	Jonathan Lewis Hansen, MD, FACEP
	Councillor	Kathleen D Keeffe, MD, FACEP
	Councillor	Edana Denise Mann, MD, FACEP
	Councillor	Richard Gentry Wilkerson, MD, FACEP
	Alternate	Arjun S Chanmugam, MD, FACEP
MASSACHUSETTS CHAPTER	Councillor	Jamie Aron, MD
	Councillor	Amy Costigan, MD, FACEP
	Councillor	Christopher DiTullio, MD
	Councillor	Stephen K Epstein, MD, MPP, FACEP
	Councillor	Gayle Marie Galletta, MD, FACEP
	Councillor	Joseph Leary, DO
	Councillor	Matthew B Mostofi, DO, FACEP
	Councillor	Mark D Pearlmutter, MD, FACEP
	Councillor	Michele Schroeder, MD, FACEP
	Councillor	Joseph C Tennyson, MD, FACEP
	Alternate	James Blum, MD
MICHIGAN CHAPTER	Councillor	Michael J Baker, MD, FACEP
	Councillor	Abigail Brackney, MD, FACEP
	Councillor	Sara S Chakel, MD, FACEP
	Councillor	Pamela N Coffey, MD, FACEP
	Councillor	Michael W Fill, DO, FACEP
	Councillor	Gregory Gafni-Pappas, DO, FACEP
	Councillor	Michael Vincent Gratson, MD, FACEP
	Councillor	Antony P Hsu, MD, FACEP
	Councillor	Robert T Malinowski, MD, FACEP
	Councillor	Therese G Mead, DO, FACEP
	Councillor	Emily M. Mills, MD, FACEP
	Councillor	James C Mitchiner, MD, MPH, FACEP
	Councillor	Diana Nordlund, DO, JD, FACEP
	Councillor	David T Overton, MD, FACEP
	Councillor	Luke Christopher Saski, MD, FACEP
	Councillor	Jennifer B Stevenson, DO, FACEP
	Councillor	Andrew Taylor, DO, FACEP
	Councillor	Larisa May Traill, MD, FACEP
	Councillor	Bradley J Uren, MD, FACEP
	Councillor	Bradford L Walters, MD, FACEP

2024 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	Miriam A Bukhsh, MD, MPH
	Alternate	Roya Zolnoor Caloia, DO, FACEP
	Alternate	Kathleen Cowling, DO, MS, MBA, FACEP
	Alternate	Lauren Eliece English, MD
	Alternate	Jeffrey McGowan, DO, FACEP
	Alternate	Ryan J Reece, MD, FACEP
	Alternate	Matthew Edward Tanis, DO
	Alternate	Kirk Jayson Trentham, MD
	Alternate	Michael Tupper, MD, FACEP
	Alternate	Gerardine Villanueva, MD
MINNESOTA CHAPTER	Councillor	Paul C Allegra, MD, FACEP
	Councillor	Heather Ann Heaton, MD, FACEP
	Councillor	Matthew E Herold, MD, FACEP
	Councillor	Donald L Lum, MD, FACEP
	Councillor	David A Milbrandt, MD, FACEP
	Councillor	David Nestler, MD, MS, FACEP
	Councillor	Lisa M Roazen, MD, FACEP
	Councillor	Andrew R Zinkel, MD, MBA, FACEP
	Alternate	Erin R Karl, MD
MISSISSIPPI CHAPTER	Councillor	Frederick B Carlton, Jr, MD, FACEP
	Councillor	Max Keeling, DO
	Councillor	David Vearrier, MD
	Alternate	Lisa M Bundy, MD, FACEP
	Alternate	Nastassjia Debourbon, MD
	Alternate	Heather Dawn Deville, MD
	Alternate	Fred E Kency, Jr, MD, FACEP
	Alternate	Matthew W Maready, MD, FACEP
MISSOURI CHAPTER	Councillor	Douglas Mark Char, MD, FACEP
	Councillor	Jonathan Heidt, MD, MHA, FACEP
	Councillor	Leslie A Hueschen, MD, FACEP
	Councillor	Dennis E Hughes, DO, FACEP
	Councillor	Marc Mendelsohn, MD, MPH, FACEP
	Councillor	Robert Francis Poirier, Jr, MD, MBA, FACEP
	Alternate	Timothy J Koboldt, MD, FACEP
	Alternate	Christopher S Sampson, MD, FACEP
MONTANA CHAPTER	Councillor	Harry Eugene Sibold, MD, FACEP
	Alternate	Robert J McMickle, MD
NEBRASKA CHAPTER	Councillor	Renee Engler, MD, FACEP
	Councillor	Julie Query, MD
NEVADA CHAPTER	Councillor	John Dietrich Anderson, MD, FACEP
	Councillor	Sabina A Braithwaite, MD, FACEP
	Councillor	John Hardwick, MD, FACEP
	Councillor	Erin Simmers Pearson, MD, FACEP

2024 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	Gregory Alan Juhl, MD, FACEP
	Alternate	Eric Z Nielsen, MD
NEW HAMPSHIRE CHAPTER	Councillor	Kathleen J Clem, MD, FACEP
	Councillor	Scott Weston Rodi, MD, MPH
NEW JERSEY CHAPTER	Councillor	Tanisha Arora, MD, FACEP
	Councillor	Chris Bryczkowski, MD, FACEP
	Councillor	William Basil Felegi, DO, FACEP
	Councillor	Rachelle Ann Greenman, MD, FACEP
	Councillor	Patrick Blaine Hinfey, MD, FACEP
	Councillor	Marjory E Langer, MD, FACEP
	Councillor	Jessica M Maye, DO, FACEP
	Councillor	J Mark Meredith, MD, FACEP
	Councillor	Scott H Pasichow, MD, MPH, FACEP
	Councillor	Chirag N Shah, MD, FACEP
	Alternate	Barnet Eskin, MD, FACEP
	Alternate	Hina Z Ghory, MD, FACEP
	Alternate	Steven M Hochman, MD, FACEP
	Alternate	Marianna Karounos, DO, MS, FACEP
	Alternate	Marco E Propersi, DO
NEW MEXICO CHAPTER	Councillor	Scott Mueller, DO, FACEP
	Councillor	Tony B Salazar, MD, FACEP
	Councillor	Aaron Snyder, MD
NEW YORK CHAPTER	Councillor	David O Andonian, MD
	Councillor	Brahim Ardolic, MD, FACEP
	Councillor	Joseph Basile, MD, FACEP
	Councillor	Nicole Berwald, MD, FACEP
	Councillor	Kirby Black, MD, FACEP
	Councillor	Erik Blutinger, MD, MSc, FACEP
	Councillor	Robert M Bramante, MD, FACEP
	Councillor	Lauren J Curato, DO, FACEP
	Councillor	Mark Curato, DO, FACEP
	Councillor	Keith Grams, MD, FACEP
	Councillor	Sanjey Gupta, MD, FACEP
	Councillor	Abbas M Hussain, MD
	Councillor	Laura Iavicoli, MD, FACEP
	Councillor	Marc P Kanter, MD, FACEP
	Councillor	Stuart Gary Kessler, MD, FACEP
	Councillor	Elyse Katz Lavine, MD, FACEP
	Councillor	Penelope Lema, MD, FACEP
	Councillor	Sophia D Lin, MD
	Councillor	Kurien Mathews, DO MBA, FACEP
	Councillor	Laura D Melville, MD
	Councillor	Joshua B Moskovitz, MD, MBA, MPH, FACEP
	Councillor	Nestor B Nestor, MD, FACEP
	Councillor	Norman Liang Ng, DO MBA

2024 COUNCILLORS & ALTERNATE COUNCILLORS

Chapter	Role	Name
	Councillor	Blake Peterson, MD
	Councillor	Jeffrey S Rabrich, DO, FACEP
	Councillor	Livia M Santiago-Rosado, MD, FACEP
	Councillor	Shivam S Shah, MD
	Councillor	Jeffrey J Thompson, MD, FACEP
	Councillor	Asa Viccellio, MD, FACEP
	Councillor	Luis Carlos Zapata, MD, FACEP
	Alternate	Mahlaqa Butt, DO, MPH
	Alternate	Courtney Chiu, MD
	Alternate	Ugo A Ezenkwele, MD, FACEP
	Alternate	Natalie Luengo McConnell, MD
	Alternate	James Gerard Ryan, MD, FACEP
	Alternate	Vinay Saggar, MD
	Alternate	Joseph A Zito, MD
NORTH CAROLINA CHAPTER	Councillor	Melanie R Artho, MD
	Councillor	Jill Lynn Benson, MD, FACEP
	Councillor	Thomas N Bernard, III, MD, FACEP
	Councillor	Scott W Brown, MD, FACEP
	Councillor	Gregory J Cannon, MD, FACEP
	Councillor	Jennifer Casaletto, MD, FACEP
	Councillor	Thomas Lee Mason, MD, FACEP
	Councillor	Eric Evan Maur, MD, FACEP
	Councillor	Madjimbaye Charles Namde, MD
	Councillor	Bret A Nicks, MD, MHA, FACEP
	Councillor	Stephen A Small, MD, FACEP
	Alternate	Smeet R Bhimani, DO
	Alternate	Christopher Allen Griggs, MD, MPH, FACEP
	Alternate	Laura Murphy, MD
	Alternate	Michael Ruzek, DO, FACEP
NORTH DAKOTA CHAPTER	Councillor	K J Temple, MD, FACEP
	Alternate	Leah Gustafson Ista, MD, FACEP
OHIO CHAPTER	Councillor	Eileen F Baker, MD, PhD, FACEP
	Councillor	Marina N Boushra Freiberg, MD
	Councillor	Christina Campana, DO, FACEP
	Councillor	Joshua S da Silva, DO, FACEP
	Councillor	Ruben Geeraert, MD
	Councillor	Daniel R Martin, MD, MBA, FACEP
	Councillor	Jesse A Park, DO
	Councillor	John R Queen, MD, FACEP
	Councillor	Matthew J Sanders, DO, FACEP
	Councillor	Brian Scharfenberg, DO, FACEP
	Councillor	George Sontag, MD, FACEP
	Councillor	Ryan Squier, MD, FACEP
	Councillor	Joseph P Tagliaferro, III, DO, FACEP
	Councillor	K Robert Thompson, III, MD, FACEP
	Councillor	Nicole Ann Veitinger, DO, FACEP

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	Alternate	Andrew Aten, MD, FACEP
	Alternate	Elissa Marie Bailey, MD
	Alternate	Garrett Bassett, DO
	Alternate	Christopher L Burnsides, DO
	Alternate	Laura Michelle Espy-Bell, MD, FACEP
	Alternate	Thomas W Lukens, MD, PhD, FACEP
	Alternate	Anthony T Martella, MD
	Alternate	Yojan Patel, MD
	Alternate	Bradley D Raetzke, MD, FACEP
	Alternate	Kirsten Schulte, DO
	Alternate	Somy Monica Thottathil, MD, FACEP
	Alternate	Pauline Wiltz, DO
	Alternate	Andrew Yocum, MD, FACEP
OKLAHOMA CHAPTER	Councillor	Cecilia Guthrie, MD, FACEP
	Councillor	James Raymond Kennedye, MD, MPH, FACEP
	Councillor	Kurtis A Mayz, JD, MD, MBA, FACEP
OREGON CHAPTER	Councillor	Brittany N Arnold, MD, FACEP
	Councillor	Patsy Chenpanas, MD
	Councillor	Alex Kaplan, MD, FACEP
	Councillor	John C Moorhead, MD, FACEP
	Councillor	Christian Smith, MD, FACEP
	Alternate	Charles C Rudy, MD, FACEP
	Alternate	Alexander P Skog, MD, FACEP
PENNSYLVANIA CHAPTER	Councillor	Lauren Altomare, DO
	Councillor	Christine Aspiotes, DO
	Councillor	Blake C Bailey, DO, FACEP
	Councillor	Christopher L Berry, MD, FACEP
	Councillor	Monisha Bindra, DO, MPH, FACEP
	Councillor	Angela Cai, MD, MBA
	Councillor	Marcus Eubanks, MD, FACEP
	Councillor	Avram Flamm, DO, FACEP
	Councillor	Richard Hamilton, MD, MBA, FACEP
	Councillor	Brian Kelly, DO
	Councillor	George Vivek Koshy, DO
	Councillor	Zeenah Mansour, MD
	Councillor	Eric M Melnychuk, DO, FACEP
	Councillor	Meaghan L Reid, DO, FACEP
	Councillor	Jennifer L Savino, DO, FACEP
	Councillor	Holly A Stankewicz, DO, FACEP
	Councillor	Theresa Ann Walls, MD, MPH
	Councillor	Elizabeth Barrall Werley, MD, FACEP
	Alternate	Todd Fijewski, MD, FACEP
	Alternate	Ronald V Hall, MD, FACEP
	Alternate	Marilyn Joan Heine, MD, FACEP
	Alternate	Kyle Felton Hughes, MD
	Alternate	Catherine Anna Marco, MD, FACEP

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	Alternate	Hannah M Mishkin, MD, FACEP
	Alternate	Shawn M Quinn, DO, FACEP
PUERTO RICO CHAPTER	Councillor	Edwin J Garcia La Torre, MD, FACEP
	Councillor	Eddie Gabriel Rodriguez, MD, FACEP
	Alternate	Cesar I Andino-Colon, MD, FACEP
	Alternate	Daniella M Santiago-Haddock, MD, FAAEM
RHODE ISLAND CHAPTER	Councillor	Achyut B Kamat, MD, FACEP
	Councillor	Charles F Pattavina, MD, FACEP
	Councillor	Jessica Smith, MD, FACEP
SOCIETY OF ACADEMIC EMERGENCY MEDICINE	Councillor	Ali S Raja, MD, DBA, MPH, FACEP
	Alternate	Michelle Lall, MD, FACEP
SOUTH CAROLINA CHAPTER	Councillor	Matthew D Bitner, MD, FACEP
	Councillor	Allison Leigh Harvey, MD, FACEP
	Councillor	Kelly M Johnson, MD, FACEP
	Councillor	Phillip Moschella, MD
	Councillor	Andriana Slavica Saric, DO
	Alternate	Scott B Gutovitz, MD, FACEP
	Alternate	Cynthia Oliva, MD
SOUTH DAKOTA CHAPTER	Councillor	Donald Neilson, MD
	Alternate	Michael Frost, MD
TENNESSEE CHAPTER	Councillor	Stanton Elseroad, MD, MBA, FACEP
	Councillor	Sanford H Herman, MD, FACEP
	Councillor	Thomas R Mitchell, MD, FACEP
	Councillor	John H Proctor, MD, MBA, FACEP
	Councillor	Sullivan K Smith, MD, FACEP
	Alternate	Kenneth L Holbert, MD, FACEP
	Alternate	Sudave D Mendiratta, MD, FACEP
TEXAS CHAPTER	Councillor	Sara Andrabi, MD, FACEP
	Councillor	Jessica Ann Best, MD, FACEP
	Councillor	Angela Pettit Cornelius, MD, FACEP
	Councillor	Bryan M Dunn, MD, FACEP
	Councillor	Diana L Fite, MD, FACEP
	Councillor	Andrea L Green, MD, FACEP
	Councillor	Robert D Greenberg, MD, FACEP
	Councillor	Robert Hancock, Jr, DO, FACEP
	Councillor	Doug Jeffrey, MD, FACEP
	Councillor	Alexander J Kirk, MD, FACEP
	Councillor	Ira R Nemeth, MD, FACEP
	Councillor	Sterling Evan Overstreet, MD, FACEP
	Councillor	Heather S Owen, MD, FACEP
	Councillor	Anant Patel, DO, FACEP
	Councillor	Daniel Eugene Peckenpaugh, MD, FACEP

2024 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	R Lynn Rea, MD, FACEP
	Councillor	Richard Dean Robinson, MD, FACEP
	Councillor	Marcus Lynn Sims, II, DO, FACEP
	Councillor	Gerad A Troutman, MD, FACEP
	Councillor	James M Williams, DO, FACEP
	Councillor	Sandra Williams, DO, MPH, FACEP
	Alternate	Trisha Anest, MD MBA MPH, FACEP
	Alternate	Chinwe Amanda Anyanwu, DO, MPH
	Alternate	Michael R Baillio, DO
	Alternate	Yashkarn Singh Bains, MD
	Alternate	Lydia Bennett, MD
	Alternate	Brook A Danboise, MD
	Alternate	Hilary E Fairbrother, MD, FACEP
	Alternate	Joshua G Farnsworth, MD
	Alternate	Ben Leeson, MD, FACEP
	Alternate	Julien A Mahler, MD
	Alternate	Robert E Mohr, Jr, MD
	Alternate	Adaeze Stephanie Onyechi, MD
	Alternate	Jose R. Rosillo, MD, FACEP
	Alternate	Sachin Santhakumar, MD
	Alternate	Anna Suessman, DO
	Alternate	Kristopher Ryan Sutherly, MD, FACEP
	Alternate	Brianna L Wapples, MD
UTAH CHAPTER	Councillor	Jim V Antinori, MD, FACEP
	Councillor	Bennion D Buchanan, MD, FACEP
	Councillor	Alison L Smith, MD, MPH, FACEP
	Councillor	Henry T Yeates, DO, FACEP
	Alternate	Joshua Berko, DO
	Alternate	Chris Evola, MD
	Alternate	Jordan Mabey, MD
VERMONT CHAPTER	Councillor	Matthew S Siket, MD, FACEP
	Councillor	Alexandra Nicole Thran, MD, FACEP
	Alternate	Gary C Starr, MD, FACEP
VIRGINIA CHAPTER	Councillor	Darwin T Castillo, MD, MBA, FACEP
	Councillor	Caroline Hollis Cox, MD
	Councillor	Joshua Easter, MD
	Councillor	James R Humble, MD
	Councillor	Jessica Maerz, MD
	Councillor	Todd Parker, MD, FACEP
	Councillor	Jesse D Spangler, MD, FACEP
	Councillor	Theodore J Tzavaras, MD
	Councillor	Courtney Terry Zydron, MD, MBA
	Alternate	Debra G Perina, MD, FACEP
WASHINGTON CHAPTER	Councillor	Herbert C Duber, MD, MPH, FACEP
	Councillor	Joshua R Frank, MD, FACEP

2024 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Sarah M Hansen, MD
	Councillor	C Ryan Keay, MD, FACEP
	Councillor	Vasisht Srinivasan, MD, FACEP
	Councillor	Jessica J Wall, MD, MPH, MSCE, FACEP
	Councillor	Aine Yore, MD, FACEP
	Alternate	Stephen H Anderson, MD, FACEP
	Alternate	Stephen LaRue Ettinger, MD
	Alternate	Carlton E Heine, MD, PhD, FACEP
	Alternate	Kathleen Y Li, MD
	Alternate	Theodore James Mclean , MD
	Alternate	Nathaniel R Schlicher, MD, JD, MBA, FACEP
WEST VIRGINIA CHAPTER	Councillor	Adam Thomas Crawford, DO, FACEP
	Councillor	Christopher S Goode, MD, FACEP
	Alternate	David Benjamin Deuell, DO, FACEP
	Alternate	Carol Lea Wright Becker, MD, FACEP
WISCONSIN CHAPTER	Councillor	Michael L Becker, MD, FACEP
	Councillor	William D Falco, MD, MS, FACEP
	Councillor	Susan E Good, MD, FACEP
	Councillor	Lisa J Maurer, MD, FACEP
	Councillor	Jamie Schneider, MD, FACEP
WYOMING CHAPTER	Councillor	Eugene Gicheru, MD, FACEP
	Alternate	Russell Lauver, DO
AAWEP SECTION	Councillor	Peta-Gay S Nolan, MD, FACEP
	Alternate	Sydney E DeAngelis, MD, FACEP
	Alternate	Christina L Shenvi, MD, PhD, MBA, FACEP
AIR MEDICAL TRANSPORT SECTION	Councillor	Woodrow James Sams, MD
	Alternate	Jeffrey H Luk, MD, FACEP
CAREERS IN EMERGENCY MEDICINE SECTION	Councillor	Skyler E Smith, DO
	Alternate	Constance J Doyle, MD, FACEP
CRITICAL CARE MEDICINE SECTION	Councillor	Nicholas Johnson, MD, FACEP
	Alternate	Katherine Allison Pollard, MD
CRUISE SHIP MEDICINE SECTION	Councillor	Brenda K Barnetson, MD
DEMOCRATIC GROUP PRACTICE SECTION	Councillor	David G Hall, MD, FACEP
DISASTER MEDICINE SECTION	Councillor	George-Thomas M Pugh, MD
	Alternate	Kylie Hayes Klemann, MD
DIVERSITY & INCLUSION SECTION	Councillor	Karen V Douglass, MD, FACEP

	Alternate	Christopher J Scott, MD, MBA, FACEP
DUAL TRAINING SECTION	Councillor	Carissa J Tyo, MD, FACEP
EM PRACTICE MGMT AND HEALTH POLICY SECTION	Councillor	Richard Lee Austin, Jr, MD, FACEP
	Alternate	Robert M McNamara, MD
EMERGENCY MEDICAL INFORMATICS SECTION	Councillor	Tricia Smith, MD, FACEP
EMERGENCY MEDICINE LOCUM TENENS SECTION	Councillor	Joffre Johnson, MD
EMERGENCY MEDICINE WORKFORCE SECTION	Councillor	Deborah D Fletcher, MD, FACEP
EMERGENCY TELEHEALTH SECTION	Councillor	Aditi U Joshi, MD, MSc, FACEP
	Alternate	Deborah A Mulligan, MD, FACEP
EMERGENCY ULTRASOUND SECTION	Councillor	Gregg Helland, MD, FPD-AEMUS
	Alternate	Ami Kurzweil, MD
EMS-PREHOSPITAL CARE SECTION	Councillor	Matthew J Levy, DO, MSc, FACEP
	Alternate	Ryan Winchell, MD
EVENT MEDICINE SECTION	Councillor	Melissa D Kohn, MD, FACEP
	Alternate	David Eng, MD, FACEP
EXPLORING RETIREMENT SECTION	Councillor	Pamela P Bensen, MD, MS, FACEP
	Alternate	Fred Dennis, MD, MBA, FACEP
FORENSIC MEDICINE SECTION	Councillor	Jessica Elizabeth Hobbs, DO, FACEP
FREESTANDING EMEGENCY CENTERS	Councillor	William H Kranichfeld, MD
	Alternate	David C Ernst, MD, FACEP
GERIATRIC EMERGENCY MEDICINE SECTION	Councillor	Phillip David Magidson, MD, FACEP
	Alternate	Angel Li, MD
INTERNATIONAL EMERGENCY MEDICINE SECTION	Councillor	Sean Kivlehan, MD, FACEP
	Alternate	Emily Chien, MD
MEDICAL DIRECTORS SECTION	Councillor	Bruce M Lo, MD, MBA, RDMS, FACEP
	Alternate	Wesley Zeger, DO, FACEP
MEDICAL HUMANITIES SECTION	Councillor	Jay A Kaplan, MD, FACEP

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2024 COUNCILLORS & ALTERNATE COUNCILLORS

Section	Role	Name
OBSERVATION SERVICES SECTION	Councillor	Adam J Rodos, MD, FACEP
	Alternate	George B. Hughes, MD
PAIN MANAGEMENT SECTION	Councillor	Reuben J Strayer, MD, FACEP
	Alternate	Donald E Stader, III, MD, FACEP
PALLIATIVE MEDICINE SECTION	Councillor	Rebecca R Goett, MD, FACEP
PEDIATRIC EMERGENCY MEDICINE SECTION	Councillor	Paula Jo Whiteman, MD, FACEP
QUALITY IMPROVEMENT AND PATIENT SAFETY SECTION	Councillor	Robert Sands Redwood, MD, MPH, FACEP
	Alternate	Cheyenne Falat, MD
	Alternate	Collin Michels, MD
RESEARCH, SCHOLARLY ACTIVITY AND INNOVATION SECTION	Councillor	Justin B Belsky, MD MPH
	Alternate	Charles B Kemmler, MD, PhD, FACEP
RURAL EMERGENCY MEDICINE SECTION	Councillor	Benjamin Knutson, MD, FACEP
SOCIAL EMERGENCY MEDICINE SECTION	Councillor	Laura Janneck, MD, FACEP
	Alternate	Aislinn D Black, DO, FACEP
	Alternate	Kelli L Jarrell, MD, MPH
SPORTS MEDICINE SECTION	Councillor	Dustin M Harris, MD, FACEP
TACTICAL EMERGENCY MEDICINE SECTION	Councillor	Ameen Mohammad Jamali, MD, FACEP
	Alternate	David Q McArdle, MD, FACEP
	Alternate	James R Waymack, MD, FACEP
TOXICOLOGY SECTION	Councillor	Jennifer Hannum, MD, FACEP
	Alternate	Evan Schwarz, MD, FACEP
TRAUMA & INJURY PREVENTION SECTION	Councillor	Gregory Luke Larkin, MD, FACEP
UNDERSEA & HYPERBARIC MEDICINE SECTION	Councillor	Drue Orwig, DO
	Alternate	Robert W Sanders, MD, FACEP
WELLNESS SECTION	Councillor	Kristen Nordenholz, MD, FACEP
	Alternate	Susan T Haney, MD, FACEP
	Alternate	Sanjay Shewakramani, MD, FACEP
WILDERNESS MEDICINE SECTION	Councillor	Tyler J Stannard, MD
	Alternate	Sally Peterson, MD

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YOUNG PHYSICIANS SECTION	Councillor	Laurel J Barr, MD, FACEP
	Alternate	Amanda K Irish, MD, MPH, MS
	Alternate	Maggie Moran, MD
	Alternate	Sophia Spadafore, MD
	Alternate	Ashley Tarchione, MD

Councillor Handbook

Councillor Handbook

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I. COMPOSITION OF THE COUNCIL

Introduction

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

What is the Council?

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

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

What Does the Council Do?

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

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

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

II. COUNCILLOR PREPARATION

How Does a Councillor Prepare for the Annual Meeting?

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

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

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

How Does the Council Conduct its Business?

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

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

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

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

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

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

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

What is a Resolution?

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

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

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

Amendments to Resolutions

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

Late Resolutions

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

Emergency Resolutions

Resolutions submitted less than 24 hours prior to, or after the beginning of the annual Council meeting, are known as "emergency resolutions." Emergency resolutions are limited to substantive issues that could not have been considered by the Steering Committee prior to the Council meeting because of their acute nature, or resolutions of commendation that become appropriate during the course of the Council meeting.

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

What if I Have Questions About the Council?

Questions about the Council can 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. Information about the Council, including important dates regarding the annual Council meeting, are posted on the ACEP website.

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. The Candidate Forum for the president-elect candidates is held in the main Council meeting room following the Town Hall meeting. The Candidate Forum for the Council officer candidates (every other year) and Board of Directors candidates is held in each of the Reference Committee meeting rooms with the candidates rotating between rooms. Members of the Candidate Forum Subcommittee moderate each session with the candidates. Candidates answer questions and declare their views on issues facing emergency medicine. An informal reception is held for members to personally meet and speak with candidates. All councillors are encouraged to attend the Candidate Forum and the reception that follows.

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

What is the Steering Committee?

The Council officers appoint the members of the Steering Committee. The Steering Committee conducts the business of the Council between the annual meeting. 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 Council 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. Members of the Council Steering are listed here on the ACEP website.

III. COUNCIL REFERENCE COMMITTEES

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

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

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

Asynchronous Testimony

Resolutions that have been submitted by the deadline and assigned to a Reference Committee will be available for asynchronous testimony on the ACEP website not less than 30 days prior to the Council meeting. Important dates regarding the annual Council meeting are posted on the ACEP website. Asynchronous testimony is open to all members of the College.

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

1. Whether you are commenting on behalf of yourself or your component body (i.e., chapter, section, AACEM, CORD, EMRA, or SAEM).

2. Whether you are commenting in support of the resolution, opposed to the resolution, or suggesting an amendment.
3. Any additional information to support your position.

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

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

Procedures

The preliminary Reference Committee reports will be the starting point for the Reference Committee hearings that occur on the first day of the Council meeting. The testimony heard in Reference Committee hearings will be added to the asynchronous testimony to form the consent report submitted to the Council.

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

The Reference Committee hearings are held **concurrently** on the first day of the Council meeting. Written testimony may be submitted to the Reference Committee if time overlaps occur.

Proceedings

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

The chair will decide the order and/or grouping of resolutions and will post times to start each discussion. Before beginning discussion on the first resolution, the chair will ask if there is a "pressing need" for any resolutions to be taken out of order to allow individuals to provide testimony to a particular issue. **Determination of a "pressing need" will be left to the discretion of the chair**. The chair will ask if the primary author(s) of the resolution is present or if another individual is present who may speak to the intent of the resolution, and if the individual wishes to provide guidance to the committee. Reference Committees may take brief breaks if the chair determines that time is available. The Reference Committee chair is requested to designate a member of the committee to keep track of all pro and con comments pertaining to each resolution.

If an individual arrives to present testimony before or after the time the resolution was scheduled for discussion, it is at the discretion of the chair as to when that member may speak to the resolution. When presenting testimony, the individual should state their name, component body, and whether speaking in support of or against the resolution. No one should speak more than once on a resolution unless it is to clarify

a point. Prior to closing debate, the chair will ask Board members, officers, staff, and others with particular expertise for their testimony.

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

Reports

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

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

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

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

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

Examples of our common variants employing the procedure are:

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

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

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

4. The Reference Committee recommends consolidation of two or more kindred resolutions into a single resolution, or it recommends adoption of one of these items in its own right as a substitute for the rest. The matter before the Council consideration is the recommendation of the Reference Committee or the substitute or consolidate version. A motion to adopt this substitute is the main motion. If the Reference Committee's version is not adopted the entire group of proposals has been rejected but it is in order for any councillor to then propose consideration and adoption of any one of the original resolutions or reports.

IV. GUIDELINES AND DEFINITIONS OF COUNCIL ACTIONS TO ASSIST THE COUNCIL IN CONSIDERING REPORTS OF REFERENCE COMMITTEES.

Summary of Council Actions on Reference Committee Reports

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

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

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

[1] Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.
[2] Requires two-thirds vote when it would suppress a motion without debate.
[3] Restricted.
[4] Withdraw may be applied to all motions.

VI. INCIDENTAL MOTIONS

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

* Per the Council Standing Rules.

VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS

The Guidelines for Writing Resolutions are available on the ACEP website. A Resolution Preparation Checklist is also available to provide additional guidance in preparing resolutions.

Questions

Please contact Sonja Montgomery, CAE, at ACEP Headquarters, by email smontgomery@acep.org, or call 469-499-0282, for further information about preparation of resolutions.

VIII.

ACEP Parliamentary Motions Guide

Based on *Sturgis Standard Code of Parliamentary Procedure (4th Ed.)*[1]

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.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
(77) Close meeting	I move that we **adjourn**	No	Yes	No	No	Majority
(75) Take break	I move to **recess** for	No	Yes	Yes	Yes	Majority
(72) Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
(68) Lay aside temporarily	I move that the main motion be **postponed temporarily**	No	Yes	No	No	Varies
(65) Close debate and vote immediately	I move to **close debate**	No	Yes	No	No	2/3
(62) **Limit or extend debate**	I move to limit debate to ...	No	Yes	Yes	Yes	2/3
(58) **Postpone to certain time**	I move to postpone the motion until ...	No	Yes	Yes	Yes	Majority
(55) **Refer** to committee	I move to refer the motion to …	No	Yes	Yes	Yes	Majority
(47) Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
(32) Bring business before assembly (a **main motion**)	I move that …	No	Yes	Yes	Yes	Majority

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

[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.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
(82) Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Yes	No	2/3
(84) Suspend rules	I move to **suspend the rule** requiring	No	Yes	No	No	2/3
(87) Enforce rules	**Point of order**	Yes	No	No	No	None
(90) Parliamentary question	**Parliamentary inquiry**	Yes	No	No	No	None
(94) Request to **withdraw motion**	I wish to withdraw my motion	Yes	No	No	No	None
(96) **Divide motion**	I request that the motion be divided …	No	No	No	No	None
(99) Demand rising vote	I call for a **division of the assembly**	Yes	No	No	No	None

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

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
(36) **Amend a previous action**	I move to amend the motion that was …	No	Yes	Yes	Yes	Varies
(38) Reconsider motion	I move to **reconsider** ...	Yes	Yes	Yes	No	Majority
(42) Cancel previous action	I move to **rescind**...	No	Yes	Yes	No	Majority
(44) Take from table	I move to **resume consideration** of ...	No	Yes	No	No	Majority

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Council Standing Rules

Revised October 2022

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Standing Rules

Revised October 2022

Preamble

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

Alternate Councillors

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

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

Amendments to Council Standing Rules

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

Announcements

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

Appeals of Decisions from the Chair

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

Board of Directors Seating

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

Campaign Rules

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

Conflict of Interest Disclosure

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

Councillor Allocation for Sections of Membership

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

Councillor Seating

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

Credentialing and Proper Identification

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

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

Debate

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

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

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

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

Distribution of Printed or Other Material During the Annual Meeting

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

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot, which may include remote communication and voting technology. There shall be no write-in voting. Individual connectivity issues or individual disruption of remote communication technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the speaker.

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

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

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

will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

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

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

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

Electronic Devices

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

Leadership Development Advisory Committee

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

Limiting Debate

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

Nominating Committee

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committee shall consider activity and involvement in the College, the Council, and component bodies, leadership experience in other organizations or practicing institution, candidate diversity, and specific experiential needs of the organization when considering the slate of candidates.

Nominations

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

Members not nominated by the Nominating Committee may self-nominate by declaring themselves "floor candidates" at any time after the release of the Nominating Committee report and before the speaker closes nominations during the Council meeting. All floor candidates must notify the Council speaker in writing. Upon receipt of this notification, the candidate becomes a "declared floor candidate," has all the rights and responsibilities of candidates otherwise nominated by the Nominating Committee, and must comply with all rules and requirements of the candidates. All required candidate materials (including but not limited to professional photo, CV, Candidate Campaign Rules Attestation, responses to written questions, candidate data sheet, conflict of interest disclosure statement) must be available immediately at the time of floor nomination – either completed by the due date for all nominees or at the time of notification to the speaker of intent to seek nomination, whichever date is later. ***See also Election Procedures.***

Parliamentary Procedure

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

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

Past Presidents, Past Speakers, and Past Chairs of the Board Seating

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

Policy Review

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

Reference Committees

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

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

A Reference Committee may recommend that a resolution:

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

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

Reports

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

Resolutions

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

Resolutions must be submitted in writing by at least two members or by component bodies, College committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a component body. All resolution sponsors and cosponsors must be confirmed at least 45 days in advance of the Council meeting.

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

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

- ***Regular Non-Bylaws Resolutions***

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

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

- ***Bylaws Resolutions***

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

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

- ***Late Resolutions***

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

- ***Emergency Resolutions***

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

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

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate.

All resolutions assigned to a Reference Committee shall be placed on a Unanimous Consent Agenda.

The Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, amendment, substitution, or not for adoption for each resolution listed. A request for extraction of any resolution from the Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Voting Immediately

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

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, including remote communication technology, voting cards, standing, or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue. Individual connectivity issues or individual disruption of remote communication and voting technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the speaker.

BYLAWS

Revised October 2023

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws

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BYLAWS

October 2023

ARTICLE I — NAME

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

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES

Section 1 — Mission

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

Section 2 — Purposes and Objectives

The purposes and objectives of the College are:

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

ARTICLE III — COLLEGE MEETINGS

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

ARTICLE IV — MEMBERSHIP

Section 1 — Eligibility

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

Section 2 — Classes of Membership

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

Section 2.1 — Regular Members

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

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

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

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

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

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

Section 2.2 — Honorary Members

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

Section 2.3 — Candidate Members

Candidate members must meet one of the following criteria: 1) medical student or intern interested in emergency medicine; 2) physician participating in an emergency medicine residency training program; 3) physician participating in a fellowship training program immediately following an emergency medicine residency; 4) physician participating in a pediatric emergency medicine fellowship training program; or 5) physician in the uniformed services while serving as

general medical officer. General medical officers shall be eligible for candidate membership for a maximum of four years. All candidate members will be assigned by the Board of Directors to either active or inactive status.

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

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

Section 2.4 — International Members

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

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

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

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

Section 3 — Agreement

Acceptance of membership in the College shall constitute an agreement by the member to comply with the ACEP Bylaws. The Board of Directors shall serve as the sole judge of such member's right to be or to remain a member, subject to Article IV, Section 4 of these Bylaws and the due process as described in the College Manual.

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

Section 4 — Disciplinary Action

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

Section 5 — Dues, Fees, and Assessments

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

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

Section 6 — Official Publications

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

ARTICLE V — ACEP FELLOWS

Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

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

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

Section 2 — Fellow Status

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

ARTICLE VI — CHAPTERS

Section 1 — Charters

This corporation may grant charters to chapters of the College according to procedures described in the College Manual.

Section 2 — Chapter Bylaws

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

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

Section 3 — Qualifications

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

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

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

Section 4 — Component Branches

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

Section 5 — Charter Suspension – Revocation

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

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

Section 6 — Ultimate Authority by College

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

ARTICLE VII — SECTIONS

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

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

ARTICLE VIII — COUNCIL

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

Section 1 — Composition of the Council

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

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

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

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

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

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

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

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

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

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

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

Section 2 — Powers of the Council

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

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

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

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

Section 3 — Meetings

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

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

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

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

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

Section 4 — Quorum

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

Whenever the term "present" is used in these Bylaws to determine a quorum present, with respect to councillor voting, "present" is defined as either in person or participating by approved remote communication technology.

Section 5 — Voting Rights

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

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

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

Section 6 — Resolutions

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

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

Section 7 — Nominating Committee

A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members, at least one of which shall be a young physician, defined as a member under the age of 40 or within the first ten years of practice, and the president shall appoint the president-elect plus two additional Board members. A member of the College cannot concurrently accept nomination to the Board of Directors and Council Office. Nominations will also be accepted from the floor.

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.

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

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

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

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

ARTICLE IX — BOARD OF DIRECTORS

Section 1 — Authority

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

Section 2 — Composition and Election

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

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

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

Section 3 — Meetings

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

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

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

Special meetings of the Board of Directors may be called by the president or the chair of the Board with not less than 48 hours notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting.

Section 4 — Removal

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

Section 5 — Vacancy

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

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

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

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

The officers of the Board of Directors shall be president, president-elect, chair, immediate past president, vice presidents, 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-presidents, 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 Presidents

There shall be two vice president positions. The vice presidents shall be members of the Board of Directors. A director shall be eligible for election to a 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. A vice president's term of office shall begin at the conclusion of the meeting at which the election as a 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. A majority of the voting membership of a committee shall constitute a quorum.

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

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

Section 3 — Steering Committee

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

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

Section 4 — Bylaws Interpretation Committee

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

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

Section 5 — Finance Committee

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

Section 6 — Bylaws Committee

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

Section 7 — Compensation Committee

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

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

ARTICLE XII — ETHICS

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

ARTICLE XIII — AMENDMENTS

Section 1 — Submission

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

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

Section 2 — Notice

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

Section 3 — Amendment Under Initial Consideration

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

Section 4 — Contested Amendment

If an Amendment Under Initial Consideration fails to receive an affirmative vote of at least two-thirds of the members of the Board of Directors, then such proposed Bylaws amendment shall be deemed a Contested Amendment.

The positions and vote of each member of the Board regarding such Contested Amendment shall be presented to the Council's Steering Committee at the Steering Committee's first meeting following said vote of the Board of Directors. The Council's component bodies and councillors shall be notified within 30 days of the Board action. The Steering Committee shall not have the authority to amend or adopt a Contested Amendment. The speaker may call a special meeting of the Council to consider a Contested Amendment. The time and place of such meeting shall be announced no less than 40 and no more than 50 days prior to the meeting.

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

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

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

ARTICLE XIV — MISCELLANEOUS

Section 1 — Inspection of Records

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

Section 2 — Annual Report

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

Section 3 — Parliamentary Authority

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

Section 4 — College Manual

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

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

ARTICLE XV — MANDATORY INDEMNIFICATION

Section 1 — Policy of Indemnification and Advancement of Expenses

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

because the person is or was a Director, Officer, or Employee of the College and the College shall advance to such person(s) such reasonable expenses as are incurred by such person in connection therewith.

Section 2 — Definitions

For purposes of this Article XV:

1. "Director" means any person who is or was a director of the College and any person who, while a director of the College, is or was serving at the request of the College as a director, officer, partner, venturer, proprietor, trustee, employee, agent, or similar functionary of the College or of another foreign or domestic corporation, partnership, joint venture, sole proprietorship, trust, employee benefit plan or other enterprise.
2. "Officer" means any person who is or was an officer of the College and any person who, while an officer of the College, is or was serving at the request of the College as a director, officer, partner, venturer, proprietor, trustee, employee, agent, or similar functionary of the College or of another foreign or domestic corporation, partnership, joint venture, sole proprietorship, trust, employee benefit plan or other enterprise.
3. "Employee" means an individual:
    a. Selected and engaged by ACEP;
    b. To Whom wages are paid by ACEP;
    c. Whom ACEP has the power to dismiss; and
    d. Whose work conduct ACEP has the power or right to control.
4. "Proceeding" means any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, arbitrative, or investigative, any appeal in such action, suit, or proceeding, and any inquiry or investigation that could lead to such an action, suit, or proceeding.

Section 3 — Non-Exclusive; Continuation

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

Section 4 — Insurance or Other Arrangement

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

Section 5 — Exclusion of Certain Acts from Indemnification

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

COLLEGE MANUAL

Revised October 2020

College Manual

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

College Manual

Revised October 2020

I. Applications for Membership

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

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

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

A. Definitions

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

B. Complaint Received

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

1. Must be in writing and signed by the complainant;
2. Must specify in reasonable detail an alleged violation by an ACEP member of an ACEP policy as it existed at the time of the alleged violation, including ACEP Bylaws, ACEP *Code of Ethics,* other ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within ten (10) years prior to the submission of the complaint, is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired;
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating documentation must accompany the complaint. Complainant is responsible for ensuring that the documentation does not provide information that can be used to identify a particular patient, including but not limited to, the patient's name, address, social security number, patient identification number, or any identifying information related to members of the patient's family;

5. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director, any additional ACEP review body listed in these *Procedures,* and the respondent should the complaint be forwarded to the respondent; and
6. Must be submitted to the ACEP Executive Director.

C. Executive Director

1. a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.
   b. If all elements of the complaint have been met, sends a written acknowledgement to the complainant confirming complainant's intent to file a complaint. Includes a copy of ACEP's *Procedures* providing guidelines and timetables that will be followed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the *Procedures*.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the *Procedures.*
3. Notifies the ACEP President and the Chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
4. a. Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, the Bylaws Committee, or other committee designee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the *Code of Ethics* or ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or
   b. Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, or other committee designee, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics*, and if so, forwards the complaint and the response together, after both are received, to each member of the Ethics Complaint Review Panel, or
   c. Determines, in consultation with the ACEP President and the Chair of the Bylaws Committee, or other committee designee, that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, after both are received, to each member of the Bylaws Committee, or at the discretion of the Chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or
   d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, the complaint will not be considered. The Ethics Complaint Review Panel or the Bylaws Committee will review the President's action. The President's action can be overturned by a majority vote of the applicable ACEP review body.
5. Within ten (10) business days after the determination specified in Section-C.4.b. or Section C.4.c. of these *Procedures*, forwards the complaint to the respondent by USPS Certified Mail with a copy of these *Procedures* and requests a written response within thirty (30) days of receipt of the documents. The communication will indicate that ACEP is providing notice of the complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the applicable ACEP review body decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant will be included in this communication. Such notice must also include a summary of the respondent's rights in the hearing, and a list of the names of the members of the applicable ACEP review body, including the Board of Directors. The respondent will have the right to raise any issues of potential conflict or reason that any individuals should recuse themselves from the review. Such recusal shall be at the discretion of the ACEP President.

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

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

1. Reviews the written record of any complaint that alleges a violation of the ACEP *Code of Ethics* or other ACEP ethics policies as they existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Applicable version of the ACEP *Code of Ethics* or other ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP *Code of Ethics* or other ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. Ethics Complaint Review Panel renders a decision to impose disciplinary action, based on the written record.
6. If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review Panel's determination and the option of:
   a. A hearing; or
   b. The imposition of the Ethics Complaint Review Panel decision based solely on the written record.
7. If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will implement its decision to impose disciplinary action based on the written record.

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

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws as it existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Applicable version of the ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. Bylaws Committee renders a decision to impose disciplinary action, based solely on the written record.
6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee's determination and the option of:
   a. A hearing; or
   b. The imposition of the Bylaws Committee's decision based solely on the written record.
7. If the respondent chooses the option described in Section E.6.b., that is, a Bylaws Committee decision based solely on the written record, the Bylaws Committee will implement its decision to impose disciplinary action based on the written record.

F. Right of Respondent to Request a Hearing

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

G. Hearing Procedures

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by USPS Certified Mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board Hearing Panel intends to call in the hearing.
2. The Executive Director will send a notification by USPS Certified Mail of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing.
3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel or any other person of their choice. Each party will bear the expense of his or her own counsel.
5. The parties have the right to have a record made of the proceedings by transcript, audiotape, or videotape at the expense of the requesting party.
6. The hearing will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person, except in circumstances in which it is impossible or commercially impracticable for the parties and the Board Hearing Panel to hold an in-person hearing, at which time the Board Hearing Panel may choose to hold a virtual hearing.
7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.
8. The Board Hearing Panel will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the filing of any written briefs, conclude the hearing.
9. The decision of the Board Hearing Panel will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the Board Hearing Panel's decision will be sent by USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board Hearing Panel's decision and a statement of the basis for that decision.

H. Notice to the Board of Directors

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

I. Possible Disciplinary Action and Disclosure to ACEP Members

1. Nature of Disciplinary Action
   a. Censure
      i. Private Censure: a private letter of censure informs a member that his or her conduct does not conform with the College's ethical standards; it may detail the manner in which ACEP

expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. Upon written request by a member of ACEP, ACEP may confirm the censure; however, contents of the letter will not be provided.

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

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

c. Expulsion from ACEP membership shall be for a period of five (5) years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors. The expulsion announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by and shall inform ACEP members that they may request further information about the disciplinary action. ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

2. Scope and Manner of Disclosure
   a. Disclosure to ACEP Members: Any ACEP member may transmit a request for information to the Executive Director regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section I.1.
   b. Disclosure to Non-Members: If a non-member makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. No further information shall be provided.

J. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the applicable ACEP review body, at which time the decision will be available upon request by ACEP members, to the extent specified in Section I. Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the ACEP review body's overall time to complete its task.
4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.

5. If a participant in this process (such as a member of the Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic competition with the respondent, that person shall recuse himself or herself from the process except as a complaining party or respondent, at which time the ACEP President will appoint a replacement.
6. Once the Ethics Complaint Review Panel or the Bylaws Committee has made a decision on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
7. The Ethics Complaint Review Panel or the Bylaws Committee's decision to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.
8. If a respondent fails to respond to a complaint, to a notice of the right to request a hearing, or to a request for information, the Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel may make a decision on the complaint solely on the basis of the information it has received.
9. If a respondent seeks to voluntarily resign his/her ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

III. Chartering Chapters

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

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

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

IV. Charter Suspension-Revocation

Any member of the College may file written charges against any chapter with the executive director of the College. Such charges must be signed, and must specify the acts of conduct for which the complaint is made. The executive director of the College must present the charges to the Board of Directors at its next meeting. The Board of Directors will then act upon the charges and will either dismiss them or proceed as hereinafter set forth.

If the Board fails to dismiss the charges it will within 10 days thereafter cause a copy of the charges to be served upon the accused chapter by sending it by registered United States mail to the secretary or other officer of the chapter. The Board will notify the accuser at the same time and in the same manner.

A hearing will be convened not less than 15 days nor more than 90 days after service of charges. The Board will, after having given the accused and the accuser reasonable opportunity to be heard in person or by counsel and to present all evidence and proofs, conclude the hearing and within 30 days render a decision. The affirmative vote of a majority of the members of the Board present and voting will constitute the decision of the Board, which may either dismiss the charges or take such actions as it deems appropriate. In

either event the Board will make known its decision in a written resolution signed by the secretary and president. In the former event the Board will furnish the accused and the accuser with a copy of the resolution. In the latter event its resolution will be read at the next regular meeting of the Board or at a special meeting duly called for that purpose, provided that a copy of the decision will be delivered to the accused in the same manner provided for the service of charges at least 15 days before such meeting. The accused and the accusers will be given reasonable opportunity to be heard at the meeting of the Board of Directors where the decision is read. A two-thirds majority vote of the entire Board of Directors will be required to suspend or to revoke the charter.

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

V. Filling Board Vacancies Created by Other Than Removal

General Provisions

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

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

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

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

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

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

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

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

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

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

VII. Amendments

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

Council Meeting
October 7-8, 2023
Philadelphia Convention Center
Philadelphia, PA

Minutes

The 52nd annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:07 am Eastern time on Saturday, October 7, 2023, by Speaker Kelly Gray-Eurom, MD, MMM, FACEP.

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

Dr. Gray-Eurom welcomed everyone. She acknowledged the tragedy occurring in Israel and asked the Council to observe a moment of silence. She then provided a meeting dedication and led the Council in reciting the Pledge of Allegiance and singing the National Anthem.

Richard Hamilton, MD, FACEP, president of the Pennsylvania Chapter, welcomed councillors and other meeting attendees.

Douglas Char, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 374 councillors of the 427 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

Eric Joy provided an overview of the Council meeting website and explained its functionality.

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

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

The following members were credentialed by the Tellers, Credentials, & Elections Committee for seating at the 2023 Council meeting:

ASSOCIATION OF ACADEMIC CHAIRS OF EM	Theodore A Christopher, MD, FACEP
ALABAMA CHAPTER	Shea A Duerring, MD, FACEP Matt Heimann, MD, FACEP Paul Daniel Kivela, MD, MBA, FACEP Annalise Sorrentino, MD, FACEP
ALASKA CHAPTER	Nicholas Papacostas, MD, FACEP Camilla Sulak, MD, FACEP
ARIZONA CHAPTER	Olga Gokova, MD, FACEP Bradley A Dreifuss, MD, FACEP Lawrence A DeLuca, MD, FACEP Rebecca B Parker, MD, FACEP Wendy Ann Lucid, MD, FACEP Todd Brian Taylor, MD, FACEP Nicole R Hodgson, MD, FACEP

	Paul Andrew Kozak, MD, FACEP
ARKANSAS CHAPTER	J Shane Hardin, MD, PhD, FACEP Robert Thomas VanHook, MD, FACEP
CALIFORNIA CHAPTER	Rodney W Borger, MD, FACEP Michael J Bresler, MD, FACEP Fred Dennis, MD, MBA, FACEP Carrieann E Drenten, MD, FACEP Andrew N Fenton, MD, FACEP Jorge A Fernandez, MD, FACEP Andrea M Brault Fuelling, MD, FACEP Michael Gertz, MD, FACEP Douglas Everett Gibson, MD, FACEP Alicia Mikolaycik Gonzalez, MD, FACEP Jason Greenspan, MD, FACEP Vikant Gulati, MD, FACEP Puneet Gupta, MD, FACEP Omar Guzman, MD, FACEP Roneet Lev, MD, FACEP Christopher Libby, MD, MPH, FACEP Nicole E McAmis, MD Aimee K Moulin, MD, FACEP Leslie Mukau, MD, FACEP Valerie C Norton, MD, FACEP Bing S Pao, MD, FACEP Chi Lee Perlroth, MD, FACEP Kelly E Quinley, MD Vivian Reyes, MD, FACEP Carolyn Joy Sachs, MD, MPH, FACEP Susanne J Spano, MD, FACEP Katherine Laurinda Staats, MD, FACEP Thomas Jerome Sugarman, MD, FACEP Gary William Tamkin, MD, FACEP David Terca, MD, FACEP Patrick Um, MD, FACEP Lori D Winston, MD, FACEP Anna L Yap, MD Randall J Young, MD, FACEP
COLORADO CHAPTER	Ramnik S Dhaliwal, MD, JD Jasmeet Singh Dhaliwal, MD, MPH, MBA Laura Edgerley-Gibb, MD, FACEP Anna Engeln, MD, FACEP Rachelle M Klammer, MD, FACEP Rebecca L Kornas, MD, FACEP Allison Marie Trop, MD, FACEP
CONNECTICUT CHAPTER	Thomas A Brunell, MD, FACEP Daniel Freess, MD, FACEP Elizabeth Schiller, MD, FACEP Gregory L Shangold, MD, FACEP Kevin Joseph Sprague, II, MD
COUNCIL OF RESIDENCY DIRECTORS IN EM	Jason Cass Wagner, MD, FACEP
DELAWARE CHAPTER	Kathryn Groner, MD, FACEP John T Powell, MD, MHCDS, FACEP

DISTRICT OF COLUMBIA CHAPTER	Christopher T Clifford, MD Stanislaw C Haciski, MD Rita A Manfredi-Shutler, MD, FACEP
EMERGENCY MEDICINE RESIDENTS' ASSOCIATION	Michaela Skylar Banks, MD Blake Denley, MD Amanda Kay Irish, MD, MPH Erin R Karl, MD Kenneth Taeyoung Kim, MD Aaron R Kuzel, DO Jessica Adkins Murphy, MD Angela Wu, MD
FLORIDA CHAPTER	Thomas P Bentley, MD, FACEP Andrew I Bern, MD, FACEP Ricki A Brown, MD Elizabeth A Calhoun, MD Damian E Caraballo, MD, FACEP Jordan Celeste, MD, FACEP Edward A Descallar, MD, FACEP Vidor E Friedman, MD, FACEP Gabriel Gomez, DO Anton Gomez, DO Shayne M Gue, MD, FACEP Brandy Milstead Hollingsworth, MD Steven B Kailes, MD, FACEP Mike Lozano, Jr, MD, MSHI, FACEP Ryan T McKenna, DO, FACEP Ashley Norse, MD, FACEP Jeremy K Selley, DO, FACOEP Todd L Slesinger, MD, FACEP Zachary C Terwilliger, MD Stephen C Viel, MD, MBA, FACEP L Kendall Webb, MD, FACEP
GEORGIA CHAPTER	Matthew R Astin, MD, FACEP Brett H Cannon, MD JD MBA, FACEP James Joseph Dugal, MD(E), FACEP Matthew Taylor Keadey, MD, FACEP Jeffrey F Linzer, Sr, MD, FACEP DW "Chip" Pettigrew, III, MD, FACEP James L Smith, Jr, MD, FACEP Johnny L Sy, DO, FACEP Matthew J Watson, MD, FACEP
GOVERNMENT SERVICES CHAPTER	Roderick Fontenette, MD, FACEP Andrea Austin, MD, FACEP Joshua S da Silva, DO, FACEP Katrina N Landa, MD, FACEP Joshua Lesko, MD David S McClellan, MD, FACEP Torree M McGowan, MD, FACEP Katey Della Giustina Osborne, MD Paul James Diggins Roszko, MD, FACEP Justine K Stremick, MD, FACEP Sean Stuart, DO, FACEP

HAWAII CHAPTER	Alexander Berk, MD, FACEP
	Mark Baker, MD, FACEP
IDAHO CHAPTER	Ken John Gramyk, MD, FACEP
	Jonathan D Miller, MD, FACEP
ILLINOIS CHAPTER	Amit D Arwindekar, MD, FACEP
	Kristen M Donaldson, MD, MPH, FACEP
	Kelly Jester Geldmacher, MD, FACEP
	John W Hafner, MD, FACEP
	Adnan Hussain, MD, FACEP
	Jason A Kegg, MD, FACEP
	Janet Lin, MD, FACEP
	Howard K Mell, MD, MPH, CPE, FACEP
	Scott H Pasichow, MD, MPH, FACEP
	Henry Pitzele, MD, FACEP
	Yanina Purim-Shem-Tov, MD, MS, FACEP
	Willard W Sharp, MD, FACEP
	Deborah E Weber, MD, FACEP
INDIANA CHAPTER	Michael D Bishop, MD, FACEP
	Timothy A Burrell, MD, MBA, FACEP
	Daniel W Elliott, MD, FACEP
	Kyle D English, MD, FACEP
	Emily M Fitz, MD, FACEP
	Lindsay Zimmerman, MD, FACEP
IOWA CHAPTER	Ryan M Dowden, MD, FACEP
	Rachael Sokol, DO, FACEP
KANSAS CHAPTER	Howard Chang, MD, FACEP
	John F McMaster, MD, FACEP
	Jeffrey G Norvell, MD, MBA, RDMS, FACEP
KENTUCKY CHAPTER	Melissa Platt, MD, FACEP
	Hugh W Shoff, MD MS, FACEP
	Steven Joseph Stack, MD, MBA, FACEP
LOUISIANA CHAPTER	Deborah D Fletcher, MD, FACEP
	Jay A Kaplan, MD, FACEP
	Jamie Kuo, MD, MHLA
	Nicole Streiff McCoin, MD, FACEP
	Michael D Smith, MD MBA CPE, FACEP
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	James B Mullen, III, MD, FACEP
MARYLAND CHAPTER	Michael C Bond, MD, FACEP
	Arjun S Chanmugam, MD, FACEP
	Karen Dixon, MD, FACEP
	Jonathan Lewis Hansen, MD, FACEP
	Kathleen D Keeffe, MD, FACEP
	Edana Denise Mann, MD, FACEP
	Richard Gentry Wilkerson, MD, FACEP
MASSACHUSETTS CHAPTER	Brien Alfred Barnewolt, MD, FACEP
	Tanesha Beckford, MD

James Blum, MD
Amy Costigan, MD, FACEP
Stephen K Epstein, MD, MPP, FACEP
Samantha A Hay, MD
Kathleen Kerrigan, MD, FACEP
Mark D Pearlmutter, MD, FACEP
Jesse Rideout, MD, FACEP
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Michael J Baker, MD, FACEP
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Sara S Chakel, MD, FACEP
Pamela N Coffey, MD, FACEP
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Gregory Gafni-Pappas, DO, FACEP
Michael Vincent Gratson, MD, FACEP
Robert T Malinowski, MD, FACEP
Therese G Mead, DO, FACEP
Emily M. Mills, MD, FACEP
James C Mitchiner, MD, MPH, FACEP
Diana Nordlund, DO, JD, FACEP
David T Overton, MD, FACEP
Luke Christopher Saski, MD, FACEP
Jennifer B Stevenson, DO, FACEP
Andrew Taylor, DO, FACEP
Larisa May Traill, MD, FACEP
Bradley J Uren, MD, FACEP
Bradford L Walters, MD, FACEP
Mildred J Willy, MD, FACEP

MINNESOTA CHAPTER

Paul C Allegra, MD, FACEP
Heather Ann Heaton, MD, FACEP
Matthew E Herold, MD, FACEP
Benjamin Knutson, MD
Donald L Lum, MD, FACEP
David Nestler, MD, MS, FACEP
Lisa M Roazen, MD, FACEP
Thomas E Wyatt, MD, FACEP

MISSISSIPPI CHAPTER

Lisa M Bundy, MD, FACEP
Nastassjia Debourbon, MD
Fred E Kency, Jr, MD, FACEP

MISSOURI CHAPTER

Brian John Bausano, MD, MBA, FACEP
Jonathan Heidt, MD, MHA, FACEP
Dennis E Hughes, DO, FACEP
Louis D Jamtgaard, MD, FACEP
Timothy J Koboldt, MD, FACEP
Marc Mendelsohn, MD, MPH, FACEP
Robert Francis Poirier, Jr, MD, MBA, FACEP

MONTANA CHAPTER

Robert J McMickle, MD

NEBRASKA CHAPTER

Renee Engler, MD, FACEP
Julie Query, MD

NEVADA CHAPTER

Jacob Mark Altholz, MD
Sabina A Braithwaite, MD, FACEP

	Gregory Alan Juhl, MD, FACEP Erin Simmers Pearson, MD, FACEP
NEW HAMPSHIRE CHAPTER	Sarah Garlan Johansen, MD, FACEP
NEW JERSEY CHAPTER	Jenice Baker, MD, FACEP Kimberly T Baldino, MD, FACEP William Basil Felegi, DO, FACEP Rachelle Ann Greenman, MD, FACEP Patrick Blaine Hinfey, MD, FACEP Steven M Hochman, MD, FACEP Marjory E Langer, MD, FACEP Jessica M Maye, DO, FACEP J Mark Meredith, MD, FACEP Michael Ruzek, DO, FACEP
NEW MEXICO CHAPTER	Emily S Bartlett, MD Scott Mueller, DO, FACEP Christopher L Swyers, DO
NEW YORK CHAPTER	David O Andonian, MD Brahim Ardolic, MD, FACEP Joseph Basile, MD, FACEP Nicole Berwald, MD, FACEP Kirby Black, MD, FACEP Robert M Bramante, MD, FACEP Courtney Chiu, MD Joan Wang Chou, MD Arlene Chung, MD, FACEP Lauren J Curato, DO, FACEP Mark Curato, DO, FACEP Brenna M Farmer, MD, FACEP Keith Grams, MD, FACEP Laura Iavicoli, MD, FACEP Marc P Kanter, MD, FACEP Stuart Gary Kessler, MD, FACEP Elyse Katz Lavine, MD, FACEP Penelope Lema, MD, FACEP Sophia D Lin, MD Kurien Mathews, DO MBA, FACEP Laura D Melville, MD Nestor B Nestor, MD, FACEP Norman Liang Ng, DO MBA Paula Rajendra Patel, MD Jeffrey S Rabrich, DO, FACEP Livia M Santiago-Rosado, MD, FACEP Manish Sharma, DO, MBA, FACEP Virgil W Smaltz, MD, FACEP Jeffrey J Thompson, MD, FACEP Luis Carlos Zapata, MD, FACEP
NORTH CAROLINA CHAPTER	Jill Lynn Benson, MD, FACEP Thomas N Bernard, III, MD, FACEP Scott W Brown, MD, FACEP Gregory J Cannon, MD, FACEP Jennifer Casaletto, MD, FACEP Thomas Lee Mason, MD, FACEP Eric Evan Maur, MD, FACEP

	Abhishek Mehrotra, MD, MBA, FACEP Madjimbaye Charles Namde, MD Bret A Nicks, MD, MHA, FACEP Stephen A Small, MD, FACEP
NORTH DAKOTA CHAPTER	K J Temple, MD, FACEP
OHIO CHAPTER	Eileen F Baker, MD, PhD, FACEP Christina Campana, DO, FACEP B Bryan Graham, DO, FACEP Thomas W Lukens, MD, PhD, FACEP Daniel R Martin, MD, MBA, FACEP Michael McCrea, MD, FACEP John R Queen, MD, FACEP Amy B Raubenolt, MD, FACEP Matthew J Sanders, DO, FACEP Brian Scharfenberg, DO, FACEP George Sontag, MD, FACEP Ryan Squier, MD, FACEP Joseph P Tagliaferro, III, DO, FACEP Nicole Ann Veitinger, DO, FACEP Pauline Wiltz, DO
OKLAHOMA CHAPTER	Cecilia Guthrie, MD, FACEP James Raymond Kennedye, MD, MPH, FACEP Kurtis A Mayz, JD, MD, MBA, FACEP
OREGON CHAPTER	Brittany N Arnold, MD, FACEP Patsy Chenpanas, MD John C Moorhead, MD, FACEP Charles C Rudy, MD Alexander P Skog, MD, FACEP
PENNSYLVANIA CHAPTER	Blake C Bailey, DO, FACEP Christopher L Berry, MD, FACEP Monisha Bindra, DO, MPH, FACEP Avram Flamm, DO, FACEP Richard Hamilton, MD, FACEP Kyle Felton Hughes, MD Annahieta Kalantari, DO, MEd, FACEP Chadd K Kraus, DO, DrPH, CPE, FACEP Catherine Anna Marco, MD, FACEP Eric M Melnychuk, DO, FACEP Hannah M Mishkin, MD, FACEP Danielle Nesbit, DO Meaghan L Reid, DO, FACEP Jennifer L Savino, DO, FACEP Kristyn J Smith, DO Holly A Stankewicz, DO, FACEP Theresa Ann Walls, MD, MPH Elizabeth Barrall Werley, MD, FACEP
PUERTO RICO CHAPTER	Jorge G Arroyo Roldan, MD Julio J Velez Rivera, MD
RHODE ISLAND CHAPTER	Nadine T Himelfarb, MD, FACEP Achyut B Kamat, MD, FACEP Jessica Smith, MD, FACEP

SOCIETY FOR ACADEMIC EMERGENCY MEDICINE	Wendy Claire Coates, MD, FACEP
SOUTH CAROLINA CHAPTER	Ryan M Barnes, DO Matthew D Bitner, MD, FACEP Allison Leigh Harvey, MD, FACEP Kelly M Johnson, MD, FACEP Charles B Kemmler, MD, PhD Phillip Moschella, MD
TENNESSEE CHAPTER	Stanton Elseroad, MD, FACEP Sanford H Herman, MD, FACEP Sudave D Mendiratta, MD, FACEP John H Proctor, MD, MBA, FACEP Sullivan K Smith, MD, FACEP
TEXAS CHAPTER	Sara Andrabi, MD, FACEP Jessica Ann Best, MD, FACEP Angela Pettit Cornelius, MD, FACEP Carrie de Moor, MD, FACEP Bryan M Dunn, MD, FACEP Hilary E Fairbrother, MD, FACEP Diana L Fite, MD, FACEP Andrea L Green, MD, FACEP Robert D Greenberg, MD, FACEP Robert Hancock, Jr, DO, FACEP Doug Jeffrey, MD, FACEP Alexander J Kirk, MD, FACEP Heather S Owen, MD, FACEP Anant Patel, DO, FACEP Daniel Eugene Peckenpaugh, MD, FACEP R Lynn Rea, MD, FACEP Marcus Lynn Sims, II, DO, FACEP Theresa Tran, MD, FACEP Gerad A Troutman, MD, FACEP James M Williams, DO, FACEP Sandra Williams, DO, MPH, FACEP
UTAH CHAPTER	Jim V Antinori, MD, FACEP Ellie Gilbertson, MD Brendan Harry Milliner, MD Alison L Smith, MD, MPH, FACEP
VERMONT CHAPTER	Matthew S Siket, MD, FACEP Alexandra Nicole Thran, MD, FACEP
VIRGINIA CHAPTER	Trisha Anest, MD MBA MPH, FACEP Darwin T Castillo, MD, MBA, FACEP Caroline Hollis Cox, MD James R Humble, MD Jessica Maerz, MD Todd Parker, MD, FACEP Jesse D Spangler, MD, FACEP Theodore J Tzavaras, MD Courtney Terry Zydron, MD, MBA
WASHINGTON CHAPTER	Herbert C Duber, MD, MPH, FACEP Joshua R Frank, MD, FACEP Carlton E Heine, MD, PhD, FACEP

	Kevin E Hodges, MD, FACEP C Ryan Keay, MD, FACEP Nathaniel R Schlicher, MD, JD, MBA, FACEP Vasisht Srinivasan, MD, FACEP Jessica J Wall, MD, MPH, MSCE, FACEP
WEST VIRGINIA CHAPTER	Adam Thomas Crawford, DO, FACEP David Benjamin Deuell, DO, FACEP Carol Lea Wright Becker, MD, FACEP
WISCONSIN CHAPTER	Michael L Becker, MD, FACEP Bradley Burmeister, MD, FACEP William D Falco, MD, MS, FACEP Susan E Good, MD, FACEP Jamie Schneider, MD Brian Sharp, MD, FACEP
WYOMING CHAPTER	Eugene Gicheru, MD, FACEP
AAWEP SECTION	Peta-Gay S Nolan, MD, FACEP
AIR MEDICAL TRANSPORT SECTION	Robert Eduard Suter, DO, MHA, FACEP
CAREERS IN EMERGENCY MEDICINE SECTION	Constance J Doyle, MD, FACEP
CRITICAL CARE MEDICINE SECTION	Nicholas Johnson, MD, FACEP
CRUISE SHIP MEDICINE SECTION	Brenda K Barnetson, MD
DEMOCRATIC GROUP PRACTICE SECTION	David G Hall, MD, FACEP
DISASTER MEDICINE SECTION	Douglas Mark Char, MD, FACEP
DIVERSITY & INCLUSION SECTION	Ugo A Ezenkwele, MD, FACEP
DUAL TRAINING SECTION	Carissa J Tyo, MD, FACEP
EM PRACTICE MGMT & HEALTH POLICY SECTION	Richard Lee Austin, Jr, MD, FACEP
EMERGENCY MEDICAL INFORMATICS SECTION	Tricia Smith, MD, FACEP
EMERGENCY MEDICINE WORKFORCE SECTION	Harry W Severance, MD, FACEP
EMERGENCY TELEHEALTH SECTION	Aditi U Joshi, MD, MSc, FACEP
EMERGENCY ULTRASOUND SECTION	Laura Oh, MD, FACEP
EMS-PREHOSPITAL CARE SECTION	Harry Eugene Sibold, MD, FACEP
EVENT MEDICINE SECTION	Melissa D Kohn, MD, FACEP
FORENSIC MEDICINE SECTION	Monika Pitzele, MD, PhD, FACEP
FREESTANDING EMEGENCY CENTERS SECTION	William H Kranichfeld, MD
GERIATRIC EMERGENCY MEDICINE SECTION	Phillip David Magidson, MD, FACEP
INTERNATIONAL EMERGENCY MEDICINE SECTION	Sean Kivlehan, MD, FACEP

MEDICAL DIRECTORS SECTION	Thomas F Spiegel, MD, MBA, MS, FACEP
MEDICAL HUMANITIES SECTION	Rachel H. Kowalsky, MD
OBSERVATION SERVICES SECTION	Sharon E Mace, MD FAAP, FACEP
PAIN MANAGEMENT SECTION	Donald E Stader, III, MD, FACEP
PALLIATIVE MEDICINE SECTION	Justin K Brooten, MD
PEDIATRIC EMERGENCY MEDICINE SECTION	Jason T Lowe, DO
QUALITY IMPROVEMENT & PATIENT SAFETY SECTION	Robert Sands Redwood, MD, MPH, FACEP
RESEARCH, SCHOLARLY ACTIVITY, & INNOVATION SECTION	Justin B Belsky, MD MPH
RURAL EMERGENCY MEDICINE SECTION	Frederick B Carlton, Jr, MD, FACEP
SOCIAL EMERGENCY MEDICINE SECTION	Laura Janneck, MD, FACEP
SPORTS MEDICINE SECTION	Katie Dolbec, MD, FACEP
TACTICAL EMERGENCY MEDICINE SECTION	James R Waymack, MD, FACEP
TOXICOLOGY SECTION	Jennifer Hannum, MD, FACEP
TRAUMA & INJURY PREVENTION SECTION	Gregory Luke Larkin, MD, FACEP
WELLNESS SECTION	Kristen Nordenholz, MD, FACEP
WILDERNESS MEDICINE SECTION	Sally Peterson, MD
YOUNG PHYSICIANS SECTION	Karina Sanchez, 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

Larry A. Bedard, MD, FACEP (CA)
Brooks F. Bock, MD, FACEP (CO)
Michael L. Carius, MD, FACEP (CT)
Angela F. Gardner, MD, FACEP (TX)
Michael J. Gerardi, MD, FACEP (NJ)
Nicholas J. Jouriles, MD, FACEP (OH)
Linda L. Lawrence, MD, CPE, FACEP (GS)
Alexander M. Rosenau, DO, FACEP (PA)
Andrew Sama, MD, FACEP (NY)
Robert W. Schafermeyer, MD, FACEP(NC)
Sandra M. Schneider, MD, FACEP (TX)
Richard L. Stennes, MD, FACEP (CA)

Past Speakers

Peter Fahrney, MD (VA)
Peter J. Jacoby, MD, FACEP (CT)

Past Chairs of the Board

Stephen H. Anderson, MD, FACEP (WA)
Ramon W. Johnson, MD, FACEP (CA)
John D. Bibb, MD, FACEP (CA)
David P. Sklar, MD, FACEP (NM)
Jon Mark Hirshon, MD, PhD, FACEP (MD)

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

Council Standing Rules

Preamble

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

Alternate Councillors

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

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

Amendments to Council Standing Rules

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

Announcements

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

Appeals of Decisions from the Chair

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

Board of Directors Seating

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

Campaign Rules

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

Conflict of Interest Disclosure

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

Councillor Allocation for Sections of Membership

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

Councillor Seating

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

Credentialing and Proper Identification

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

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

Debate

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

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

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

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

Distribution of Printed or Other Material During the Annual Meeting

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

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot, which may include remote communication and voting technology. There shall be no write-in voting. Individual connectivity issues or individual disruption of remote communication technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the speaker.

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

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

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

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

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

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

Electronic Devices

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

Leadership Development Advisory Committee

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

Limiting Debate

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

Nominating Committee

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committee shall consider activity and involvement in the College, the Council, and component bodies, leadership experience in other organizations or practicing institution, candidate diversity, and specific experiential needs of the organization when considering the slate of candidates.

Nominations

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

Members not nominated by the Nominating Committee may self-nominate by declaring themselves "floor candidates" at any time after the release of the Nominating Committee report and before the speaker closes nominations during the Council meeting. All floor candidates must notify the Council speaker in writing. Upon receipt of this notification, the candidate becomes a "declared floor candidate," has all the rights and responsibilities of candidates otherwise nominated by the Nominating Committee, and must comply with all rules and requirements of the candidates. All required candidate materials (including but not limited to professional photo, CV, Candidate Campaign Rules Attestation, responses to written questions, candidate data sheet, conflict of interest disclosure statement) must be available immediately at the time of floor nomination – either completed by the due date for all nominees or at the time of notification to the speaker of intent to seek nomination, whichever date is later. ***See also Election Procedures.***

Parliamentary Procedure

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

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

Past Presidents, Past Speakers, and Past Chairs of the Board Seating

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

Policy Review

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

Reference Committees

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

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

A Reference Committee may recommend that a resolution:

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

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

Reports

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

Resolutions

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

Resolutions must be submitted in writing by at least two members or by component bodies, College committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a component body. All resolution sponsors and cosponsors must be confirmed at least 45 days in advance of the Council meeting.

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

Background information, including financial analysis, will be prepared by staff on all resolutions 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.

All resolutions assigned to a Reference Committee shall be placed on a Unanimous Consent Agenda.

The Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, amendment, substitution, or not for adoption for each resolution listed. A request for extraction of any resolution from the Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Voting Immediately

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

for and against, must be presented before the motion to "vote immediately" will be considered in order. ***See also Debate and Limiting Debate.***

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, including remote communication technology, voting cards, standing, or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue. Individual connectivity issues or individual disruption of remote communication and voting technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the speaker.

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The councillors reviewed and accepted the minutes of the September 29-30, 2022, Council meeting and approved the actions of the Steering Committee taken at their January 31, 2023, and April 30, 2023, meetings.

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

Dr. Gray-Eurom called for submission of emergency resolutions. None were submitted.

The Michigan College of Emergency Physicians requested to withdraw Resolution 41. There were no objections and the resolution was withdrawn.

Dr. Gray-Eurom reported that seven late resolutions were received and reviewed by the Steering Committee. One commendation and four memorial resolutions were accepted by the Steering Committee. Commendations and memorial resolutions are not assigned to a Reference Committee for testimony. Two late resolutions were accepted for submission to the Council. "ACEP Financial Decision Transparency" and "Cooperation Between National ACEP and State Chapters" were numbered 61 and 62 and assigned to Reference Committee A.

Dr. Gray-Eurom presented the Nominating Committee report.

Dr. Costello was the only nominee for Speaker of the Council. Dr. Gray-Eurom called for floor nominations. There were no floor nominees. The nominations were then closed. A vote was then conducted and Dr. Costello was elected as the 2023-25 speaker of the Council.

Three members were nominated for Council Vice Speaker: Kurtis A. Mayz, MD, JD, FACEP; Michael J. McCrea, MD, FACEP; and Larisa M. Traill, MD, FACEP. Dr. Gray-Eurom called for floor nominations. There were no floor nominees. The nominations were then closed.

Six members were nominated for four positions on the Board of Directors: William B. Felegi, DO, FACEP;

Robert Hancock, DO, FACEP; Chadd K. Kraus, DO, DrPH, FACEP; Abhi Mehrotra, MD, MBA, FACEP; Henry Z. Pitzele, MD, FACEP; and James L. Shoemaker, Jr., MD, FACEP. Dr. Gray-Eurom called for floor nominations. There were no nominees. The nominations were then closed.

Three members were nominated for President-Elect: Jeffrey M. Goodloe, MD, FACEP; Alison J. Haddock, MD, FACEP, and Ryan A. Stanton, MD, FACEP. Dr. Gray-Eurom called for floor nominations. There were no floor nominees. The nominations were then closed.

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

The Council recessed at 9:45 am for the Reference Committee hearings. The resolutions considered by the 2023 Council appear below as submitted.

2023 Council Resolutions

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians commends Patrick Elmes, EMT-P, for his outstanding service and commitment to the College and the specialty of emergency medicine.

RESOLUTION 2

RESOLVED, That the American College of Emergency Physicians commends Kelly Gray-Eurom, MD, MMM, FACEP, for her service as Council Speaker, Council Vice Speaker, and for her enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

RESOLUTION 3

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the contributions of Russell H. Harris, MD, FACEP, to the advancement of emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians commends Russell H. Harris, MD, FACEP for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

RESOLUTION 4

RESOLVED, That the American College of Emergency Physicians commends Rick Murray, EMT-P, FAEMS, for his outstanding service and commitment to the College, the specialty of emergency medicine, and the subspecialty of emergency medical services.

RESOLUTION 5

RESOLVED, That the American College of Emergency Physicians commends Gillian R. Schmitz, MD, FACEP, for her outstanding service, leadership, and commitment to the specialty of emergency medicine and to the patients and communities we serve.

RESOLUTION 6

RESOLVED, That the American College of Emergency Physicians commends and thanks JoAnne Tarantelli for her outstanding career and decades of dedicated service, leadership, commitment to the College, the emergency physicians of New York, the specialty of emergency medicine, and the patients that we serve.

RESOLUTION 7

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the contributions of a trailblazing pioneer, visionary leader, invaluable mentor, and outstanding emergency physician, J. Clifford "Cliff" Findeiss, MD, and his selfless contributions to emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians extends condolences and appreciation to his wife Jean; his four sisters Marcia, Joan, Pat, and Michele; as well as his four children and his granddaughter in whom his legacy lives on: Dr. Laura Findeiss, Craig Findeiss, Amanda (Findeiss) Rosillo, Allison Findeiss, granddaughter Elizabeth (Lily) Rosillo; and to his family, friends, and colleagues for his remarkable service to the specialty of emergency medicine, patient care, and the communities he served.

RESOLUTION 8

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments of Scott A. Hall, MD, and offer our heartfelt condolence to his wife, daughter, and the entire Hall family.

RESOLUTION 9

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to the family of Gene W. Kallsen, MD, gratitude for his tremendous service to emergency medicine.

RESOLUTION 10

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

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Jacklyn, his sons Dr. Steve Kleinman and David Kleinman, gratitude for his tremendous service as an emergency physician at the WellSpan York Hospital, as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 11

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians hereby expresses their enduring appreciation to Gloria J. Kuhn, DO, PhD, as a champion for emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extends to the family of Gloria J. Kuhn, DO, PhD, her colleagues, and former residents, our condolences along with our profound gratitude for her lifetime of service to the specialty of emergency medicine, Michigan emergency physicians, and patients, who will never fully know her impact, across the United States of America and likely beyond.

RESOLUTION 12

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Richard M. Nowak, MD, MBA, FACEP, to the specialty of emergency medicine as a clinician, educator, researcher, scholar, and leader; and be it further

RESOLVED, That the College extends condolences to his wife, Deborah, and children, Michael and Kathryn, and he will forever endure in the minds of all who had the great opportunity to interact with him.

RESOLUTION 13

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to her daughter Karyn Trainor and son William Trainor and his partner Patrice Pineda, her brothers David Wallace and Doug Wallace, and sisters Carolyn Wallace Dee and Melanie Wallace, and the many others she impacted, gratitude for her tremendous service to emergency medicine.

RESOLUTION 14

RESOLVED, That the American College of Emergency Physicians, the California Chapter, and the Wellness and Wilderness Medicine Sections hereby acknowledge the many contributions made by Lori Weichenthal, 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 and the California Chapter extends to her family gratitude for her tremendous service to emergency medicine.

RESOLUTION 15

RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 1 – Officers, Section 2 – Election of Officers, and Section 7 – Vice President, and Article XI – Committees, Section 2 – Executive Committee, be revised to read:

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**s**, 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**s**, 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 7 — Vice Presidents

There shall be two vice president positions. The vice president**s** shall be ~~a~~ member**s** of the Board of Directors. A director shall be eligible for election to ~~the~~ **a** 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~~ **A** vice president's term of office shall begin at the conclusion of the meeting at which the election as **a** 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.

ARTICLE XI – COMMITTEES

Section 2 — Executive Committee

The Board of Directors shall have an Executive Committee, consisting of the president, president-elect, vice president**s**, 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.

RESOLUTION 16

RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 4 – Quorum, of the ACEP Bylaws be amended to read:

Article VIII - COUNCIL

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.

Whenever the term "present" is used in these Bylaws to determine a quorum present, with respect to councillor voting, "present" is defined as either in person or participating by approved remote communication technology.

RESOLUTION 17

RESOLVED, That the ACEP Bylaws be amended to read:

ARTICLE VIII — COUNCIL

Section 8 — Board of Directors Action on Resolutions (paragraph 3)

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

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

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~~ **speaker-elect**. 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~~ **speaker-elect** elected every other year by a majority vote of the councillors present and voting at the annual meeting.

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~~ **speaker-elect** 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 4.4 — Council Officers

In the event of a vacancy in the office of ~~vice speaker~~ **speaker-elect**, the Steering Committee shall nominate and elect an individual who meets the eligibility requirements of these Bylaws to serve as ~~vice speaker~~ **speaker-elect.** 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~~ **speaker-elect** will serve until the next meeting of the Council when the Council shall elect a ~~vice speaker~~ **speaker-elect** to serve the remainder of the unexpired term.

In the event of a vacancy in the office of speaker, the ~~vice speaker~~ **speaker-elect** shall succeed to the office of speaker for the remainder of the unexpired term, and an interim ~~vice speaker~~ **speaker-elect** shall then be elected as described above. **Any time remaining in the unexpired term of the previous speaker will not abbreviate the term that the new speaker would have originally served prior to the occurrence of the vacancy.**

In the event that the offices of both speaker and ~~vice speaker~~ **speaker-elect** become vacant, the Steering Committee shall elect a speaker, **as outlined in paragraph one of Section 4.4**, to serve until the election of a new speaker and ~~vice speaker~~ **speaker-elect** at the next meeting of the Council. **This individual, having served as speaker following election by the Steering Committee, shall be eligible for nomination to serve the full terms of speaker or speaker-elect, provided that all other candidate eligibility criteria are met.**

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~~ **speaker-elect** ~~is elected~~ **shall succeed** to the office of speaker**. Any time remaining in the unexpired term of the previous speaker will not abbreviate the term that the new speaker would have originally served prior to the removal.**

In the event of removal of the speaker-elect, ~~the office of vice speaker~~ **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** ~~shall then be filled by majority vote at that same~~

~~meeting~~ , ~~from nominees from the floor of the Council~~. **The new speaker-elect will succeed to the office of speaker at the end of the unexpired term.**

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~~ **speaker-elect** 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 **of a new speaker-elect has** 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 **except in fulfillment of a partial unexpired term.**

Section 12 — ~~Vice Speaker~~ **Speaker-Elect**

The term of office of the ~~vice speaker~~ **speaker-elect** of the Council shall be two years. The ~~vice speaker~~ **speaker-elect** shall attend meetings of the Board of Directors and may address any matter under discussion. The ~~vice speaker~~ **speaker-elect** 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~~ **speaker-elect** 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~~ **speaker-elect** is ineligible to accept nomination to the Board of Directors of the College. No ~~vice speaker~~ **speaker-elect** may serve consecutive terms.

RESOLUTION 18

RESOLVED, That ACEP create two separate "Refer to Board" options: "Refer to Board for Decision" and "Refer to Board for Report" then return the resolution back to the Council for final decision.

RESOLUTION 19

RESOLVED, For transparency as part of the vendor contract, vendors recruiting emergency physicians for employment be required to bring sample contracts for physicians to review during Scientific Assembly exhibits and the sample contracts must include stipulations relating to non-compete clauses, due process, and policies on transparency in billing/collections.

RESOLUTION 20

RESOLVED, That ACEP establish a formal emergency medicine research mentorship program that promptly identifies and creates collaborative ACEP-staffed networks based on academic topics including, but not limited to, patient-centered social issues, racial and gender-identity concerns, rural and non-academic research mentorship networks; and be it further

RESOLVED, That ACEP's emergency medicine research mentorship program not be limited to either virtually only or in-person only; and be it further

RESOLVED, That ACEP develop multiple emergency medicine research mentorship models with support by ACEP staff with an ACEP.org-based and aligned online structure; and be it further

RESOLVED, That ACEP's emergency medicine research mentorship resources include, but are not limited to, constructive surveys and ACEP-staff curated anonymized feedback with an ongoing mentor development track replete with recognition of contributions and standardized mentorship training opportunities.

RESOLUTION 21

RESOLVED, That ACEP support emergency medicine resident physicians' right of first refusal over non-physicians, such as physician assistants and nurse practitioners, in performing ACGME-required procedures that are deemed medically necessary in emergency medicine.

RESOLUTION 22

RESOLVED, That ACEP recognizes the value of choice in emergency medicine residency training formats and supports the continued accreditation of both three-year and four-year emergency medicine residency programs.

RESOLUTION 23

RESOLVED, That ACEP advocate for regulatory agencies and other entities, as appropriate, to closely monitor, discourage, and oppose sale-leaseback transactions involving health systems, ensuring transparency, accountability, and consideration of the long-term impact on patient care and health care infrastructure.

RESOLUTION 24

RESOLVED That ACEP advocate for changes in product packaging so as not to resemble non-cannabis containing products, i.e., candy commonly marketed towards children; and be it further

RESOLVED, That ACEP appeal to regulatory bodies and public health agencies for labeling regulations to reduce the likelihood of accidental ingestion by young children and clearly communicate dosing information as well as the potential risks to children associated with cannabis products.

RESOLUTION 25

RESOLVED, That ACEP support allowing patients access to medical cannabis; and be it further

RESOLVED, That ACEP endorse and support the passage of Ryan's Law across the entire United States; and be it further

RESOLVED, That ACEP endorse, support, and assist ACEP chapters in the passage of Ryan's Law legislation in their states.

RESOLUTION 26

RESOLVED, That ACEP endorse and support the decriminalization of the personal possession and use of small amounts of all illicit drugs in the United States; and be it further

RESOLVED, That ACEP endorse and support ACEP chapters to develop and introduce state legislation that decriminalizes the personal possession and use of small amounts of all illicit drugs.

RESOLUTION 27

RESOLVED, That ACEP work with state and federal agencies to create state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems and to report their activities publicly; and be it further

RESOLVED, That ACEP advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not available at the referring hospital, even when capacity is limited at the tertiary center; and be it further

RESOLVED, That ACEP advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined as patient catchment areas rather than jurisdictional boundaries; and be it further

RESOLVED, That ACEP support research to strengthen the evidence base regarding rural hospital transfer processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes and experience and include investigation of common challenges experienced by all small, non-networked hospitals; and be it further

RESOLVED, That ACEP create a task force to examine current models and existing research yielding detailed recommendations for ACEP advocacy efforts regarding interhospital transfer challenges for rural EDs and the task force should:

- Examine existing and theoretical transfer models to identify best practices, including coordination of transfers across state borders.
- Enumerate and endorse effective mechanisms to facilitate tertiary care hospitals' acceptance of patients in transfer with time-sensitive conditions who are initially treated at EDs without needed services.
- Identify key capacity measures for public reporting of hospital capacity limitations, and propose mechanisms to create and sustain appropriate state/regional dashboards.

RESOLUTION 28

RESOLVED, That ACEP work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA; and be it further

RESOLVED, That ACEP support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

RESOLUTION 29

RESOLVED, That ACEP advocate for federal support to decrease ED boarding of pediatric mental health patients; and be it further

RESOLVED, That ACEP advocate for tiered reimbursement for pediatric mental health admissions and a standard payment for boarding of children for whom there is no other medical necessity for hospital care.

RESOLUTION 30

RESOLVED, That ACEP advocate for increased funding for EMS services to address the inadequacies in reimbursement rates for EMS services and advocate for increased funding for EMS services recognizing the importance of fair and adequate reimbursements to ensure the provision of high-quality emergency medical care for patients and the sustainability of EMS services and be it further

RESOLVED, That ACEP advocate for a premium rate for EMS reimbursement in rural areas; and be it further

RESOLVED, That ACEP advocate for EMS reimbursement rates for services and mileage to increase in line with Medicare rates based on changes to the CPI, ensuring that EMS agencies can keep pace with the increased cost of providing these vital services to our communities; and be it further

RESOLVED, That ACEP advocate for reimbursement of EMS based on the value of the care provided; and be it further

RESOLVED, That ACEP actively advocate for reimbursement models for EMS that allow for "treatment-in-place" health care delivery.

RESOLUTION 31

RESOLVED, That ACEP advocate and commit resources for the elimination of discrimination against individuals with treated mental health conditions in insurance policies; and be it further

RESOLVED, That ACEP work with other organizations to promote equitable access to insurance for all emergency physicians, regardless of their mental health status.

RESOLUTION 32

RESOLVED, That ACEP lobby at the federal level and provide assistance to chapters for state lobbying efforts, for the enactment of legislation and/or regulations requiring health insurers to waive "network" rules and considerations for their insured patients during times at which a Declaration of Emergency has been declared and placed in force by a state governor or by the President of the United States, whether that state of emergency is the result of a natural disaster, an act of war, a pandemic, or other causative forces; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association for consideration by its House of Delegates at its upcoming Interim Meeting, asking the AMA to join ACEP in the seeking of legislative or regulatory change designed to compel health insurers to waive "network" considerations during times at which a Declaration of Emergency has been declared and placed in force by a state governor or by the President of the United States, whether that state of emergency is the result of a natural disaster, an act of war, a pandemic, or other causative forces.

RESOLUTION 33

RESOLVED, That ACEP support a ban on the sale, transfer, importation, and possession of weapons intended for military or law enforcement use, including semi-automatic rifles and handguns, that are designed to rapidly fire multiple rounds; and be it further

RESOLVED, That ACEP encourage policymakers at the local, state, and federal levels to enact comprehensive legislation that addresses the ban on weapons intended for military or law enforcement use while respecting the rights of responsible gun owners; and be it further

RESOLVED, That ACEP advocate for evidence-based measures, including the ban on weapons intended for military or law enforcement use, to prevent and reduce gun-related injuries and fatalities through public education, research, and collaboration with relevant stakeholders; and be it further

RESOLVED, That ACEP urge members to engage in discussions with their patients, communities, and lawmakers to promote policies and initiatives aimed at reducing the availability and potential harm caused by weapons intended for military or law enforcement use, while recognizing the importance of mental health services and violence prevention programs in comprehensive strategies for reducing gun violence.

RESOLUTION 34

RESOLVED, That ACEP develop a white paper on the examination of weapons intended for military or law

enforcement use to inform evidence-based policies, interventions, and public health strategies to address the risks and consequences associated with these firearms and seek collaboration among experts in emergency medicine, public health, and other stakeholders as appropriate to ensure a multidisciplinary approach in the development of the white paper; and be it further

RESOLVED, That the ACEP white paper on the examination of weapons intended for military or law enforcement use include, but not be limited to, the following components:

1. A comprehensive review of existing literature, studies, and research on the medical and public health impact of weapons intended for military or law enforcement use, including injury patterns, morbidity, mortality, and the unique challenges they present to emergency medical response and care.
2. Examination of the specific characteristics and features of weapons intended for military or law enforcement use that contribute to increased lethality and potential for mass casualties.
3. Assessment of the societal impact and psychological consequences associated with the use of weapons intended for military or law enforcement use in mass shootings and other acts of violence.
4. Evaluation of existing policies, legislative measures, and firearm regulations pertaining to weapons intended for military or law enforcement use at the federal and state levels and analysis of their effectiveness in preventing and mitigating firearm-related injuries and fatalities.
5. Consideration of potential interventions, strategies, and evidence-based approaches to reduce the risks and impact of weapons intended for military or law enforcement use on public health and safety, including but not limited to, firearm safety education, mental health services, and law enforcement initiatives; and be it further

RESOLVED, That ACEP seek funding, partnerships, and collaboration with relevant stakeholders, organizations, and governmental bodies to support the development of the white paper on the examination of weapons intended for military or law enforcement use; and be it further

RESOLVED, That upon completion of a white paper on the examination of weapons intended for military or law enforcement use, ACEP will disseminate it to members, policymakers, public health officials, medical organizations, and other interested parties to promote awareness, education, and evidence-based decision-making on the topic of weapons intended for military or law enforcement use; and be it further

RESOLVED, That ACEP actively engage in advocacy efforts to promote evidence-based policies aimed at reducing the risks and impact of weapons intended for military or law enforcement use on public health and safety.

RESOLUTION 35

RESOLVED, That ACEP declare firearm violence to be a public health crisis in the United States.

RESOLUTION 36

RESOLVED, That ACEP advocate for a mandatory federal waiting period prior to firearm purchases; and be it further

RESOLVED, That ACEP assist state chapters in promoting legislation on mandatory waiting periods at the state level; and be it further

RESOLVED, That ACEP add language to its "Firearm Safety and Injury Prevention" policy statement supporting mandatory waiting periods prior to firearm purchases.

RESOLUTION 37

RESOLVED, That ACEP support efforts to improve firearm safety in the United States, including smart gun technology, while respecting responsible firearm ownership; and be it further

RESOLVED, That ACEP promote child-protective firearm safety and storage systems.

RESOLUTION 38

RESOLVED, That ACEP advocate for sufficient reimbursement for emergency physician services in critical access hospitals and rural emergency hospitals to ensure the availability of board certified emergency physicians who possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient safety, and supporting the sustainability of health care services in rural communities.

RESOLUTION 39

RESOLVED, That ACEP advocate at the federal level and support chapters in advocating at the state level for Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association to advocate for

reimbursing emergency physicians at rates equivalent to or above Medicare rates.

RESOLUTION 40

RESOLVED, That ACEP advocate for and support the development of policies that will allow for appropriate reimbursement for high value geriatric emergency department care processes that have been shown to improve both health system focused and patient centered outcomes.

RESOLUTION 41 *(This resolution was withdrawn.)*

RESOLVED, That ACEP advocate for Centers for Medicare and Medicaid Services (CMS) to require that Independent Dispute Resolution Entities use experienced medical billing coders to determine the appropriate billing code in arbitration cases under the No Surprises Act involving disagreements between the code submitted by the physician and the code allowed by the patient's health plan.

RESOLUTION 42

RESOLVED, That ACEP work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments; and be it further

RESOLVED, That ACEP continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

RESOLUTION 43

RESOLVED, That ACEP adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

RESOLUTION 44

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is medication management safe, effective, and patient-centered compared to expectant management?; and be it further

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is procedural management safe, effective, and patient-centered compared to expectant management.

RESOLUTION 45

RESOLVED, That ACEP, ABEM, CORD and other relevant stakeholders, form a task force to determine the best approaches for preparing emergency medicine trainees for the management of early pregnancy loss, including prescribing medication management (utilizing ACOG best practice approaches), and to provide or support provision of manual uterine aspiration procedural management, such that future emergency physicians will be able respond to early pregnancy loss emergencies in care settings where immediate obstetrical services may not be available; and be it further

RESOLVED, That ACEP recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and be it further

RESOLVED, That ACEP develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

RESOLUTION 46

RESOLVED, That ACEP endorse the American College of Obstetricians & Gynecologists Committee Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist; and be it further

RESOLVED, That ACEP issue a publicly available policy statement: "Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and the fetus. In states with legislation that punishes women for substance abuse during pregnancy, ACEP advocates for the retraction of such policies."

RESOLUTION 47

RESOLVED, That ACEP clarify its position in writing, that the 2009 white paper is inaccurate and outdated,

and that while the ACEP Board of Directors had previously approved the 2009 White Paper Report on Excited Delirium, it has withdrawn such approval; and be it further

RESOLVED, That ACEP and its sections either remove or update content and/or literature on its website that relies on the outdated information regarding "excited delirium" or conditions with a similar definition as that described in the 2009 White Paper Report on Excited Delirium; and be it further

RESOLVED, That ACEP disseminate their position that they no longer endorse or approve the 2009 White Paper on Excited Delirium among the wider medical and public health community, law enforcement organizations, and ACEP members acting as expert witnesses testifying in relevant civil or criminal litigation; and be it further

RESOLVED, That future ACEP work on the evaluation and management of in-hospital and out-of-hospital behavioral emergencies should utilize not only experts in emergency medical services, neurology, emergency psychiatry, and health equity, but must also consider the perspectives of community and advocacy leaders.

RESOLUTION 48

RESOLVED, That ACEP recommend an affidavit of merit must be from a doctor who is board certified and licensed in the same specialty.

RESOLUTION 49

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department prior to completion of care may not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, and all indicated consults; and be it further

RESOLVED, That ACEP create a document acknowledging that physicians and hospitals/systems share a joint responsibility to notify patients who have left prior to the completion of care regarding testing requiring intervention that results after their departure and develop reasonable systems to help communicate these results; and be it further

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department prior to completion of care may not have all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.

RESOLUTION 50

RESOLVED, That ACEP develop practices and policies to prevent the publishing, transmitting, and releasing of unblinded metric-related information about individual emergency physician performance to safeguard the welfare of our membership.

RESOLUTION 51

RESOLVED, That ACEP advocate for alignment with current policy and previous recommendations that patient satisfaction surveys be extended to all categories of emergency department patients for true validity; and be it further

RESOLVED, That ACEP oppose reimbursement metrics and employment decisions correlated with or dependent on patient satisfaction surveys until external validity can be established and their effect on patient outcomes is known; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to study the correlation (or lack of) between following Merit-based Incentive Payment System (MIPS) quality measures and patient satisfaction.

RESOLUTION 52

RESOLVED, That ACEP report back to the 2024 Council meeting with a strategy for expanding and transforming acute care delivery in the community setting.

RESOLUTION 53

RESOLVED, That ACEP enact policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient; and be it further

RESOLVED, That ACEP amend its "Code of Ethics for Emergency Physicians" policy statement to state that it is unethical for an emergency physician, who has not personally evaluated the patient, to coerce a treating emergency physician, to transfer a patient when the treating physician believes the patient is unstable for transfer and that a transfer may compromise a patient's safety; and be it further

RESOLVED, That ACEP amend its "Code of Ethics for Emergency Physicians" policy statement to state that it is unethical for an emergency physician, who has not personally evaluated the patient, to threaten a financial penalty for further treating the patient claiming treatment constitutes "post-stabilization care" when the treating emergency

physician believes a transfer or discontinuation of care may compromise a patient's safety.

RESOLUTION 54

RESOLVED, That ACEP engage with The Joint Commission to oppose credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

RESOLUTION 55

RESOLVED, That ACEP convene a working group to evaluate supporting fair compensation for required training, including accurate estimates of the time to completion, time to completion is fairly compensated, and in employed physician compensation models, the appropriate time is protected to allow for training without requiring completion during off hours; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations to reduce unnecessary or redundant annual or onboarding training for physician employment.

RESOLUTION 56

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of William A. Nice, MD, to emergency medicine and extends the College's condolences to his family and his life-long medical group partners.

RESOLUTION 57

RESOLVED, That the American College of Emergency Physicians commends Raymond Logan Fowler, MD, FACEP, FAEMS, for his outstanding service and commitment to the College, the specialty of emergency medicine, the subspecialty of EMS medicine, and his patients.

RESOLUTION 58

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Bradley Middleton, MD, whose short career touched many lives; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife Liz, their daughters Penelope (3) and Mae (2), and son Vander (2 months), as well as the extended Middleton and West families, gratitude for his tremendous service to emergency medicine.

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

RESOLVED, That the American College of Emergency Physicians remembers with honor and appreciation the accomplishments and contributions of a gifted emergency physician, Ann Harwood-Nuss, MD, and extends condolences and gratitude to her husband, Robert C. Nuss, MD; her step-daughters Jennifer Nuss, and Robin Gefin; her brothers George, John, David, and Donald Harwood; family; friends; and colleagues for her remarkable service to the specialty of emergency medicine, patient care, and the communities she served so well.

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

RESOLVED, That the American College of Emergency Physicians honors and commends Frank S. Pettyjohn, MD, who dedicated his life to emergency medicine and was critical in its inception, and offers our sincerest condolences to his beloved family, both at home and in the emergency department.

RESOLUTION 61 *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP suspend passing on credit processing fees pending an open comment period from member chapters; and be it further

RESOLVED, That ACEP provide a substantial notice period to chapters and/or sections before passing on costs to allow for budgeting; and be it further

RESOLVED, That ACEP allow for transparency to the membership on fees and how dues are utilized for chapters and sections by making this information available to members and reported by the treasurer to the Council.

RESOLUTION 62 *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP staff revise the membership payment process to allow members to voluntarily pay for any credit card fees that are permitted to be passed on to the member and then require each state chapter to pay for any fees not paid.

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

Resolutions 15-26 and 61 and 62 were assigned to Reference Committee A. Scott H. Pasichow, MD, MPH, FACEP, chaired Reference Committee A and other members were: William D. Falco, MD, FACEP; Gregory Gafni-Pappas, DO, FACEP; Catherine A. Marco, MD, FACEP; Laura Oh, MD, FACEP; Stephen C. Viel, MD, FACEP; Maude Surprenant Hancock, CAE; and Laura Lang, JD.

Resolutions 27-42 were assigned to Reference Committee B. Diana Nordlund, DO, JD, FACEP, chaired Reference Committee B and other members were: Lisa M. Bundy, MD, FACEP; Puneet Gupta, MD, FACEP; Joshua S. da Silva, DO, FACEP; Torree M. McGowan, MD, FACEP; Michael Ruzek, DO, FACEP; Erin Grossmann; and Ryan McBride, MPP.

Resolutions 43-55 were assigned to Reference Committee C. Dan Freess, MD, FACEP, chaired Reference Committee C and other members were: Angela P. Cornelius, MD, FACEP; Joshua R. Frank, MD, FACEP; Patrick Hinfey, MD, FACEP; Jeffrey F. Linzer, Sr., MD, FACEP; Jennifer L. Savino, DO, FACEP; Jonathan Fisher, MD, FACEP; and Travis Schulz, MLS, AHIP.

At 12:45 pm a Town Hall Meeting was convened. The topic was "What's AI Got to Do With IT? The Future of Health Care Automation. Todd B. Taylor, MD, FACEP, served as the moderator and the discussants were Michael Gillam, MD, FACEP, and Christopher Alban, MD.

The Candidate Forum for the president-elect candidates began at 2:20 pm with the president-elect candidates in the main Council meeting room. The Candidate Forum for the Vice Speaker candidates and the Board of Directors candidates began at 3:00 pm with candidates rotating through each of the Reference Committee meeting rooms.

At 4:45 pm Dr. Gray-Eurom addressed the Council and then reviewed the procedure for the adoption of the 2023 memorial resolutions. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. Gray-Eurom then read the resolveds of the memorial resolutions for J. Clifford "Cliff" Findeiss, MD; Scott A. Hall, MD; Ann L. Harwood-Nuss, MD; Gene W. Kallsen, MD; Michael Kleinman, DO; Gloria J. Kuhn, DO, PhD; Bradley Middleton, MD; William A. Nice, MD; Richard M. Nowak, MD, MBA, FACEP; Frank S. Pettyjohn, MD; Barbara W. Trainor; and Lori Weichenthal, MD, FACEP. The Council honored the memory of those who passed away since the last Council meeting and adopted the memorial resolutions by observing a moment of silence.

Jessica Adkins Murphy, MD, president of the Emergency Medicine Residents' Association, addressed the Council.

Ramon Johnson, MD, FACEP, president of the American Board of Emergency Medicine, addressed the Council.

Dr. Shoemaker presented the secretary-treasurer's report.

Dr. Kang addressed the Council. He reflected on the past year as ACEP president and highlighted the successes of the College.

The Council recessed at 6:19 pm for the candidate reception and reconvened at 8:08 am on Sunday, October 8, 2023.

Dr. Char reported that 417 councillors of the 427 eligible for seating had been credentialed.

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

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

Dr. Gray-Eurom reviewed the procedure for submitting resolution amendments electronically.

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

REFERENCE COMMITTEE A

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 16, Resolution 22, and Resolution 24.

For adoption as amended or substituted: Amended Resolution 15, Amended Resolution 19, Substitute Resolution 20, Substitute Resolution 21, and Amended Resolution 61.

Not for adoption: Resolution 17, Resolution, 18, Resolution 25, and Resolution 26.

For referral to the Board of Directors: Resolution 23 and Resolution 62.

Substitute Resolution 21, Resolution 26, and Resolution 62 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 15.

RESOLVED, THAT THE ACEP BYLAWS ARTICLE X – OFFICERS/EXECUTIVE DIRECTOR, SECTION 1 – OFFICERS, SECTION 2 – ELECTION OF OFFICERS, AND SECTION 7 – VICE PRESIDENT, AND ARTICLE XI – COMMITTEES, SECTION 2 – EXECUTIVE COMMITTEE, BE REVISED TO READ:

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**S**, 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**S**, 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 7 – VICE PRESIDENT**S**

THERE SHALL BE TWO VICE PRESIDENT POSITIONS. THE~~-~~VICE PRESIDENT**S** SHALL BE ~~A~~ MEMBER**S** OF THE BOARD OF DIRECTORS. A DIRECTOR SHALL BE ELIGIBLE FOR ELECTION TO ~~THE~~ **A** 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~~ **A** VICE PRESIDENT'S TERM OF OFFICE SHALL BEGIN AT THE CONCLUSION OF THE MEETING AT WHICH THE ELECTION AS **A** 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.

ARTICLE XI – COMMITTEES

SECTION 2 – EXECUTIVE COMMITTEE

THE BOARD OF DIRECTORS SHALL HAVE AN EXECUTIVE COMMITTEE, CONSISTING OF THE PRESIDENT, PRESIDENT-ELECT, VICE PRESIDENT**S**, 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.**; AND BE IT FURTHER**

RESOLVED, THAT THE ADDITIONAL VICE PRESIDENT POSITION ON THE ACEP BOARD OF DIRECTORS BE IMPLEMENTED IN A BUDGET NEUTRAL MANNER.

AMENDED RESOLUTION 19

RESOLVED, FOR TRANSPARENCY AS PART OF THE VENDOR CONTRACT, VENDORS RECRUITING EMERGENCY PHYSICIANS FOR EMPLOYMENT BE ~~REQUIRED~~ **ENCOURAGED** TO BRING ~~SAMPLE~~ **A CURRENT** CONTRACT~~S~~ FOR PHYSICIANS TO REVIEW DURING SCIENTIFIC ASSEMBLY EXHIBITS AND THE SAMPLE CONTRACTS MUST INCLUDE STIPULATIONS RELATING TO NON-COMPETE CLAUSES, DUE PROCESS, AND POLICIES ON TRANSPARENCY IN BILLING/COLLECTIONS.

SUBSTITUTE RESOLUTION 20

~~RESOLVED THAT ACEP ESTABLISH A FORMAL EMERGENCY MEDICINE RESEARCH MENTORSHIP PROGRAM THAT PROMPTLY IDENTIFIES AND CREATES COLLABORATIVE ACEP-STAFFED NETWORKS BASED ON ACADEMIC TOPICS INCLUDING, BUT NOT LIMITED TO, PATIENT-CENTERED SOCIAL ISSUES, RACIAL AND GENDER-IDENTITY CONCERNS, RURAL AND NON-ACADEMIC RESEARCH MENTORSHIP NETWORKS; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP'S EMERGENCY MEDICINE RESEARCH MENTORSHIP PROGRAM NOT BE LIMITED TO EITHER VIRTUALLY ONLY OR IN-PERSON ONLY; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP DEVELOP MULTIPLE EMERGENCY MEDICINE RESEARCH MENTORSHIP MODELS WITH SUPPORT BY ACEP STAFF WITH AN ACEP.ORG-BASED AND ALIGNED ONLINE STRUCTURE; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP'S EMERGENCY MEDICINE RESEARCH MENTORSHIP RESOURCES INCLUDE, BUT ARE NOT LIMITED TO, CONSTRUCTIVE SURVEYS AND ACEP-STAFF CURATED ANONYMIZED FEEDBACK WITH AN ONGOING MENTOR DEVELOPMENT TRACK REPLETE WITH RECOGNITION OF CONTRIBUTIONS AND STANDARDIZED MENTORSHIP TRAINING OPPORTUNITIES~~

RESOLVED, THAT ACEP FOSTER COLLABORATIONS WITH SOCIETY FOR ACADEMIC EMERGENCY MEDICINE, COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE, AND EMERGENCY MEDICINE FOUNDATION, AND OTHER STAKEHOLDERS TO SUPPORT ROBUST RESEARCH MENTORSHIP OPPORTUNITIES.

AMENDED RESOLUTION 61

RESOLVED, THAT ACEP SUSPEND PASSING ON CREDIT PROCESSING FEES PENDING AN OPEN COMMENT PERIOD FROM MEMBER CHAPTERS; AND BE IT FURTHER

RESOLVED, THAT ACEP PROVIDE A SUBSTANTIAL NOTICE PERIOD TO CHAPTERS AND/OR SECTIONS BEFORE PASSING ON COSTS TO ALLOW FOR BUDGETING; AND BE IT FURTHER

~~RESOLVED, THAT ACEP ALLOW FOR TRANSPARENCY TO THE MEMBERSHIP ON FEES AND HOW DUES ARE UTILIZED FOR CHAPTERS AND SECTIONS BY MAKING THIS INFORMATION AVAILABLE TO MEMBERS AND REPORTED BY THE TREASURER TO THE COUNCIL.~~

RESOLVED, THAT ACEP EVALUATE MECHANISMS FOR IMPROVED COMMUNICATION BETWEEN ACEP AND CHAPTER LEADERS AND REPRESENTATIVES TO INCREASE TRANSPARENCY TO THE MEMBERSHIP REGARDING DUES RELATED FEES.

The committee recommended that Substitute Resolution 21 be adopted.

It was moved THAT SUBSTITUTE RESOLUTION 21 BE ADOPTED:

~~RESOLVED, THAT ACEP SUPPORT EMERGENCY MEDICINE RESIDENT PHYSICIANS' RIGHT OF FIRST REFUSAL OVER NON-PHYSICIANS, SUCH AS PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS, IN PERFORMING ACGME-REQUIRED PROCEDURES THAT ARE DEEMED MEDICALLY NECESSARY IN EMERGENCY MEDICINE.~~
RESOLVED, THAT ACEP SUPPORT RESIDENTS' PROCEDURAL EDUCATION AND EXPERIENCE, AND THAT THE PRESENCE OF OTHER LEARNERS AND HEALTH CARE PERSONNEL MUST NOT NEGATIVELY IMPACT THE RESIDENTS' EDUCATION AND EXPERIENCE

It was moved THAT SUBSTITUTE RESOLUTION 21 BE AMENDED BY SUBSTITUTION OF THE ORIGINAL RESOLUTION. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 26 not be adopted.

It was moved THAT RESOLUTION 26 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 62 be referred to the Board of Directors.

It was moved THAT RESOLUTION 62 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

REFERENCE COMMITTEE C

Dr. Freess 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 43 and Resolution 54.

For adoption as amended or substituted: Amended Resolution 44, Amended Resolution 45, Substitute Resolution 46 with the amended title ~~Consensus with ACOG~~ **Policy Statement** on the Care of Pregnant Individuals with Substance Use Disorder, Amended Resolution 47, Amended Resolution 48, Amended Resolution 49, Amended Resolution 50, Amended Resolution 51 with the amended title Quality Measures and Patient ~~Satisfaction~~ **Experience** Scores, Amended Resolution 53, and Amended Resolution 55.

Not for adoption: Resolution 52.

Amended Resolution 44, Amended Resolution 45, Amended Resolution 47, Amended Resolution 48, Amended Resolution 49, and Amended Resolution 50 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 46

RESOLVED, THAT ACEP CREATE A POLICY STATEMENT ON THE CARE OF PREGNANT INDIVIDUALS WITH SUBSTANCE USE DISORDER, BASED UPON THE CONCEPTS OF THE "AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS COMMITTEE OPINION ON THE SUBSTANCE ABUSE REPORTING AND PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST."
~~RESOLVED, THAT ACEP ENDORSE THE AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS COMMITTEE OPINION ON THE SUBSTANCE ABUSE REPORTING AND PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP ISSUE A PUBLICLY AVAILABLE POLICY STATEMENT: "DRUG ENFORCEMENT POLICIES THAT DETER WOMEN FROM SEEKING PRENATAL CARE ARE CONTRARY TO THE WELFARE OF THE MOTHER AND THE FETUS. IN STATES WITH LEGISLATION THAT PUNISHES WOMEN FOR SUBSTANCE ABUSE DURING PREGNANCY, ACEP ADVOCATES FOR THE RETRACTION OF SUCH POLICIES."~~

AMENDED RESOLUTION 51

RESOLVED, THAT ACEP ADVOCATE FOR ALIGNMENT WITH CURRENT **ACEP** POLICY AND PREVIOUS RECOMMENDATIONS THAT PATIENT ~~SATISFACTION~~ **EXPERIENCE** SURVEYS BE EXTENDED TO ALL **APPROPRIATE** CATEGORIES OF EMERGENCY DEPARTMENT PATIENTS ~~FOR TRUE~~ **TO ATTEMPT TO IMPROVE** VALIDITY; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSE REIMBURSEMENT METRICS AND EMPLOYMENT DECISIONS CORRELATED WITH OR DEPENDENT ON PATIENT ~~SATISFACTION~~ **EXPERIENCE** SURVEYS ~~UNTIL EXTERNAL VALIDITY CAN BE ESTABLISHED AND THEIR EFFECT ON PATIENT OUTCOMES IS KNOWN~~; AND BE IT FURTHER

~~RESOLVED, THAT ACEP WORK WITH APPROPRIATE STAKEHOLDERS TO STUDY THE CORRELATION (OR LACK OF) BETWEEN FOLLOWING MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) QUALITY MEASURES AND PATIENT SATISFACTION; AND BE IT FURTHER~~

RESOLVED, THAT ACEP WORK WITH RELEVANT STAKEHOLDERS TO DECREASE OR ELIMINATE THE ROLE OF PATIENT EXPERIENCE SURVEYS IN REIMBURSEMENT DECISIONS.

AMENDED RESOLUTION 53

RESOLVED, THAT ACEP ENACT POLICY THAT THE TREATING EMERGENCY PHYSICIAN AT THE PATIENT'S BEDSIDE IS BEST QUALIFIED TO DETERMINE A PATIENT'S STABILITY FOR TRANSFER AND THEIR DECISION SHOULD NOT BE OVERRULED BY A PHYSICIAN OR A NON-PHYSICIAN PRACTITIONER WHO HAS NOT PERSONALLY EVALUATED THE PATIENT; AND BE IT FURTHER

~~RESOLVED, THAT ACEP AMEND ITS "CODE OF ETHICS FOR EMERGENCY PHYSICIANS" POLICY STATEMENT TO STATE THAT IT IS UNETHICAL FOR AN EMERGENCY PHYSICIAN, WHO HAS NOT PERSONALLY EVALUATED THE PATIENT, TO COERCE A TREATING EMERGENCY PHYSICIAN, TO TRANSFER A PATIENT WHEN THE TREATING PHYSICIAN BELIEVES THE PATIENT IS UNSTABLE FOR TRANSFER AND THAT A TRANSFER MAY COMPROMISE A PATIENT'S SAFETY; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP AMEND ITS "CODE OF ETHICS FOR EMERGENCY PHYSICIANS" POLICY STATEMENT TO STATE THAT IT IS UNETHICAL FOR AN EMERGENCY PHYSICIAN, WHO HAS NOT PERSONALLY EVALUATED THE PATIENT, TO THREATEN A FINANCIAL PENALTY FOR FURTHER TREATING THE PATIENT CLAIMING TREATMENT CONSTITUTES "POST-STABILIZATION CARE" WHEN THE TREATING EMERGENCY PHYSICIAN BELIEVES A TRANSFER OR DISCONTINUATION OF CARE MAY COMPROMISE A PATIENT'S SAFETY.~~

RESOLVED, THAT ACEP DEVELOP AN ADDITIONAL POLICY STATEMENT THAT SPEAKS TO THE IMPLICATIONS OF COERCION OR THREATS OF FINANCIAL PENALTIES TO THE EMERGENCY PHYSICIAN WHO HAS NOT PERSONALLY EVALUATED THE PATIENT TO COERCE OR THREATEN FINANCIAL PENALTIES TO FORCE THE TREATING EMERGENCY PHYSICIAN TO TRANSFER A PATIENT WHEN THE TREATING PHYSICIAN BELIEVES THAT THE PATIENT IS UNSTABLE AND SUCH A TRANSFER MAY COMPROMISE PATIENT SAFETY.

AMENDED RESOLUTION 55

RESOLVED, THAT ACEP CONVENE A WORKING GROUP TO EVALUATE FAIR **MARKET** COMPENSATION FOR REQUIRED TRAINING, ~~INCLUDING~~ ACCURATE ESTIMATES OF THE TIME TO COMPLETION, **AND** APPROPRIATE PROTECTED TIME ~~TO ALLOW~~ **ALLOWANCES** FOR TRAINING WITHOUT REQUIRING COMPLETION DURING OFF HOURS; AND BE IT FURTHER

RESOLVED, THAT ACEP EXPLORE OPPORTUNITIES TO PARTNER WITH OTHER LIKE-MINDED ORGANIZATIONS TO REDUCE UNNECESSARY OR REDUNDANT ANNUAL OR ONBOARDING TRAINING FOR PHYSICIAN EMPLOYMENT.

The committee recommended that Amended Resolution 44 be adopted.

It was moved THAT AMENDED RESOLUTION 44 BE ADOPTED:

RESOLVED, THAT THE BOARD OF DIRECTORS DIRECT THE CLINICAL POLICIES COMMITTEE TO ISSUE A RECOMMENDATION ON THE FOLLOWING CLINICAL QUESTION: FOR PATIENTS EXPERIENCING EARLY PREGNANCY LOSS, IS MEDICATION MANAGEMENT INITIATED **IN THE EMERGENCY DEPARTMENT BY AN EMERGENCY PHYSICIAN** SAFE~~,~~ **AND** EFFECTIVE~~, AND PATIENT-CENTERED~~ COMPARED TO EXPECTANT MANAGEMENT?; AND BE IT FURTHER

RESOLVED, THAT THE BOARD OF DIRECTORS DIRECT THE CLINICAL POLICIES COMMITTEE TO ISSUE A RECOMMENDATION ON THE FOLLOWING CLINICAL QUESTION: FOR PATIENTS EXPERIENCING EARLY PREGNANCY LOSS, IS PROCEDURAL MANAGEMENT **IN THE EMERGENCY DEPARTMENT BY AN EMERGENCY PHYSICIAN** SAFE~~,~~ **AND** EFFECTIVE~~, AND PATIENT-CENTERED~~ COMPARED TO EXPECTANT MANAGEMENT?

It was moved THAT DISCUSSION OF AMENDED RESOLUTION 44 BE TABLED UNTIL AFTER DISCUSSION OF AMENDED RESOLUTION 45. There was no objection to the motion.

The committee recommended that Amended Resolution 45 be adopted.

It was moved THAT AMENDED RESOLUTION 45 BE ADOPTED:

RESOLVED, THAT ACEP~~, ABEM, CORD~~ ~~AND~~ **WORK** WITH OTHER RELEVANT STAKEHOLDERS~~, TO FORM A TASK FORCE~~ TO DETERMINE THE BEST APPROACHES FOR PREPARING EMERGENCY MEDICINE TRAINEES ~~FOR~~ **IN** THE MANAGEMENT OF EARLY PREGNANCY LOSS~~,~~**.** ~~INCLUDING PRESCRIBING MEDICATION MANAGEMENT (UTILIZING ACOG BEST PRACTICE APPROACHES), AND TO PROVIDE OR SUPPORT PROVISION OF MANUAL UTERINE ASPIRATION PROCEDURAL MANAGEMENT, SUCH THAT FUTURE EMERGENCY PHYSICIANS WILL BE ABLE RESPOND TO EARLY PREGNANCY LOSS EMERGENCIES IN CARE SETTINGS WHERE IMMEDIATE OBSTETRICAL SERVICES MAY NOT BE AVAILABLE~~; AND BE IT FURTHER

RESOLVED, THAT ACEP RECOGNIZE THE IMPORTANCE OF THE EMERGENCY PHYSICIAN'S ROLE IN STABILIZING AND TREATING PATIENTS EXPERIENCING EARLY PREGNANCY LOSS, INCLUSIVE OF THE POTENTIAL FOR MEDICATION AND PROCEDURAL MANAGEMENT, ESPECIALLY IN LOW-RESOURCE SETTINGS, HOSPITALS WITHOUT LABOR AND DELIVERY, OR WHERE THERE ARE NO OBSTETRICAL SERVICES AVAILABLE; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT ACKNOWLEDGING THE EMERGENCY PHYSICIAN'S ROLE IN THE MANAGEMENT OF EMERGENCY MEDICINE PATIENTS PRESENTING WITH EARLY PREGNANCY LOSS AND ENCOURAGE AND SUPPORT PHYSICIANS WORKING IN LOW-RESOURCE SETTINGS, HOSPITALS WITHOUT LABOR AND DELIVERY, OR WHERE THERE ARE INSUFFICIENT OBSTETRICAL SERVICES AVAILABLE TO FURTHER THEIR EDUCATION ON FIRST-TRIMESTER MISCARRIAGE MANAGEMENT.

The motion was adopted.

The Council continued discussion of Amended Resolution 44.

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

The committee recommended that Amended Resolution 47 be adopted.

It was moved THAT AMENDED RESOLUTION 47 BE ADOPTED:

RESOLVED, THAT ACEP DEVELOP A STATEMENT TO CLARIFY THAT THE 2009 WHITE PAPER REPORT ON EXCITED DELIRIUM IS NO LONGER CURRENT WITH THE

COLLEGE'S POSITION BASED ON NEW SCIENCE AND UNDERSTANDING OF THE ENTITY; AND BE IT FURTHER

RESOLVED, THAT ACEP CLARIFY ITS POSITION IN WRITING, THAT THE 2009 WHITE PAPER IS INACCURATE AND OUTDATED, AND THAT WHILE THE ACEP BOARD OF DIRECTORS HAD PREVIOUSLY APPROVED THE 2009 WHITE PAPER REPORT ON EXCITED DELIRIUM, IT HAS WITHDRAWN SUCH APPROVAL; AND BE IT FURTHER

~~RESOLVED, THAT ACEP AND ITS SECTIONS EITHER REMOVE OR UPDATE CONTENT AND/OR LITERATURE ON ITS WEBSITE THAT RELIES ON THE OUTDATED INFORMATION REGARDING "EXCITED DELIRIUM" OR CONDITIONS WITH A SIMILAR DEFINITION AS THAT DESCRIBED IN THE 2009 WHITE PAPER REPORT ON EXCITED DELIRIUM; AND BE IT FURTHER~~

RESOLVED, THAT ACEP DISSEMINATE THEIR POSITION THAT THEY NO LONGER ENDORSE OR APPROVE THE 2009 WHITE PAPER ON EXCITED DELIRIUM AMONG THE WIDER MEDICAL AND PUBLIC HEALTH COMMUNITY, LAW ENFORCEMENT ORGANIZATIONS, AND ACEP MEMBERS ACTING AS EXPERT WITNESSES TESTIFYING IN RELEVANT CIVIL OR CRIMINAL LITIGATION; AND BE IT FURTHER

RESOLVED, THAT FUTURE ACEP WORK ON THE EVALUATION AND MANAGEMENT OF IN-HOSPITAL AND OUT-OF-HOSPITAL BEHAVIORAL EMERGENCIES SHOULD UTILIZE NOT ONLY EXPERTS IN EMERGENCY MEDICAL SERVICES, NEUROLOGY, EMERGENCY PSYCHIATRY, AND HEALTH EQUITY, BUT MUST ALSO CONSIDER THE PERSPECTIVES OF COMMUNITY AND ADVOCACY LEADERS.

It was moved THAT THE LAST RESOLVED OF AMENDED RESOLTION 47 BE DELETED. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 48 be adopted.

It was moved THAT AMENDED RESOLUTION 48 BE ADOPTED:

RESOLVED, THAT ACEP RECOMMEND**S** AN AFFIDAVIT OF MERIT MUST BE FROM ~~A DOCTOR~~ **AN EMERGENCY PHYSICIAN** WHO IS BOARD CERTIFIED ~~AND LICENSED~~ **PER ACEP POLICY** IN THE SAME SPECIALTY OF **EMERGENCY MEDICINE, AS WELL AS LICENSED AND CURRENTLY PRACTICING IN THE SAME STATE**.

It was moved THAT THEWORDS "**AS WELL AS LICENSED AND CURRENTLY PRACTICING IN THE SAME STATE**" BE DELETED. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 49 be adopted.

It was moved THAT AMENDED RESOLUTION 49 BE ADOPTED:

RESOLVED, THAT ACEP CREATE A DOCUMENT ACKNOWLEDGING THAT PATIENTS LEAVING THE EMERGENCY DEPARTMENT PRIOR TO COMPLETION OF CARE MAY NOT HAVE RECEIVED A COMPLETE EVALUATION, RESULTS OF ALL ANCILLARY TESTING INCLUDING INCIDENTAL FINDINGS, ALL INDICATED THERAPIES, AND ALL INDICATED CONSULTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~CREATE A DOCUMENT ACKNOWLEDGING THAT PHYSICIANS AND HOSPITALS/SYSTEMS SHARE A JOINT RESPONSIBILITY TO NOTIFY PATIENTS WHO HAVE LEFT PRIOR TO THE COMPLETION OF CARE REGARDING TESTING REQUIRING INTERVENTION THAT RESULTS AFTER THEIR DEPARTURE AND DEVELOP REASONABLE SYSTEMS TO HELP COMMUNICATE THESE RESULTS~~ **WORK WITH RELEVANT STAKEHOLDERS SUCH AS THE AMERICAN HOSPITAL ASSOCIATION TO CREATE A DOCUMENT OR TOOL OUTLINING RESPONSIBILITIES AND SYSTEMS OF COMMUNICATION FOR THE CONVEYANCE OF INFORMATION ABOUT TESTING AND FOLLOW UP OF PATIENTS WHO LEAVE THE EMERGENCY DEPARTMENT PRIOR TO THE**

COMPLETION OF CARE; AND BE IT FURTHER

RESOLVED, THAT ACEP CREATE A DOCUMENT ACKNOWLEDGING THAT PATIENTS LEAVING THE EMERGENCY DEPARTMENT PRIOR TO COMPLETION OF ~~CARE~~ **EVALUATION AND TREATMENT BEAR SOME RESPONSIBILITY FOR ONGOING CARE AND** MAY NOT HAVE ALL MEDICATION RECOMMENDATIONS AND PRESCRIPTIONS, NOR A COMPLETE LIST OF DISCHARGE DIAGNOSES, INCIDENTAL FINDINGS REQUIRING FOLLOW UP, INSTRUCTIONS, AND REFERRALS UPON DEPARTURE.

It was moved THAT THE WORD “SOME” BE REMOVED IN THE THIRD RESOLVED.

It was moved that AMENDED RESOLUTION 49 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 50 be adopted.

It was moved THAT AMENDED RESOLUTION 50 BE ADOPTED:

RESOLVED, THAT ACEP DEVELOP PRACTICES AND POLICIES TO PREVENT THE ~~PUBLISHING~~ **PUBLIC OR EXTERNAL** **PUBLICATION**, ~~TRANSMITTING~~ **TRANSMISSION**, AND/OR ~~RELEASING~~ **RELEASE** OF UNBLINDED METRIC-RELATED INFORMATION ABOUT INDIVIDUAL EMERGENCY PHYSICIAN PERFORMANCE TO SAFEGUARD THE WELFARE OF OUR MEMBERSHIP.

It was moved THAT THE WORD “PRODUCTIVITY” BE INSERTED AFTER THE WORD “METRIC-RELATED.” There was no objection to inserting the word.

It was moved THAT THE WORDS “OTHER THAN THAT REQUIRED FOR VOLUNTARY PAYER PROGRAMS” BE INSERTED AFTER THE WORD “PERFORMANCE.

It was moved that AMENDED RESOLUTION 50 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

REFERENCE COMMITTEE B

Dr. Nordlund 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 28, Resolution 35, Resolution 36, and Resolution 38.

For adoption as Amended or Substituted: Amended Resolution 27, Amended Resolution 29, Amended Resolution 31, Amended Resolution 37, Amended Resolution 39, Amended Resolution 40, and Amended Resolution 42.

Not for adoption: Resolution 30, Resolution 32, Resolution 33, and Resolution 34.

Amended Resolution 27, Resolution 33, Resolution 34, Resolution 36, Amended Resolution 37, Resolution 38, Amended Resolution 39, Amended Resolution 40, and Amended Resolution 42 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 29

RESOLVED, THAT ACEP ADVOCATE FOR FEDERAL SUPPORT TO DECREASE ED BOARDING OF PEDIATRIC MENTAL HEALTH PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR ~~TIERED~~ **INCREASED, ADEQUATE** REIMBURSEMENT FOR PEDIATRIC MENTAL HEALTH ADMISSIONS AND A STANDARD PAYMENT FOR BOARDING OF CHILDREN FOR WHOM THERE IS NO OTHER MEDICAL NECESSITY FOR HOSPITAL CARE.

AMENDED RESOLUTION 31

RESOLVED, THAT ACEP ADVOCATE AND COMMIT RESOURCES FOR THE ELIMINATION OF DISCRIMINATION AGAINST ~~INDIVIDUALS~~ **EMERGENCY PHYSICIANS** WITH TREATED MENTAL HEALTH CONDITIONS IN **LIFE, HEALTH, DISABILITY, AND/OR PROFESSIONAL LIABILITY (MALPRACTICE)** INSURANCE POLICIES; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH OTHER ORGANIZATIONS TO PROMOTE EQUITABLE ACCESS TO **LIFE, HEALTH, DISABILITY, AND/OR PROFESSIONAL LIABILITY (MALPRACTICE)** INSURANCE FOR ALL EMERGENCY PHYSICIANS~~, REGARDLESS OF THEIR MENTAL HEALTH STATUS~~.

The committee recommended that Resolution 36 be adopted:

It was moved THAT RESOLUTION 36 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 38 be adopted.

It was moved THAT RESOLUTION 38 BE ADOPTED.

It was moved THAT THE WORDS "AND OTHER RURAL HOSPITALS" BE INSERTED AFTER THE WORDS "CRITICAL ACCESS HOSPITALS AND RURAL EMERGENCY DEPARTMENTS." There was no objection to the motion.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 27 be adopted.

It was moved THAT AMENDED RESOLUTION 27 BE ADOPTED:

RESOLVED, THAT ACEP WORK WITH STATE AND FEDERAL AGENCIES TO ~~CREATE~~ **ADVOCATE FOR** STATE AND REGIONAL TRANSFER COORDINATION CENTERS TO FACILITATE TRANSFER OF PATIENTS WHEN NORMAL TRANSFER MECHANISMS ARE IMPAIRED BY HOSPITAL AND ED CAPACITY PROBLEMS AND TO REPORT THEIR ACTIVITIES PUBLICLY; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR STATE AND FEDERAL REQUIREMENTS THAT TERTIARY CENTERS HAVE A REGIONAL PROCESS FOR RAPIDLY ACCEPTING PATIENTS FROM RURAL HOSPITALS WHEN THE PATIENT NEEDS AN EMERGENCY INTERVENTION NOT AVAILABLE AT THE REFERRING HOSPITAL EVEN WHEN CAPACITY IS LIMITED AT THE TERTIARY CENTER; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR REGIONAL DASHBOARDS WITH UPDATED INFORMATION ON HOSPITAL SPECIALTY SERVICE AVAILABILITY INCLUDING PROCEDURAL INTERVENTIONS AND OTHER TREATMENT MODALITIES (E.G., ERCP, ECMO, DIALYSIS, STEMI, INTERVENTIONAL STROKE, INTERVENTIONAL PE, NEUROSURGERY, ACUTE ONCOLOGIC DISEASE) AND IN THIS REGION IS DEFINED AS PATIENT CATCHMENT AREAS RATHER THAN JURISDICTIONAL BOUNDARIES; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT RESEARCH TO STRENGTHEN THE EVIDENCE BASE REGARDING RURAL HOSPITAL TRANSFER PROCESSES INCLUDING DELAYS, ADMINISTRATIVE BURDEN ON SENDING HOSPITALS, AND CLINICAL ASSOCIATION WITH PATIENT OUTCOMES AND EXPERIENCE AND INCLUDE INVESTIGATION OF COMMON CHALLENGES EXPERIENCED BY ALL SMALL, NON-NETWORKED HOSPITALS**.**~~;~~ ~~AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP CREATE A TASK FORCE TO EXAMINE CURRENT MODELS AND EXISTING RESEARCH YIELDING DETAILED RECOMMENDATIONS FOR ACEP ADVOCACY EFFORTS REGARDING INTERHOSPITAL TRANSFER CHALLENGES FOR RURAL EDS AND THE TASK FORCE SHOULD:~~

- ~~EXAMINE EXISTING AND THEORETICAL TRANSFER MODELS TO IDENTIFY BEST PRACTICES, INCLUDING COORDINATION OF TRANSFERS ACROSS STATE BORDERS.~~
- ~~ENUMERATE AND ENDORSE EFFECTIVE MECHANISMS TO FACILITATE TERTIARY CARE HOSPITALS' ACCEPTANCE OF PATIENTS IN TRANSFER WITH TIME-SENSITIVE~~

~~CONDITIONS WHO ARE INITIALLY TREATED AT EDS WITHOUT NEEDED SERVICES.~~

- ~~IDENTIFY KEY CAPACITY MEASURES FOR PUBLIC REPORTING OF HOSPITAL CAPACITY LIMITATIONS, AND PROPOSE MECHANISMS TO CREATE AND SUSTAIN APPROPRIATE STATE/REGIONAL DASHBOARDS.~~

The Council recessed at 11:45 am for the awards luncheon and reconvened at 1:45 pm on Sunday, October 8, 2023.

Dr. Char reported that 425 councillors of the 427 eligible for seating had been credentialed.

The Council then resumed discussion of Amended Resolution 27.

It was moved THAT THE WORDS "EVEN WHEN CAPACITY IS LIMITED AT THE TERTIARY CENTER" BE DELETED IN THE SECOND RESOLVED. The motion was adopted.

It was moved THAT THE WORDS "EVEN WHEN CAPACITY IS LIMITED" BE REINSTATED IN THE SECOND RESOLVED. The motion was not adopted.

It was moved THAT AMENDED RESOLUTION 27 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 37 be adopted.

It was moved THAT AMENDED RESOLUTION 37 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT EFFORTS TO IMPROVE FIREARM SAFETY IN THE UNITED STATES, INCLUDING ~~SMART GUN~~ **EFFECTIVE EMERGING SAFETY** TECHNOLOGY, WHILE RESPECTING RESPONSIBLE FIREARM OWNERSHIP; AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE CHILD-PROTECTIVE FIREARM SAFETY AND STORAGE SYSTEMS.

The motion was adopted.

The committee recommended that Amended Resolution 39 be adopted:

RESOLVED, THAT ACEP ADVOCATE AT THE FEDERAL LEVEL AND SUPPORT CHAPTERS IN ADVOCATING AT THE STATE LEVEL FOR MEDICAID PROGRAMS TO REIMBURSE EMERGENCY PHYSICIANS AT RATES EQUIVALENT TO OR ABOVE MEDICARE RATES; AND BE IT FURTHER

~~RESOLVED, THAT ACEP SUBMIT A RESOLUTION TO THE AMERICAN MEDICAL ASSOCIATION TO ADVOCATE FOR REIMBURSING EMERGENCY PHYSICIANS AT RATES EQUIVALENT TO OR ABOVE MEDICARE RATES.~~

RESOLVED, THAT ACEP WORK WITH THE AMA TO ASSIST STATES WITH MODEL LEGISLATION AND REGULATORY LANGUAGE TO REQUIRE THAT ALL PUBLICLY FUNDED INSURANCE PLANS BE REIMBURSED AT A MINIMUM OF 100% OF THE PREVAILING MEDICARE RATE.

It was moved THAT AMENDED RESOLUTION 39 BE ADOPTED.

It was requested that each resolved be discussed separately.

It was moved THAT THE SECOND RESOLVED BE REFERRED TO THE BOARD OF DIRECTORS. There was no objection to the motion.

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

The committee recommended that Amended Resolution 40 be adopted.

It was moved THAT AMENDED RESOLUTION 40 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATE FOR AND SUPPORT THE DEVELOPMENT OF POLICIES THAT WILL ALLOW FOR APPROPRIATE REIMBURSEMENT**, OUTSIDE OF THE CPT AND RUC PROCESSES,** FOR HIGH-VALUE ~~GERIATRIC EMERGENCY DEPARTMENT~~ **GERIATRIC EMERGENCY DEPARTMENT ACCREDITATION PROGRAM-DEFINED** CARE PROCESSES THAT HAVE BEEN SHOWN TO IMPROVE BOTH HEALTH SYSTEM FOCUSED AND PATIENT CENTERED OUTCOMES.

It was moved THAT THE WORDS "OUTSIDE OF THE CPT AND RUC PROCESSES" BE DELETED. The motion was not adopted.

It was moved THAT THE WORDS "THE CPT AND RUC PROCESSES" BE REPLACED WITH THE WORDS "BUDGET NEUTRALITY." The motion was not adopted.

It was moved THAT AMENDED RESOLUTION 40 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 42 be adopted.

It was moved THAT AMENDED RESOLUTION 42 BE ADOPTED:

RESOLVED, THAT ACEP WORK WITH STATE CHAPTERS TO ENCOURAGE AND SUPPORT LEGISLATION PROMOTING THE MINIMUM REQUIREMENT OF ON-SITE AND-ON-DUTY PHYSICIANS IN ALL EMERGENCY DEPARTMENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO PROMOTE THAT THE GOLD STANDARD FOR THOSE PHYSICIANS WORKING IN AN EMERGENCY DEPARTMENT IS A BOARD-CERTIFIED/BOARD-ELIGIBLE EMERGENCY PHYSICIAN **CERTIFIED BY THE AMERICAN BOARD OF EMERGENCY MEDICINE, AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE, OR CERTIFIED BY THE AMERICAN BOARD OF PEDIATRICS IN PEDIATRIC EMERGENCY MEDICINE.**

It was moved THAT THE WORDS "ON-SITE AND" BE DELETED FROM THE FIRST RESOLVED AND THE SECOND RESOLVED BE AMENDED TO READ:

RESOLVED, THAT ACEP CONTINUE TO PROMOTE THAT THE GOLD STANDARD FOR THOSE PHYSICIANS WORKING IN **OR PROVIDING COVERAGE IN** AN EMERGENCY DEPARTMENT IS A BOARD-CERTIFIED/BOARD-ELIGIBLE EMERGENCY PHYSICIAN **CERTIFIED BY THE AMERICAN BOARD OF EMERGENCY MEDICINE, AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE, OR CERTIFIED BY THE AMERICAN BOARD OF PEDIATRICS IN PEDIATRIC EMERGENCY MEDICINE. ACEP SHOULD ADVOCATE THAT ALL EMERGENCY PATIENTS DESERVE REAL TIME ACCESS TO AN EMERGENCY PHYSICIAN WHETHER IN PERSON OR VIA TELEHEALTH.**

It was moved THAT THE WORDS "ON-SITE AND" BE REINSTATED IN THE FIRST RESOLVED. The motion was adopted.

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

It was moved THAT THE WORDS "ACEP DEFINED EMERGENCY" BE INSERTED IN THE FIRST RESOLVED AFTER THE WORDS "ON-DUTY." The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 33 not be adopted.

It was moved THAT RESOLUTION 33 BE ADOPTED.

It was moved THAT RESOLUTION 33 BE AMENDED TO READ:

RESOLVED, THAT ACEP SUPPORT A BAN ON THE SALE, TRANSFER, IMPORTATION, AND POSSESSION OF WEAPONS ~~INTENDED~~ **MUNITIONS, AND LARGE CAPACITY MAGAZINES THAT ARE DESIGNED** FOR MILITARY **USE** ~~OR LAW ENFORCEMENT USE, INCLUDING SEMI-AUTOMATIC RIFLES AND HANDGUNS, THAT ARE DESIGNED TO RAPIDLY FIRE MULTIPLE ROUNDS~~; AND BE IT FURTHER

RESOLVED, THAT ACEP ENCOURAGE POLICYMAKERS AT THE LOCAL, STATE, AND FEDERAL LEVELS TO ENACT COMPREHENSIVE LEGISLATION THAT ADDRESSES THE BAN ON WEAPONS INTENDED FOR MILITARY ~~OR LAW ENFORCEMENT~~ USE WHILE RESPECTING THE RIGHTS OF RESPONSIBLE GUN OWNERS; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR EVIDENCE-BASED MEASURES, ~~INCLUDING THE BAN ON WEAPONS INTENDED FOR MILITARY OR LAW ENFORCEMENT USE~~, TO PREVENT AND REDUCE GUN-RELATED INJURIES AND FATALITIES THROUGH PUBLIC EDUCATION, RESEARCH, AND COLLABORATION WITH RELEVANT STAKEHOLDERS~~; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP URGE MEMBERS TO ENGAGE IN DISCUSSIONS WITH THEIR PATIENTS, COMMUNITIES, AND LAWMAKERS TO PROMOTE POLICIES AND INITIATIVES AIMED AT REDUCING THE AVAILABILITY AND POTENTIAL HARM CAUSED BY WEAPONS INTENDED FOR MILITARY OR LAW ENFORCEMENT USE, WHILE RECOGNIZING THE IMPORTANCE OF MENTAL HEALTH SERVICES AND VIOLENCE PREVENTION PROGRAMS IN COMPREHENSIVE STRATEGIES FOR REDUCING GUN VIOLENCE~~.

The motion was not adopted.

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

The committee recommended that Resolution 34 not be adopted.

It was moved THAT RESOLUTION 34 BE ADOPTED. The motion was not adopted.

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Aisha T. Terry, MD, MBA, FACEP, president-elect, addressed the Council.

Dr. Char reported that 425 councillors of the 427 eligible for seating had been credentialed.

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

The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Kraus, Dr. Mehrotra, and Dr. Pitzele were elected to a three-year term. Dr. Shoemaker was re-elected to a three-year term.

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

There being no further business, Dr. Gray-Eurom adjourned the 2023 Council meeting at 5:23 pm on Sunday, October 8, 2023.

The next meeting of the ACEP Council is scheduled for September 27-28, 2024, at the Mandalay Bay Convention Center in Las Vegas, NV.

Respectfully submitted,

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

Approved by,

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

Steering Committee Virtual Meeting
January 25, 2024

Minutes

Speaker Melissa Costello, MD, FACEP, called to order a virtual meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:06 am Central time on Thursday, January 25, 2024.

Steering Committee members present for all or portions of the meeting were: Eric Blutinger, MD, MSc, FACEP; Sara Ann Brown, MD, FACEP; Melissa Costello, MD, FACEP, speaker; Emily Fitz, MD, FACEP; Deborah Fletcher, MD, FACEP; Vik Gulati, MD, FACEP; Robert Hancock, DO, FACEP; Amanda Irish, MD, MPH; C. Ryan Keay, MD, FACEP; Alexander Kirk, MD, FACEP; Michael McCrea, MD, FACEP, vice speaker; Marc Mendelsohn, MD, FACEP; David Nestler, MD, MS, FACPE; Diana Nordlund, DO, JD, FACEP; Scott Pasichow, MD, MPH, FACEP; Christopher Sampson, MD, FACEP; Matthew Sanders, DO, FACEP; and Michaela Banks, MD.

Other members and guests present for all or portions of the meeting were: L. Anthony Cirillo, MD, FACEP; Jeffrey Goodloe, MD, FACEP, chair of the Board; Alison Haddock, MD, FACEP, president-elect; Gabor Kelen, MD, FACEP; Chadd Kraus, DO, DrPH, FACEP; Kurtis Mayz, JD, MD, MBA, FACEP; Abhi Mehrotra, MD, MBA, FACEP; Henry Pitzele, MD, FACEP; James Slaughter, JD; Ryan Stanton, MD, FACEP, vice president communications; and Aisha Terry, MD, FACEP, president.

Staff present for all or portions of the meeting were: Mary Beth Collins; Mary Ellen Fletcher, CPC, CEDC, CAE; Pawan Goyal, MD, MHA, FHIMSS; Maude Suprenant Hancock, CAE; Scott Mackinaw; Sonja Montgomery, CAE; Leslie Moore, JD; Sandra Schneider, MD, FACEP; Susan Sedory, MA, CAE; and Carole Wollard.

Officer and Staff Reports
Speaker

Dr. Costello welcomed everyone and thanked them for their participation and commitment to the College. She reported on the Board meeting that was held January 23-24, 2024, and provided a brief overview of the Steering Committee meeting agenda.

Vice Speaker

Dr. McCrea reported on his role as a member of the Finance Committee as the speaker's designee.

President

Dr. Terry highlighted discussions held during the Board held December 4-7, 2023, the recent Board meeting, and the upcoming congressional briefing on health care workplace violence with the American Hospital Association.

President-Elect

Dr. Haddock discussed key changes that are planned for ACEP24 in Las Vegas and her attendance at the recent AMA State Advocacy Conference.

Dr. Cirillo informed the Steering Committee that a Board and staff workgroup has been appointed to strengthen the process of planning and executing future Leadership & Advocacy Conferences.

Executive Director

Ms. Sedory reported on several programs of the College including residency visits, plans for a new three-year dues package for graduating residents, enhancing membership recruitment and retention, targeted communications to

members, the ACEP Anytime learning video modules, the new Accelerate meeting that will be held in March, the Open Book project, ED Accreditation, and development of a new app for the PEER product.

Steering Committee Expectations

Dr. Costello reminded the Steering Committee of their expectation to attend the April 14, 2024, Steering Committee meeting and the Leadership & Advocacy Conference April 14-16. 2024, in Washington, DC. A Council Forum will be held 1:00 pm – 3:00 pm for members to learn more about the Council and participate in a resolution writing workshop. Additionally, the Leadership Development Advisory Committee will host a meeting 3:00 pm – 4:00 pm as an opportunity for members interested in seeking nomination to learn more about the process and hear about serving on the Board of Directors or as a Council officer.

The Steering Committee will also meet at 6:00 pm on Thursday, September 26, 2024, in Las Vegas, NV, the evening prior to the Council meeting.

Tellers, Credentials, & Elections Committee Report

Dr. Costello reviewed the Tellers, Credentials, & Elections Committee report from the 2023 Council meeting. There were 427 councillors allocated and 424 were credentialed. The Undersea & Hyperbaric Medicine Section was unrepresented. The following chapters were underrepresented by one councillor: New Hampshire and South Dakota. Multiple attempts were made to identify members to fill these unrepresented and underrepresented councillor positions.

Electronic voting was conducted using online voting software from www.associationvoting.com. The electronic voting software was programmed with the unique membership numbers of councillors prior to the Council meeting. The voting software was updated onsite to accommodate any last minute changes to delegations. There were no problems identified regarding the electronic voting system beyond the reliability of the Wi-Fi. ACEP's Technology Services staff are researching potential solutions to address continuing problems with Wi-Fi capacity during the Council meeting.

Five survey questions were prepared for the Council meeting. The survey results were distributed to the Steering Committee.

Councillor Allocation

Dr. Costello reported that councillor allocation for 2024 is 422 based on the total membership as of December 31, 2023. This is 5 less councillors than were allocated for the 2023 meeting. Three chapters gained a councillor this year: Connecticut, Idaho, and Kentucky. The following chapters each lost one councillor: Alaska, California, Colorado, Government Services, Kansas, Louisiana, Missouri, South Carolina, Washington, and West Virginia. Multiple communications were sent to chapters to remind them of the councillor allocation deadline and to follow up with any lapsed members.

The Aerospace Medicine Section has had difficulty meeting the minimum membership requirement of 100 members since the section was established in 2019. The Board approved revoking the section charter on April 30, 2023, and the section was converted to a Member Interest Group. All other sections met the minimum membership requirement of 100 members, including the Locum Tenens Section, which was unrepresented last year, and the new Exploring Retirement Section will have a councillor for the 2024 Council meeting.

2023 Council Meeting

Dr. Costello and Dr. McCrea discussed various aspects of the 2023 Council meeting and requested suggestions for potential changes for the 2024 meeting.

There was consensus to continue allowing asynchronous testimony on resolutions submitted for the 2024 Council meeting and to develop preliminary Reference Committee reports with any suggestions for amended or substituted language in the summary of the asynchronous testimony. The basis for the live Reference Committee hearings will be the resolutions as submitted.

The Town Hall meeting topic was "What's AI Got to Do With IT? The Future of Health Care Automation." The Steering Committee suggested potential topics for the 2024 Town Hall discussion: unionization, Advocacy 101, and the role of telehealth in emergency medicine. The Annual Meeting Subcommittee will also be assigned an objective to identify potential Town Hall meeting topics for the 2024 Council meeting and provide their suggestions at the April 14 Steering Committee meeting. The Council officers will determine the topic during the summer.

Dr. Costello reminded everyone that continental breakfast on both days of the Council meeting and the traditional Council Awards Luncheon were provided. Continental breakfast and the awards luncheon will again be proposed to be included in the FY 2024-25 budget

The 2024 Council meeting will be held at the Mandalay Bay Resort Convention Center. The exact location of the Council meeting (North Convention Center or South Convention Center) is not known at this time. Staff are exploring options for the best location and considering the walking distance from the hotel and the costs. Meetings that occur the evening prior to the Council meeting will also be held at the Mandalay Bay Resort Convention Center. These meetings include: Candidate Forum Subcommittee; Council Steering Committee; Tellers, Credentials, & Elections Committee; Reference Committee briefing; and Councillor Orientation.

It was noted that the reliability of the Wi-Fi during the Council meeting has been an ongoing challenge for several years and actions are taken during the meeting to alleviate the problems. Each year staff work with the meeting venue attempting to prevent problems and ensure sufficient Wi-Fi capacity is provided. Multiple reminders were provided to the Council encouraging everyone to disable Wi-Fi on devices that were not being used for conducting Council business and to download documents prior to the meeting instead of during the meeting to help eliminate capacity overload. A major impact on the Wi-Fi capacity during the 2023 meeting occurred because several councillors were live streaming events during the meeting, which caused a significant drain on the Wi-Fi. The Wi-Fi capacity at the Mandalay Bay Convention Center is not expected to be a problem given their experience with hosting many large conventions each year. ACEP's Technology Services staff are researching potential solutions to address problems with Wi-Fi capacity.

2024 Council Meeting Agenda

The Steering Committee reviewed the draft 2024 Council meeting agenda and discussed potential changes. There was support for continuing the executive director's report on the first day of the Council meeting before recessing to the Reference Committee hearings and the EMF and NEMPAC reports the second morning before discussion of the Reference Committee reports. It was suggested that the ABEM report may need to be extended to 10 minutes and to allow questions from councillors. The Annual Meeting Subcommittee will review the Council meeting agenda and provide their suggestions at the April 14 Steering Committee meeting.

Electronic Voting

Dr. Costello reviewed the electronic voting system. The Steering Committee did not identify any issues or concerns about continuing to use the Association Voting platform for electronic voting during the 2024 Council meeting.

Elections Process

The Steering Committee discussed the format of the Candidate Forum and did not identify any potential changes. Dr. Costello informed the Steering Committee that a question has been raised whether candidates can use slides during their remarks to the Council. The Candidate Campaign Rules, item 16.a , do not prohibit candidates using slides during their remarks, although slides have not been used in the past. The Steering Committee identified several potential problems if candidates are allowed to use electronic technology during their remarks, such as technical failure and extending the time needed for the opening remarks if technical difficulties are experienced. It was also mentioned that guidelines for conformity and a review process would be needed prior to implementation of this potential change. The Candidate Forum Subcommittee will discuss the issue of allowing candidates to use slides or other electronic technology during their remarks to the Council and provide their recommendations for potential changes to the Candidate Campaign Rules at the April 14 Steering Committee meeting.

Action on Resolutions

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2023, 2022, and 2021 Council meetings were provided for review. The reports were assigned to the Annual Meeting Subcommittee for further review.

ACEP's Parliamentary Authority

Dr. Costello and Dr. McCrea provided the history of ACEP's use of *The Standard Code of Parliamentary Procedure, 4th Edition* (TSC) and the conversations with Mr. Slaughter, ACEP's Parliamentarian, regarding when ACEP should change the parliamentary authority to the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (AIPSC). The Bylaws Committee has also had conversations during the past few years about the need for and timing of changing the parliamentary authority. It was mentioned that the American Medical Association and the Emergency Medicine Residents' Association have already made the change to the AIPSC. Mr. Slaughter provided additional information about the functional aspects of changing to the AIPSC. Additional changes to the CSR, beyond updating the name of the parliamentary authority, would probably not be required since anything in the CSR would override the parliamentary authority as the higher authority, i.e., Bylaws and CSR are higher authority governing documents. The Steering Committee expressed support for making the change to the AIPSC.

Updating ACEP's parliamentary authority from TSC to the AIPSC will require amendments to the Bylaws and the Council Standing Rules. The Bylaws & Council Standing Rules Subcommittee will be assigned an objective to develop the draft resolutions for discussion at the April 14 Steering Committee meeting.

Subcommittee Appointments

Dr. Costello asked Steering Committee members to notify Ms. Montgomery of their interest in serving on the Annual Meeting Subcommittee, Bylaws & Council Standing Rules Subcommittee, or the Candidate Forum Subcommittee. All subcommittee members should plan to serve on at least two subcommittees. All second year Steering Committee members will be appointed to the Candidate Forum Subcommittee unless planning to seek nomination to the Board of Directors. Ms. Montgomery will email the objectives and deadlines of the subcommittees. The subcommittee reports will be discussed at the April 14, 2024, Steering Committee meeting.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Sunday, April 14, 2024, during the Leadership & Advocacy Conference in Washington, DC.

With no further business, the meeting was adjourned at 11:48 am Central time on Thursday, January 25, 2024.

Respectfully submitted,

Melissa W. Costello, MD, FACEP
Council Speaker and Chair

Michael J. McCrea, MD, FACEP
Council Vice Speaker and Vice Chair

DEFINITION OF COUNCIL ACTIONS

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

ADOPT
Approve resolution exactly as submitted as recommendation implemented through the Board of Directors.

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

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

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

American College of Emergency Physicians®
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2024 Council Meeting
Reference Committees

Reference Committee A – Governance & Membership
Resolutions 13-23

Larisa M. Traill, MD, FACEP (MI) – Chair
Laurel Barr, MD, FACEP (OH)
Amanda Irish, MD, MPH (IA)
Catherine A. Marco, MD, FACEP (PA)
Emily Mills, MD, FACEP (MI)
Aine Yore, MD, FACEP (WA)

Amanda Pairitz-Campo
Laura Lang, JD

Reference Committee B – Advocacy & Public Policy
Resolutions 24-42

Torree M. McGowan, MD, FACEP (GS) – Chair
Blake Bailey, DO, MBA, FACEP (PA)
Lisa M. Bundy, MD, FACEP (MS)
Joshua R. Frank, MD, FACEP (WA)
George RJ Sontag, MD, FACEP (OH)
James C. Mitchner, MD, MPH, FACEP (MI)

Erin Grossmann
Ryan McBride, MPP

Reference Committee C – Emergency Medicine Practice
Resolutions 43-62

Kurtis Mayz, JD, MD, MBA, FACEP – Chair
Sara Ann Brown, MD, FACEP – (IN)
Angela P. Cornelius, MD, FACEP (TX)
Dan Freess, MD, FACEP (CT)
Michael C. Smith, MD, MBA, FACEP (LA)
Carol Wright Becker, MD, FACEP (WV)

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

INTRODUCTION

2024 Annual Council Meeting
Thursday Evening, September 26, 2024, through Saturday, September 28, 2024
Mandalay Bay Resort Hotel and Convention Center

Background information has been prepared on the resolutions that were submitted by the deadline. Please review the resolutions and background information in advance of the Council meeting. Councillors and others receiving these materials are reminded that these items are yet to be considered by the Council.

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

Asynchronous testimony will open on Thursday, August 29 for all resolutions assigned to a Reference Committee. An announcement with the link to the 2024 resolutions will be posted on the Council engagED when asynchronous testimony opens. After clicking on the link provided:

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

The asynchronous testimony platform is open to all members. When commenting please include the following:

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

The asynchronous platform is the only method to introduce testimony until the live Reference Committee hearings in Las Vegas. Opinions posted elsewhere (including Council engagED) will not be considered in the Reference Committee deliberations. All comments should be addressed to the Reference Committee Chair or the Council Speaker. **Please do not direct any communications to another member, including anyone who has posted comments before you, with whom you may or may not agree.** Proper decorum is expected within the asynchronous testimony platform as well as the in-person Reference Committee hearings during the Council meeting.

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

Asynchronous testimony will close at 12:00 noon Central time on Wednesday, September 18. Comments from the online testimony will be used to develop the preliminary Reference Committee reports. The preliminary reports will be distributed to the Council on Monday, September 23 and will be the starting point for the live Reference Committee hearings during the Council meeting in Las Vegas on Friday, September 27.

Visit the Council Meeting Web site: https://acep.elevate.commpartners.com/ to access all materials and information for the Council meeting. The resolutions and other resource documents for the meeting are located under the "Document Library" tab. You may download and print the entire Council notebook compendium, or

individual section tabs from the Table of Contents. You will also find separate compendiums of the President-Elect candidates, Board of Directors candidates, and the resolutions. Additional documents may be added over the next several days, so please check back if what you need is not currently available.

We are looking forward to seeing everyone in Las Vegas!

Your Council Officers,

Melissa W. Costello, MD, FACEP
Speaker

Michael J. McCrea, MD, FACEP
Vice Speaker

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2024 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Stephen V. Cantrill, MD, FACEP *William P. Jaquis, MD, FACEP* *Christopher S. Kang, MD, FACEP* *Mark S. Rosenberg, DO, MBA, FACEP* *Gillian R. Schmitz, MD, FACEP*	
2	Commendation for JT Finnell, II, MD, MSc, FACEP, FACMI *Indiana Chapter*	
3	Commendation for Mary Ellen Fletcher, CPC, CEDC, CAE *Douglas Char, MD, FACEP* *Kelly Gray-Eurom, MD, MMM, FACEP* *Aaron Kuzel, DO, MBA* **See Attachment A for list of additional individual cosponsors*	
4	Commendation for Christopher S. Kang, MD, FACEP *Washington Chapter*	
5	Commendation for Rami R. Khoury, MD, FACEP *Michigan College of Emergency Physicians*	
6	Commendation for Shari Purpura *Jay Brenner, MD, FACEP* *Michael J. McCrea, MD, FACEP* *John Moskop, PhD* *Raquel Schears MD, FACEP* *James D. Thompson, MD, FACEP* *Larisa M. Traill, MD, FACEP* **See Attachment A for list of additional individual cosponsors*	
7	In Memory of Neal F. Aulick II, MD, FACEP *Ohio Chapter* *Pennsylvania College of Emergency Physicians* *West Virginia College of Emergency Physicians*	
8	In Memory of Marilyn J. Gifford, MD *Douglas Hill, DO, FACEP* *Carla Murphy, DO, FACEP* *Colorado Chapter*	
9	In Memory of Veronica Greer, MD *Texas College of Emergency Physicians*	
10	In Memory of Christopher H. Linden, MD, FACEP *Massachusetts College of Emergency Physicians*	
11	In Memory of Gregory L. Walker, MD, FACEP *Michigan College of Emergency Physicians*	

Resolution #	Subject/Submitted by	Reference Committee
12	In Memory of Jesse A. Weigel, MD, FACEP *Pennsylvania College of Emergency Physicians*	
13	Allocation of Councillors – Bylaws Amendment *Colorado Chapter* *Louisiana Chapter* *Pennsylvania College of Emergency Physicians*	A
14	College Parliamentary Authority – Bylaws Amendment *Bylaws Committee* *Board of Directors* *Council Steering Committee*	A
15	College Parliamentary Authority - Council Standing Rules Amendment *Council Steering Committee*	A
16	International Members Serving as Section Officers – Bylaws Amendment *Bylaws Committee* *Board of Directors* *Cruise Ship Medicine Section* *International Emergency Medicine Section*	A
17	Removing Gendered Pronouns from ACEP's Bylaws – Bylaws Amendment *Jacob Altholz, MD* *Scott Pasichow, MD, MPH, FACEP*	A
18	ACEP Council and Scientific Assembly Meeting Location *Alicia Mikolaycik Gonzalez, MD, FACEP* *Aimee Moulin, MD, FACEP* *David Terca, MD, FACEP* *Randall Young, MD, FACEP* *California Chapter* *Nevada Chapter* *New York Chapter*	A
19	Vetting Intended Speakers with Divisive Language or Ideologies for ACEP Events *Diversity, Inclusion, Health Equity Section* *Social Emergency Medicine Section*	A
20	Advisory Council for All of Emergency Medicine *Pennsylvania College of Emergency Physicians*	A
21	Printable Volunteer Recognition Certificate *Alecia Gende, DO, FACEP* *Sarah Hoper, MD, FACEP* *AAWEP Section*	A
22	Support for the "Well Workplace" Policy Statement *Wellness Section* *Arizona College of Emergency Physicians* *Colorado Chapter* *District of Columbia Chapter*	A
23	Supporting a Statement Affirming Diversity, Equity, and Inclusion in Emergency Medicine *Diversity, Inclusion & Health Equity Section* *Social Emergency Medicine Section*	A

Resolution #	Subject/Submitted by	Reference Committee
24	Address ED Boarding and the Medicare Three-Midnight Rule for Post Acute Rehabilitation *James Humble, MD* *Virginia College of Emergency Physicians* *Dual Training Section* *Observation Medicine Section* *Young Physicians Section*	B
25	Boarding – Follow the Money *John Bibb, MD, FACEP* *Fred Dennis, MD, FACEP* *New Mexico Chapter* *Exploring Retirement Section*	B
26	Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events *Erik Blutinger MD FACEP* *Elaine Rabin MD FACEP* *Nicholas Stark, MD, MBA* *Arjun Venkatesh, MD, FACEP* *New York Chapter* *Quality Improvement & Patient Safety Section* *Young Physicians Section*	B
27	Continuous Physician Staffing for Rural Emergency Departments *Rural Emergency Medicine Section* *Social Emergency Medicine Section* *Oklahoma Chapter* *Michigan College of Emergency Physicians* *Virginia College of Emergency Physicians*	B
28	Data Gathering on Free Standing EDs: Examining Regulations, Services Offered, and Staffing Policies *Utah Chapter*	B
29	Minimum Standards for Freestanding Emergency Departments *Utah Chapter*	B
30	Hospital Network Requirements for Emergency Physicians *Elisabeth Giblin, MD* *Paul Kivela, MD, FACEP* *Bing Pao, MD, FACEP* *Thomas Sugarman, MD, FACEP* *California Chapter*	B
31	NEMPAC Contributions Transparency and Ethical Standards *Diversity, Inclusion & Health Equity Section* *Social Emergency Medicine Section*	B
32	Preventing Harmful Health Care Deals *Pennsylvania College of Emergency Physicians*	B
33	Promotion of Nursing in Emergency Medicine *Pennsylvania College of Emergency Physicians*	

Resolution #	Subject/Submitted by	Reference Committee
34	Reimbursement for Emergency Physician Services Provided Out-of-Hospital *Pennsylvania College of Emergency Physicians*	B
35	Sharing of Protected Health Information *Massachusetts College of Emergency Physicians* *New York Chapter*	B
36	EMTALA Reform to Improve Patient Access to Necessary Care *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Texas College of Emergency Physicians* *Locums Tenens Emergency Medicine Section* *Wellness Section*	B
37	Reinforcing EMTALA in Pregnancy Related Emergency Medical Care *Emily Ager, MD* *Michael Bresler, MD, FACEP* *Joshua da Silva, DO, FACEP* *Kelly Quinley, MD* *Monica Rakesh Saxena, MD, JD* *Rachel Solnick, MD* *Sophia Spadafore, MD* *Katherine Wegman, MD* *AAWEP Section* *California Chapter*	B
38	Termination of Pregnancy *Michael Bresler, MD, FACEP* *Monica Saxena, MD, JD* *Kelly Quinley, MD* *Sarah Hoper, MD, FACEP* *AAWEP Section* *California Chapter* *Ohio Chapter*	B
39	Urgent Care Transparency on Available Resources and Credentials *Pennsylvania College of Emergency Physicians*	B
40	Telehealth Emergency Physician Standards *New York Chapter*	B
41	Workplace Violence Data Collection *Wellness Section* *Arizona College of Emergency Physicians* *Colorado Chapter* *District of Columbia Chapter* *South Carolina Chapter*	B
42	Workplace Violence *New York Chapter*	B
43	Addressing Challenges Related to the New ABEM Oral Board Exam Format *Young Physicians Section* *California Chapter*	C

Resolution #	Subject/Submitted by	Reference Committee
44	Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations *Rural Emergency Medicine Section*	C
45	Climate Change Research and Education in Emergency Medicine *Tabitha Baca, MD* *Marc Futernick, MD, FACEP* *Gayle Galletta, MD, FACEP* *Rita Manfredi-Shutler, MD, FACEP* *Dana Mathew, DO, FACEP* *Scott Mueller, DO, FACEP* *Kristen Nordenholz, MD, FACEP* *Matthew Siket, MD, FACEP* *David Terca, MD, FACEP* *Kreager Taber, MS4* *Alexandra Thran, MD, FACEP* *California Chapter* *Vermont Chapter*	C
46	Human Trafficking Training for All Emergency Medicine Residents *Michael J. Bresler, MD, FACEP* *Gus M. Garmel, MD, FACEP* *Nicole Exeni McAmis, MD* *California Chapter* *Colorado Chapter* *Georgia College of Emergency Physicians* *Massachusetts College of Emergency Physicians* *West Virginia College of Emergency Physicians*	C
47	Human Trafficking is a Public Health Crisis *Michael Bresler, MD, FACEP* *Gus Garmel, MD, FACEP* *Nicole Exeni McAmis, MD* *California Chapter* *Colorado Chapter* *Massachusetts College of Emergency Physicians* *New York Chapter* *Oregon Chapter* *West Virgina College of Emergency Physicians* *Wisconsin Chapter*	C
48	Alarm Fatigue *Laurel Barr, MD, FACEP* *Elyse Lavine, MD, FACEP* *Samuel Sondheim, MD* *AAWEP Section* *Quality Improvement & Patient Safety Section* *Young Physicians Section*	C
49	Centralized Repository of Credentialing Data *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Texas College of Emergency Physicians* *Locums Tenens Emergency Medicine Section* *Wellness Section*	C

Resolution #	Subject/Submitted by	Reference Committee
50	Communication to Established Patients Being Referred to the Emergency Department *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Locums Tenens Emergency Medicine Section* *Wellness Section*	C
51	Consultant Communication and Feedback to Referring Emergency Physicians *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Locums Tenens Emergency Medicine Section* *Wellness Section*	C
52	Delegation of Critical Care to Non-Physician Practitioners *Louisiana Chapter*	C
53	Emergency Nursing and Emergency Department Accreditation *Pennsylvania College of Emergency Physicians*	C
54	Mandated Public Health Screening *New York Chapter*	C
55	Patient Experience Reporting *New York Chapter*	C
56	Patient and Visitor Code of Conduct *New York Chapter*	C
57	Rationalizing Communication of Imaging Hazards to Improve Care *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Locums Tenens Emergency Medicine Section* *Wellness Section*	C
58	Reducing Waste in Our Emergency Departments *Rita Manfredi-Shutler, MD, FACEP* *Kristen Nordenholz, MD, FACEP* *Matthew Siket, MD, FACEP* *Alexandra Thran, MD, FACEP* *Vermont Chapter*	C
59	Tap Water is Sufficient Treatment *Tabitha Baca, MD* *Marc Futernick, MD, FACEP* *Gayle Galletta, MD, FACEP* *Rita Manfredi-Shutler, MD, FACEP* *Dana Mathew, DO, FACEP* *Scott Mueller, DO, FACEP* *Kristen Nordenholz, MD, FACEP* *Matthew Siket, MD, FACEP* *David Terca, MD, FACEP* *Kreager Taber (MS4)* *Alexandra Thran, MD, FACEP* *California Chapter* *Vermont Chapter*	C
60	Lethal Means Firearm Safety Counseling *Ashley Foster, MD, FACEP* *Sophia Lin, MD* *Theresa Walls, MD, MPH* *Pediatric Emergency Medicine Section*	C

Resolution #	Subject/Submitted by	Reference Committee
61	Safe Storage of Firearms *Andrea Green, MD, FACEP* *Michael McGee, MD, MPH, FACEP* *Ugo Ezenkwele, MD, FACEP* *Christopher L. Smith, MD, FACEP* *Alexndra Nicole Thran, MD, FACEP* *Diversity, Inclusion, & Health Equity Section* *Social Emergency Medicine Section*	C
62	Stop the Bleed Education *Ugo Ezenkwele, MD, FACEP* *Andrea Green, MD, FACEP* *Michael McGee, MD, MPH, FACEP* *Christopher L. Smith, MD, FACEP* *Alexandra Nicole Thran, MD, FACEP* *Diversity, Inclusion, & Health Equity Section* *Social Emergency Medicine Section*	C

Late Resolutions

63	Commendation for Todd B. Taylor, MD, FACEP *James Augustine, MD, FACEP* *Nicholas Genes, MD, PhD, FACEP* *Emily Hayden, MD, FACEP*	
64	In Memory of Amy H. Kaji, MD, PhD, MPH *Richelle Cooper, MD, MSHS, FACEP* *Gregory Hendey, MD, FACEP* *David Schriger, MD, MPH, FACEP* *Kabir Yadav, MDCM, MD, MSHS, FACEP* *Donald M. Yealy MD, FACEP*	
65	In Memory of Joseph Sabato, Jr., MD, FACEP *Massachusetts College of Emergency Physicians*	
66	In Memory of Christopher J. Karns, DO *Pennsylvania College of Emergency Physicians*	

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

RESOLUTION: 1(24)

SUBMITTED BY: William P. Jaquis, MD, FACEP
Christopher S. Kang, MD, FACEP
Mark S. Rosenberg, DO, MBA, FACEP
Gillian R. Schmitz, MD, FACEP

SUBJECT: Commendation for Stephen V. Cantrill, MD, FACEP

1 WHEREAS, Stephen V. Cantrill, MD, FACEP, has been a long standing member of ACEP's Clinical Policies
2 Committee and ACEP's Epidemic Expert Panel; and
3
4 WHEREAS, Dr. Cantrill was selected to serve on the National Institute of Health's COVID-19 Treatment
5 Guidelines Panel; and
6
7 WHEREAS, Dr. Cantrill was the sole emergency physician and representative for emergency medicine on this
8 national panel; and
9
10 WHEREAS, Dr. Cantrill's service on this national panel entailed innumerable personal hours, more than 400
11 meetings, and 72 national treatment updates over the course of four years and through the conclusion of the historic
12 COVID-19 pandemic federal health emergency; and
13
14 WHEREAS, Dr. Cantrill's expertise guided the triage, evaluation, management, and disposition of countless
15 patients in the United States and around the world; and
16
17 WHEREAS, Dr. Cantrill represented and safeguarded the health, wellbeing, and professional identities of
18 millions of emergency physicians and emergency care personnel in the United States; therefore be it
19
20 RESOLVED, That the American College of Emergency Physicians commends Stephen V. Cantrill, MD,
21 FACEP, for his outstanding dedication and contributions on behalf of the College and the specialty of emergency
22 medicine.

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

RESOLUTION: 2(24)

SUBMITTED BY: Indiana Chapter

SUBJECT: Commendation for J.T. Finnell, II, MD, MSc, FACMI, FACEP

1 WHEREAS, J.T. Finnell, II, MD, MSc, FACMI, FACEP, has served the American College of Emergency
2 Physicians with highest distinction since becoming a member in 1990; and
3
4 WHEREAS, Dr. Finnell provided outstanding leadership to the Indiana Chapter through his service on its
5 Board of Directors 2009-present, as chapter president 2013-14, and has maintained an active presence in the chapter;
6 and
7
8 WHEREAS, Dr. Finnell was elected to the national ACEP Board of Directors in 2018 and served as Vice
9 President of the Board 2022-23; and
10
11 WHEREAS, Dr. Finnell served as Board Liaison to the following committees: Academic Affairs Committee
12 Clinical Policies Committee, Ethics Committee, Health Innovation Technology Committee, and the Research
13 Committee; and
14
15 WHEREAS, Dr. Finnell served as Board Liaison to the Critical Care Medicine Section, Cruise Ship Medicine
16 Section, Dual Training Section, Emergency Medicine Informatics Section, Emergency Ultrasound Section, Forensic
17 Medicine Section, Medical Humanities Section, Research, Scholarly Activity, & Innovation Section, Wilderness
18 Medicine Section, and the Young Physicians Section; and
19
20 WHEREAS, Dr. Finnell served as Board Liaison to the Emergency Medicine Group Ownership Task Force and
21 the New Practice Models Task Force; and
22
23 WHEREAS, Dr. Finnell has passionately devoted his heart, energy, and dedication to his patients and all
24 aspects of emergency medicine; and
25
26 WHEREAS, Dr. Finnell will continue to be involved and committed to the cause and mission of ACEP and
27 emergency medicine; therefore be it
28
29 RESOLVED, That the American College of Emergency Physicians commends and thanks J.T. Finnell, II, MD,
30 MSc, FACMI, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of
31 emergency medicine.

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

RESOLUTION 3(24)

SUBMITTED BY: Douglas Char, MD, FACEP
Kelly Gray-Eurom, MD, MMM, FACEP
Aaron Kuzel, DO, MBA
**See Attachment A for list of additional cosponsors*

SUBJECT: Commendation for Mary Ellen Fletcher, CPC, CEDC, CAE

1 WHEREAS, Mary Ellen Fletcher, CPC, CEDC, CAE, has been a valued and dedicated ACEP staff member
2 since February 27, 2001; and
3
4 WHEREAS, Ms. Fletcher worked tirelessly for 10 years in the Reimbursement Department supporting the
5 Reimbursement Committee and the Coding and Nomenclature Advisory Committee assisting with the assigned
6 objectives; and
7
8 WHEREAS, Ms. Fletcher assisted in supporting the ACEP CPT and RUC teams for several years, including
9 attending the CPT and RUC meetings, and was active in preparing the strategy and presentations that secured the wins
10 in the 2007 Medicare Physician Fee Schedule that increased emergency medicine revenues collectively by $1 billion
11 per year going forward; and
12
13 WHEREAS, Ms. Fletcher assisted in the planning and implementation of ACEP's Reimbursement and Coding
14 Conferences for years, and earned her Certified Professional Coder (CPC) and Certified Emergency Department Coder
15 (CEDC) credentials and helped to write the initial CEDC certification exam and study materials; and
16
17 WHEREAS, Ms. Fletcher has worked in the Governance Operations Department for the past 13 years
18 supporting ACEP's Board of Directors, Council, committees, past leaders, and liaison representatives; and
19
20 WHEREAS, Ms. Fletcher obtained her Certified Association Executive (CAE) certification demonstrating her
21 commitment as an association professional; and
22
23 WHEREAS, Ms. Fletcher has been instrumental in streamlining and improving ACEP's governance processes,
24 particularly for the Council and committee operations, and continues to identify and implement process improvements;
25 and
26
27 WHEREAS, Ms. Fletcher provides exceptional staff support to the ACEP Awards Committee, Council Steering
28 Committee, Council Awards Committee, Council Reference Committees, and the Tellers, Credentials, & Elections
29 Committee; and
30
31 WHEREAS, Ms. Fletcher's incredible memory, attention to detail, and strategic thinking enhances every
32 project in which she was involved; and
33
34 WHEREAS, Ms. Fletcher's bright smile, cheery disposition, and infectious laugh will be remembered by
35 everyone within ACEP who has had the pleasure to know her and work with her; and
36
37 WHEREAS**,** ACEP has benefited greatly from Ms. Fletcher's unique ability to adapt, amazing gift of patience,
38 and willingness to attend to the needs of ACEP members and staff; therefore be it
39
40 RESOLVED, That the American College of Emergency Physicians commends Mary Ellen Fletcher, CPC,
41 CEDC, CAE, for her outstanding service and dedication to the College and the specialty of emergency medicine and
42 extends heartfelt gratitude and appreciation for her extraordinary contributions.

Attachment A

List of Additional Cosponsors

Stephen Anderson, MD, FACEP
Andrew Bern, MD, FACEP
Michael Bishop, MD, FACEP
Jordan Celeste, MD, FACEP
Marco Coppola, DO, FACEP
Nicholas Cozzi, MD, MBA
Michael Gerardi, MD, FACEP
Sanford Herman, MD, FACEP
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Nicholas Jouriles, MD, FACEP
Steven Kailes, MD, FACEP
Jay Kaplan, MD, FACEP
Gary Katz, MD, MBA, FACEP
Paul Kivela, MD, MBA, FACEP
Jeffrey Linzer, MD, FACEP
Mark Meredith, MD, FACEP
Rebecca Parker, MD, FACEP
Debra Perina, MD, FACEP
Randy Pilgrim, MD, FACEP
John Proctor, MD, FACEP
John Rogers, MD, FACEP
Alex Rosenau, DO, FACEP
Mark Rosenberg, DO, MBA, FACEP
Michael Ruzek, DO, CPE, FACEP
Andrew Sama, MD, FACEP
Robert Schafermeyer, MD, FACEP
Gillian Schmitz, MD, FACEP
Sullivan Smith, MD, FACEP
Todd Taylor, MD, FACEP
James Thompson, MD, FACEP
Arlo Weltge, MD, FACEP
Florida College of Emergency Physicians
Indiana Chapter
NJ Chapter
Ohio Chapter
Tennessee College of Emergency Physicians

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

RESOLUTION: 4(24)

SUBMITTED BY: Washington Chapter

SUBJECT: Commendation for Christopher S. Kang, MD, FACEP

1 WHEREAS, Christopher S. Kang, MD, FACEP, has served the College diligently throughout his entire career
2 in emergency medicine starting with his terms as the Washington Chapter Treasurer, and Chapter President; and
3
4 WHEREAS, During Dr. Kang's tenure as national ACEP president, he brought honor to the Washington
5 Chapter by hosting the 2013 ACEP Scientific Assembly in Seattle; and
6
7 WHEREAS, Dr. Kang's leadership progressed to the National ACEP Board of Directors from 2015-2024,
8 and during that time he served in the highest positions of leadership in the College including Secretary-Treasurer,
9 Chair of the Board, President-Elect, President, and Immediate Past President; and
10
11 WHEREAS, During Dr. Kang's service as Secretary-Treasurer of both the Washington Chapter and National
12 ACEP Board of Directors he navigated challenging times with fiscal responsibility; and
13
14 WHEREAS, Dr. Kang fought hard in his leadership roles to bring respect back to the working members in the
15 trenches, with a priority to return emergency physicians to the standing they deserve; and
16
17 WHEREAS, Along this journey, Dr. Kang has served in many roles and as Board Liaison to numerous
18 committees, sections, and task forces, including the Board Liaison to the Workforce Task Force whose goal was to
19 study and make recommendations for recruitment and retention of membership following the peak of the COVID
20 pandemic; and
21
22 WHEREAS, Dr. Kang believes in the science of emergency medicine, and in addition to being the Residency
23 Research Director at Madigan Army Medical Center, he served on the Board of Trustees of the Emergency Medicine
24 Foundation and commits to all levels including being a member of the Wiegenstein Legacy Society; and
25
26 WHEREAS, Dr. Kang, as an Army veteran, served overseas, and since his return to Washington State he has
27 practiced at Madigan Army Medical Center and is a leader in their residency program, as well as being active in the
28 Government Services Chapter; and
29
30 WHEREAS, Dr. Kang believes in uniting all the fields in the House of Medicine and has been an active
31 liaison to the American Medical Association, the American College of Surgeons, and many others; and
32
33 WHEREAS, Dr. Kang has a field training history in trauma from his experience in the Army and he has
34 extended that to bridge the combined expertise of ACEP and the American College of Surgeons and he has become
35 the first emergency medicine trained ACEP Board member to be an editor of the Advanced Trauma Life Support text;
36 and
37
38 WHEREAS, Dr. Kang shines brightest in the roles he has played as a mentor, and his mentorship at the local,
39 state, national, and governmental levels has been instrumental in bestowing multiple Council Horizon and Council
40 Teamwork awards within ACEP; and
41
42 WHEREAS, Dr. Kang will continue to serve the College and be involved with the practice of emergency
43 medicine and dedicated to the mission of ACEP; therefore be it

44 RESOLVED, That the American College of Emergency Physicians commends Christopher S. Kang, MD,
45 FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine,
46 and to the patients we serve.

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

RESOLUTION: 5(24)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Commendation for Rami R. Khoury, MD, FACEP

1 WHEREAS, Rami R. Khoury, MD, FACEP, has served the American College of Emergency Physicians with
2 distinction since joining as a member in 2001; and
3
4 WHEREAS, After completing the Michigan College of Emergency Physicians Leadership Development
5 Program in 2012, Dr. Khoury has served the Michigan College with distinction including as an elected member of the
6 MCEP Board of Directors from 2013-20, MCEP President from 2018-19, and chair of the Legislative Committee from
7 2015-19; and
8
9 WHEREAS, Dr. Khoury's innovative work pertaining to pain management and opiate abuse paved the way for
10 many pain management initiatives in the state of Michigan and his health finance advocacy has tangibly improved
11 reimbursement for emergency physicians in the state of Michigan; and
12
13 WHEREAS, Dr. Khoury was elected to the ACEP Board of Directors in 2021 and has served with dedication
14 from 2021-24; and
15
16 WHEREAS, Dr. Khoury has served as ACEP Board Liaison to numerous committees, including the Clinical
17 Emergency Data Registry Committee; the Diversity, Equity, and Inclusion Committee; the Health Innovation
18 Technology Committee; and the Quality & Patient Safety Committee; and
19
20 WHEREAS, Dr. Khoury has served as ACEP Board Liaison to multiple sections, including the Diversity,
21 Inclusion, and Health Equity Section; the Emergency Medicine Workforce Section; the Emergency Medicine
22 Informatics Section; the Pain Management and Addiction Medicine Section; the Palliative Medicine Section; and the
23 Quality Improvement and Patient Safety Section; and
24
25 WHEREAS, Dr. Khoury has been active in multiple ACEP committees, including the State Legislative and
26 Regulatory Committee, the Council Tellers, Credentials, and Elections Committee, and the Council Steering
27 Committee, as well as in ACEP Council for nine years prior to his election to the Board of Directors; and
28
29 WHEREAS, Dr. Khoury has served on the Emergency Medicine Foundation Board of Trustees from 2022-24;
30 and
31
32 WHEREAS, Dr. Khoury has been a steadfast supporter of the National Emergency Medicine Political Action
33 Committee; and
34
35 WHEREAS, Dr. Khoury is known for his diplomatic nature, his well-reasoned opinions, his dedication as a
36 mentor to future physician leaders and medical students, and his willingness to advocate for both emergency physicians
37 and emergency department patients; therefore be it
38
39 RESOLVED, That the American College of Emergency Physicians commends Rami R. Khoury, MD,
40 FACEP, for his outstanding service, leadership, and commitment to the College, the specialty of emergency
41 medicine, and the patients we serve.

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

RESOLUTION 6(24)

SUBMITTED BY: Jay Brenner, MD, FACEP
Michael J. McCrea, MD, FACEP
John Moskop, PhD
Raquel Schears MD, FACEP
James D. Thompson, MD, FACEP
Larisa M. Traill, MD, FACEP
See Attachment A for list of additional individual cosponsors

SUBJECT: Commendation for Shari Purpura

1 WHEREAS, Shari Purpura, was a dedicated ACEP staff member from January 29, 2015, through March 15,
2 2024; and
3
4 WHEREAS, Ms. Purpura was an exceptional staff liaison for the ACEP Bylaws Committee and the ACEP
5 Ethics Committee; and
6
7 WHEREAS, Ms. Purpura worked tirelessly assisting every chapter of the College in updating, streamlining,
8 and improving their bylaws; and
9
10 WHEREAS, Ms. Purpura not only supported the Ethics Committee members in their endeavors, but also
11 ethically interacted with all College members she encountered; and
12
13 WHEREAS, During the COVID-19 pandemic she was not only invaluable in assisting the committees in
14 navigating operational shifts and facilitating meetings, but also in supporting ACEP chapters through urgent bylaws
15 amendments allowing chapters to continue operations remotely; therefore be it
16
17 RESOLVED, That the American College of Emergency Physicians commends Shari Purpura for her
18 outstanding service and commitment to the College, its chapters, and the specialty of emergency medicine.

Attachment A

List of Additional Individual Cosponsors

ACEP Bylaws Committee Members

Sara Chakel, MD FACE
Doug Char, MD, FACEP
Joshua da Silva, MD FACEP
Amye Farag, MD
Anna Heffron, MD, PhD
Fred Kency, Jr, MD, FACEP
Kurtis Mayz, JD, MD, FACEP
Michael McCrea, MD, FACEP
Scott Pasichow, MD, FACEP
James Paxton, MD, FACEP
Paul Pomeroy, MD, FACEP
Annabella Salvador-Kelly, MD, FACEP
Annalise Sorrentino, MD, FACEP
Larisa Traill, MD, FACEP
Bradford Walters, MD, FACEP
Luke Wohlford, MD, MHP

ACEP Ethics Committee Members

Nathan Allen, MD, FACEP
Andrew Aswegan, MD FACEP
Eileen Baker, MD, PhD, FACEP
Paul Bissmeyer, DO
Kelly Bookman, MD, FACEP
Samantha Chao, MD
Elizabeth P. Clayborne, MD, MA, FACEP
Michele Delpier, MD, FACEP
Arthur Derse, MD, JD, FACEP
Monisha Dilip, MD
Venkata Ramana Feeser, MD
John Finnell MD, FACMI, FACEP
Joel Geiderman, MD, FACEP
Rebecca Goett, MD, FACEP
James Hall, MD, MPH, FCCM, FAWM, FACEP
Kenneth Iserson, MD, FACEP
Breanne Jacobs, MD, FACEP
Karen Jubanyik-Barber, MD
Nicholas Kluesner, MD, FACEP
Gregory Larkin, MD FACEP
Catherine Marco, MD, FACEP
Evie Marcolini, MD, FACEP
Kenneth Marshall, MD, FACEP
Daniel Martin, MD, MBA, FACEP
Derek Martinez, DO
Norine McGrath, MD, FACEP
Michael O’Brien, DM, FAEMS, FACEP
Aasim Padela, MD, FACEP
Haley Sauder, MD
Tamar Sauer, MD
Raquel Schears, MD, FACEP
Jeremy Simon, MD, FACEP
Laura Vearrier, MD, DBe, FACEP
Dina Wallin, MD, FACEP

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

RESOLUTION: 7(24)

SUBMITTED BY: Ohio Chapter
Pennsylvania College of Emergency Physicians
West Virginia College of Emergency Physicians

SUBJECT: In Memory of Neal F. Aulick, II, MD, FACEP

1 WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Neal Aulick,
2 II, MD, FACEP, passed away surrounded by his family and loved ones on May 9, 2024, at the age of 55; and
3
4 WHEREAS, Dr. Aulick completed his undergraduate studies at Northern Kentucky University in 1991 and
5 while there met his future wife, and they were united in marriage one week following their graduation by their college
6 biology professor and ordained minister, Dr. Thomas Rambo; and
7
8 WHEREAS, Dr. Aulick completed his medical school training at the University of Kentucky in 1995; and
9
10 WHEREAS, He completed his residency at the WVU School of Medicine in Morgantown in 1998; and
11
12 WHEREAS, Dr. Aulick was a fellow of the American College of Emergency Physicians; and
13
14 WHEREAS, Dr. Aulick spent his emergency career working in emergency departments throughout West
15 Virginia, Ohio, and Pennsylvania; and
16
17 WHEREAS, He was an emergency physician at United Hospital Center in West Virginia from 1997 to 2005
18 and he served there as the director since 1999; and
19
20 WHEREAS, He worked at Ohio Valley Medical Center in West Virginia and East Ohio Regional Hospital in
21 Ohio from 2005 until their closures in 2019 and he served as their director since 2007; and
22
23 WHEREAS, He worked at Cannonsburg General Hospital in Pennsylvania from 2014 to 2017; and
24
25 WHEREAS, His final employment was at WVU Medicine Reynolds Memorial Hospital in West Virginia; and
26
27 WHEREAS, Dr. Aulick was also involved in educating future emergency physicians as a lecturer and instructor
28 to the Ohio Valley Medical Center Emergency Medicine Residency Program and Wilderness Medicine Rotation; and
29
30 WHEREAS, He was a clinical assistant professor at the West Virginia School of Osteopathic Medicine, the
31 Department of Emergency Medicine at West Virginia University, and the Ohio University Heritage College of
32 Osteopathic Medicine; and
33
34 WHEREAS, Dr. Aulick was also a certified Black Lung Examiner for the Respiratory & Occupational Lung
35 Disease Clinic through the Department of Labor; and
36
37 WHEREAS, Dr. Aulick served on numerous committees and boards including national ACEP's Emergency
38 Medicine Practice Committee, Membership Committee, and the Section Affairs Committee; and
39
40 WHEREAS, He was involved at the state level with the West Virginia College of Emergency Physicians and
41 served on their Board of Directors and held multiple leadership roles including president; and

42 WHEREAS, Dr. Aulick's other interests included playing guitar for Al Buterol and the Inhalers, a charity cover
43 band of local physicians and health care professionals; and
44
45 WHEREAS, He was a champion Texas Hold 'Em poker player; and
46
47 WHEREAS, He also enjoyed reading, heavy metal music, racquetball, pickleball, golfing, and deer hunting;
48 and
49
50 WHEREAS, Dr. Aulick was in two episodes of Untold Stories of the ER: "Secrets and Hives" 2013 Season 8,
51 Episode 6 and "Better to be Lucky" 2014 Season 9, Episode 6; and
52
53 WHEREAS, Dr. Aulick had a huge heart, was a great mentor, loved without limits, and his family and friends
54 were everything to him; therefore be it
55
56 RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Neal
57 Aulick, II, MD, FACEP; and be it further
58
59 RESOLVED, That the American College of Emergency Physicians, the Ohio Chapter, the Pennsylvania
60 College of Emergency Physicians, and the West Virginia College of Emergency Physicians extends to his wife Ginger
61 of 33 years, and his daughters Afton and Harper Aulick, gratitude for his service as an emergency physician at multiple
62 hospitals in Ohio, Pennsylvania, and West Virginia, as well as for his dedication and commitment to the specialty of
63 emergency medicine.

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

RESOLUTION: 8(24)

SUBMITTED BY: Douglas Hill, DO, FACEP
Carla Murphy, DO, FACEP
Colorado Chapter

SUBJECT: In Memory of Marilyn J. Gifford, MD

1 WHEREAS, Emergency medicine lost a longtime champion and advocate when Marilyn J. Gifford, MD,
2 passed away at the age of 80 on January 16, 2024; and
3
4 WHEREAS, Dr. Gifford was a military veteran and served in the United States Navy as a Lieutenant (LT MC
5 0-3) at the United States Naval Training Center, Bainbridge, Maryland, from 1970 through 1972 while continuing her
6 medical training; and
7
8 WHEREAS, Dr. Gifford served as the 8th President of the Colorado Chapter of the American College of
9 Emergency Physicians in 1979; and
10
11 WHEREAS, Dr. Gifford was on staff in the emergency department at Memorial Hospital of Colorado Springs
12 from 1980 to 2013, and despite very few women in emergency medicine, she became their Medical Director of
13 Emergency Medical Services (EMS); and
14
15 WHEREAS, While Dr. Gifford was at Memorial Hospital, she became Medical Director of the Emergency
16 Department, earning a reputation as a staunch advocate for her colleagues, staff, patients, EMS personnel, and the
17 community at large and during her directorship, Memorial Hospital had the highest volume of any emergency
18 department in the State of Colorado; and
19
20 WHEREAS, Dr. Gifford authored protocols used by ambulance and fire services to assist first responders in
21 helping patients in Colorado; and
22
23 WHEREAS, Dr. Gifford served the El Paso County Medical Society of Colorado on many committees and in
24 many capacities from 1982-1996 including Council on Legislation, Pre-Hospital Care Physician Advisory Committee,
25 and Board President from 1993-1994; and
26
27 WHEREAS, Dr. Gifford served as a delegate to the Colorado Medical Society (CMS) House of Delegates for
28 several terms from 1984-2015, as well as on the CMS Board of Directors from 1996-1998; and
29
30 WHEREAS, Dr. Gifford served as Board Chair of the National Registry of EMTs from 1992-1993 and again
31 from 1998-1999, and was the first woman to hold that position; and
32
33 WHEREAS, Dr. Gifford, during her tenure with the National Registry of EMTs Board of Directors, endorsed
34 the EMS Education and Practice Blueprint and pledged support to the Commission on Accreditation of Allied Health
35 Education Programs (CAAHEP) as the accrediting body; and
36
37 WHEREAS, During her second term at CAAHEP, Dr. Gifford spearheaded substantial revisions to the
38 practical examinations for EMT-I/85, EMT-I/99, and EMT-Paramedic; and
39
40 WHEREAS, Dr. Gifford received national ACEP's Award for Outstanding Contribution in EMS in Chicago on
41 October 17, 2001, at the Scientific Assembly held just 5 weeks after 9/11, and in her acceptance remarks she praised
42 and honored the many first responders who gave their lives in the line of duty on that fateful day; therefore be it

43 RESOLVED, That the American College of Emergency Physicians and the Colorado Chapter extend to
44 Marilyn J. Gifford, MD's son, Eric Caplan, MD, and his wife Melissa Ewer, MD, son Brian Caplan, JD, and his wife
45 Christina, brother Steve Gifford, and his wife Mimi, her five grandchildren Connor, Carson, Alaina, Piper, and Relic,
46 other family members, friends and colleagues, condolences and profound gratitude for her advocacy to Emergency
47 Medical Services and her commitment to the specialty of emergency medicine.

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

RESOLUTION: 9(24)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: In Memory of Veronica Greer, MD

1 WHEREAS, With the untimely death of Veronica Greer, MD, on May 26, 2024, Texas lost a devoted
2 emergency physician and educator; and
3
4 WHEREAS, Dr. Greer was a distinguished alumnus of McGovern Medical School at UT Houston, furthering
5 her training in family medicine at John Peter Smith Hospital in Fort Worth and subsequently in emergency medicine at
6 Texas Tech Health Science Center in El Paso; and
7
8 WHEREAS , Dr. Greer dedicated many years of her career to Texas Tech, serving as the Emergency Medicine
9 Residency Director, where she guided and mentored countless aspiring emergency physicians with clinical expertise,
10 empathy, and integrity; and
11
12 WHEREAS, Dr. Greer served with distinction as Chief of Staff at University Medical Center from 2016-18,
13 ensuring that University Medical Center's medical staff adhered to the highest standards of compliance and ethical
14 practice, providing exceptional care to patients; and
15
16 WHEREAS, Dr. Greer most recently contributed as Physician Advisor of the Clinical Documentation Integrity
17 Department since 2020, further enhancing the quality and accuracy of medical records; and
18
19 WHEREAS, Dr. Greer was renowned for her unwavering commitment to education, excellence, compassion,
20 and quality, impacting the lives of rotating residents, students, hospital staff, and patients alike; and
21
22 WHEREAS, Dr. Greer's legacy of humility, dedication, and kindness will forever endure in the hearts of her
23 colleagues, friends, and the broader emergency medicine community; therefore be it
24
25 RESOLVED, That the American College of Emergency Physicians hereby honors the memory of Veronica
26 Greer, MD, for her exceptional contributions to the field of emergency medicine, her inspiring leadership, and her
27 unwavering dedication to education and patient care; and be it further
28
29 RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Veronica
30 Greer, MD, acknowledging that though she may be gone, her legacy as a friend, mentor, and role model will live on in
31 perpetuity.

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

RESOLUTION: 10(24)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: In Memory of Christopher H. Linden, MD, FACEP

1 WHEREAS**,** Dr. Christopher Linden, renowned for his groundbreaking contributions in the fields of
2 emergency medicine and medical toxicology, died on August 26, 2023, leaving an indelible mark on the medical
3 community, his peers, colleagues, and students; and
4
5 WHEREAS, Dr. Linden studied psychology at Amherst College before completing his medical degree at
6 the University of Massachusetts Medical School in 1979, demonstrating his commitment to academic excellence
7 and the pursuit of medical knowledge; and
8
9 WHEREAS**,** After residency training in emergency medicine at the Milton Hershey Medical Center, Dr.
10 Linden pursued his medical toxicology fellowship at the Rocky Mountain Poison Control Center, where he
11 developed lasting friendships and conducted seminal research with Barry Rumack, MD, and Kenneth Kulig,
12 MD, on acetaminophen poisoning and other toxicological emergencies; and
13
14 WHEREAS**,** Dr. Linden published practice-changing papers on the use of physostigmine, MAOI
15 toxicity, and cyanide poisoning, significantly advancing the field of medical toxicology and improving patient
16 care globally; and
17
18 WHEREAS**,** After his fellowship, Dr. Linden became the founding director of the Division of Medical
19 Toxicology at the University of Massachusetts, where he developed a robust fellowship program that attracted
20 fellows from around the world and mentored a generation of toxicologists from 1986 to 1997; and
21
22 WHEREAS**,** Dr. Linden served as Chair of the Toxicology Section of the American College of
23 Emergency Physicians from 1995 to 1997, and as the Medical Toxicology sub-board director for the American
24 Board of Emergency Medicine from 1992 to 1997, further contributing to the governance and advancement of
25 the field; and
26
27 WHEREAS, Dr. Linden was a member of American College of Emergency Physicians for over 40 years
28 and a longstanding member of the American Academy of Clinical Toxicologists, demonstrating his commitment
29 to professional development and the dissemination of emergency medicine and toxicological knowledge; and
30
31 WHEREAS**,** In 1997, Dr. Linden joined the staff of Milford-Whitinsville Regional Hospital, where he
32 was beloved by colleagues and patients alike for his fearless approach to medicine, his encyclopedic knowledge,
33 humility, sense of humor, and his dedication to challenging conventional wisdom and inspiring innovation; and
34
35 WHEREAS, Dr. Linden's legendary incident of consulting on a case of methemoglobinemia from his
36 own ICU bed exemplifies his unwavering dedication to patient care and his exceptional clinical expertise; and
37
38 WHEREAS**,** Dr. Linden served as the Chair of the Pharmacy and Therapeutics Committee at Milford-
39 Whitinsville Regional Hospital for over two decades, leaving a lasting legacy of leadership and excellence in
40 clinical practice; and

41 WHEREAS, Outside the realm of medicine, Dr. Linden was known for his joy of life, maintaining
42 extraordinary collections of toxicologic images, vintage poison bottles, and a Harley-Davidson motorcycle,
43 becoming an accomplished, self-taught stonemason, and engaging in big mountain skiing; and
44
45 WHEREAS, Dr. Linden's social gatherings, including discussions on dram shop laws and Daubert
46 proceedings over dinner or late-night poker sessions, exemplified his generosity in sharing knowledge and
47 fostering camaraderie among colleagues; and
48
49 WHEREAS Dr. Linden's contributions to academia, medicine, and humanity as a whole will continue to
50 resonate through the generations of emergency physicians and medical toxicologists he mentored and inspired;
51 therefore be it
52
53 RESOLVED, That the American College of Emergency Physicians honors the life and legacy of
54 Christopher H. Linden, MD, FACEP, expressing our deepest condolences to his family and all who loved him
55 and acknowledging his remarkable achievements and the profound impact he had on the fields of emergency
56 medicine and medical toxicology and the lives of those fortunate enough to have known him.

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

RESOLUTION: 11(24)

SUBMITTED BY: Michigan College of Emergency Physicians

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

1 WHEREAS, With the passing of Gregory L. Walker, MD, FACEP, on March 26, 2024, emergency medicine
2 lost a champion for the Michigan College of Emergency Physicians (MCEP), the American College of Emergency
3 Physicians (ACEP), a longtime leader and teacher in the field, and a beloved friend in emergency medicine; and
4
5 WHEREAS, Dr. Walker received his bachelor's and medical degrees from Michigan State University (MSU),
6 completed his residency at the Michigan State University Sparrow Emergency Medicine residency program in
7 Lansing, Michigan, and will forever be a Spartan; and
8
9 WHEREAS, Dr. Walker was board certified in emergency medicine by the American Board of Emergency
10 Medicine (ABEM) and the National Board of Medical Examiners, was sub-specialty boarded in pediatric emergency
11 medicine by ABEM, and was a Fellow of ACEP; and
12
13 WHEREAS, Dr. Walker worked tirelessly as an attending physician at Sparrow Hospital in Lansing,
14 Michigan starting in 1991 as an early partner of Emergency Medical Associates, PLLC, and in 2014 earned the ACEP
15 Tenure Award for having the longest active career in the same emergency department, continuing to work for a total
16 of 30 years; and
17
18 WHEREAS, Dr. Walker demonstrated exceptional leadership skills as he led Emergency Medical Associates,
19 PLLC as an executive leader and staunch advocate for emergency medicine for over 15 years; and
20
21 WHEREAS, Dr. Walker was a committed and dedicated faculty member, serving as core faculty, including
22 Program Director, for the MSU EM Sparrow Lansing Residency for over 12 years, receiving the program's Resident
23 Advocate and the Faculty Recognition awards; and
24
25 WHEREAS, Dr. Walker believed everyone who worked in the emergency department should be adequately
26 trained and prepared, and as such, he developed and directed the Sparrow Hospital Emergency Medicine Physician's
27 Assistant program from 1994-2004; and
28
29 WHEREAS, Dr. Walker never stopped representing and advocating for the specialty of emergency medicine,
30 serving on multiple hospital committees over the years at Sparrow Hospital; and
31
32 WHEREAS, Dr. Walker in 1988 embarked on advocacy for emergency medicine early in his career by
33 becoming a resident member of both MCEP and ACEP, serving on multiple state committees, and becoming the
34 founding president of the Emergency Medicine Residents' Association of Michigan in 1990; and
35
36 WHEREAS, Dr. Walker served as an MCEP Board member, including as an Executive Board member, and
37 served as President of MCEP in 1998; and
38
39 WHEREAS, Dr. Walker was passionate about teaching and served as the Program Director for the MCEP
40 Resident's Assembly for 25 years, educating countless EM residents, and serving as an ABEM Oral Board examiner
41 for over 20 years; and
42
43 WHEREAS, Dr. Walker used his voice, knowledge, and vote to represent MCEP at the ACEP Council
44 starting in 1991, serving over 30 years; and

45 WHEREAS, Dr. Walker was recognized for his outstanding service and dedication to EM and received the
46 MCEP Ronald L. Krome Meritorious Service Award in 2001, the MCEP Legacy Award in 2009, and the MCEP
47 Significant Contribution Award in 2020; and
48
49 WHEREAS, Dr. Walker believed emergency medicine should be represented broadly in the house of
50 medicine, serving as a member and president of the Michigan Trauma Coalition and in the Michigan State Medical
51 Society (MSMS) as an executive leader and Chair of the Young Physicians Section and earning recognition as a
52 leader on the cover of the MSMS May 1996 Michigan Medicine Journal as a physician "Taking charge in an era of
53 change;" and
54
55 WHEREAS, Dr. Walker believed that the only thing better than being an emergency nedicine doctor was
56 raising his two exceptional children, Andy and Sam, spending time with his lifetime partner, Jamie, and playing
57 hockey, which he did as much as possible; therefore be it
58
59 RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency
60 Physicians recognize the outstanding dedication and contribution of Gregory L. Walker, MD, FACEP, to the specialty
61 of emergency medicine as a clinician, partner, educator, leader, and advocator; and be it further
62
63 RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency
64 Physicians extend to the family of Gregory L. Walker, MD, FACEP, especially his sons Andy and Sam, his
65 colleagues, partners, former residents, and all friends, our condolences along with our profound gratitude for his
66 lifetime of service to his patients and the specialty of emergency medicine in Michigan, where his impact will be felt
67 for generations to come.

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

RESOLUTION: 12(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory Jesse A. Weigel, MD, FACEP

1 WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Jesse A.
2 Weigel, MD, FACEP, passed away on December 12, 2023, at the age of 90; and
3
4 WHEREAS, Dr. Weigel completed his undergraduate studies at the University of Pittsburgh; and
5
6 WHEREAS, He also completed his medical school training at the University of Pittsburgh in 1960; and
7
8 WHEREAS, He initially began his career in family medicine, but soon found his passion in emergency
9 medicine; and
10
11 WHEREAS, Dr. Weigel was a pioneer in the field of emergency medicine and was instrumental in establishing
12 it as a specialty; and
13
14 WHEREAS, He was a founding member of the American College of Emergency Physicians and started the
15 Pennsylvania Chapter; and
16
17 WHEREAS, Dr. Weigel was a fellow of the American College of Emergency Physicians; and
18
19 WHEREAS, Dr. Weigel was the first Director of Emergency Medicine at Passavant Hospital in Pittsburgh, PA;
20 and
21
22 WHEREAS, He helped create three emergency medical service organizations and then united the area’s diverse
23 services into a cohesive system; and
24
25 WHEREAS, He was the Director of the Pennsylvania Medical Services Council and was a national speaker;
26 and
27
28 WHEREAS, Dr. Weigel was involved in the startup of the Pittsburgh Paramedic Program and served as its
29 Medical Operations Director; and
30
31 WHEREAS, Dr. Weigel became the Director of Emergency Medical Service at Harrisburg Hospital in 1979;
32 and
33
34 WHEREAS, He later became the Senior Vice President and Chief Medical Officer of Pinnacle Health System
35 in 1984 until his retirement in 2000; and
36
37 WHEREAS, He developed the paramedic program at the Harrisburg Area Community College; and
38
39 WHEREAS, Throughout his career and into retirement, Dr. Weigel continued to be a leader in emergency
40 medicine by serving in many leadership roles, on various boards, establishing new programs, and sharing his
41 knowledge with others across various organization; and
42
43 WHEREAS, His passion for cooking family dinners led him to his second career as a sous chef at the Kitchen
44 Shoppe Cooking School in Carlisle, PA; and

45 WHEREAS, He also enjoyed traveling, gardening, anything Snoopy, and rooting for his Pittsburgh Panthers;
46 and
47
48 WHEREAS, Dr. Weigel was active in his church and in the Scottish Society of Central Pennsylvania; and
49
50 WHEREAS, He was married for 53 years to Janet Kay (McMeans) Weigel, who preceded him in death, and
51 together they built a life centered on family and service to others; therefore be it
52
53 RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Jesse
54 A. Weigel, MD, FACEP; and be it further
55
56 RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of
57 Emergency Physicians extends to his children Karen Weigel, Kevin Weigel, and Jennifer Hudson gratitude for his
58 service as an emergency physician as well as for his dedication and commitment to the specialty of emergency
59 medicine.

2024 Council Meeting
Reference Committee Members

Reference Committee A – Governance & Membership
Resolutions 13-23

Larisa M. Traill, MD, FACEP (MI) – Chair
Laurel Barr, MD, FACEP (OH)
Amanda Irish, MD, MPH (IA)
Catherine A. Marco, MD, FACEP (PA)
Emily Mills, MD, FACEP (MI)
Aine Yore, MD, FACEP (WA)

Amanda Pairitz-Campo
Laura Lang, JD

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

Bylaws Amendment

RESOLUTION: 13(24)

SUBMITTED BY: Colorado Chapter
Louisiana Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Allocation of Councillors

PURPOSE: Amend the Bylaws to determine councillor allocation for the annual Council meeting by using the average number of members during the calendar year instead of the actual number of members as of December 31 of the preceding year.

FISCAL IMPACT: Budgeted staff resources to assess the number of members of each component body for councillor allocation based on the requirements in the Bylaws.

1 WHEREAS, The ACEP Council consists of members representing ACEP's 53 chartered chapters (50 states,
2 Puerto Rico, the District of Columbia, and Government Services), its sections of membership, the Association of
3 Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors
4 (CORD), the Emergency Medicine Residents' Association (EMRA) and the Society for Academic Emergency
5 Medicine (SAEM); and
6
7 WHEREAS, The Council elects the president-elect and four members to the Board of Directors each year and
8 the Council Speaker and Vice Speaker every two years; and
9
10 WHEREAS, The Council votes on resolutions, including changes to the Bylaws, College Manual, and the
11 Council Standing Rules; and
12
13 WHEREAS, The Council ensures "grassroots" involvement in ACEP's democratic decision-making process;
14 and
15
16 WHEREAS, The current ACEP Bylaws specify each chartered chapter shall have a minimum of one councillor
17 as representative of all of the members of such chartered chapter; and
18
19 WHEREAS, There shall be allowed one additional councillor for each 100 members of the College in that
20 chapter as shown by the membership rolls of the College on December 31 of the preceding year; and
21
22 WHEREAS, ACEP membership renewal options are yearly, quarterly, or monthly and payment options include
23 phone, mail, or online and auto-renewal is not required; and
24
25 WHEREAS, Membership rolls fluctuate throughout the year due to variable membership renewal options,
26 delayed renewals, variable payment options, inaccurate credit/debit card/bank draft information leading to failures, etc.;
27 and
28
29 WHEREAS, If membership rolls are below threshold on December 31, then chapters lose a councillor; and
30
31 WHEREAS, Several chapters have lost members due to current Bylaws but would have met the threshold at
32 other times of the year; and
33
34 WHEREAS, Using the average membership number over the calendar year more accurately reflects each

chapter's membership totals given that this number can change daily due to new enrollments and drops; and

WHEREAS, In 2018 there was a resolution concerning the growth of the Council, however comparing 2021 when there were 407 total chapter councillors to 2024 when there are 382 total chapter councillors, there are now 25 less councillors; and

WHEREAS, Loss of councillors leads to less grassroots involvement; and

WHEREAS, ACEP should support efforts to increase member engagement and trust and grassroots involvement in decision-making processes in line with ACEP's strategic plan and Council goals; 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 **average** membership roll~~s~~ of the College ~~on December 31 of the preceding~~ **during the calendar** 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.

Background

This resolution seeks to amend the Bylaws to determine councillor allocation for the annual Council meeting by using the average number of members during the calendar year instead of the actual number of members as of December 31 of the preceding year.

December 31 has been used as the date to determine councillor allocation since 1987. The date for determining councillor allocation before 1987 was 45 days prior to the annual meeting.

Councillor distribution can change each year as members move among different chapters, particularly when candidate members graduate residency and move to another chapter. Chapters receive monthly membership reports and have access to their membership reports through the chapter portal. Additionally, chapters are sent reports every month providing a list of members that will be cancelled. Cancellations typically occur the third Friday of the third month following the membership expiration date. The grace period to renew membership allows graduating residents an opportunity to become settled in their new location. Multiple reminders are sent to chapters to remind them of the councillor allocation deadline and to follow up with any lapsed members.

ACEP membership was at an all-time high in 2020 and councillor allocation reached a peak of 446 for the 2021 Council meeting. Membership declined in 2021, 2022, and 2023 and the number of councillors for 2024 is 422 based on the total membership as of December 31, 2023, which is a decline of 24 councillors over the past 4 years.

Based on the December 31, 2023, date, the following chapters gained one councillor for the 2024 Council meeting: Connecticut, Idaho, and Kentucky. Using the average number of members would not have changed their councillor allocation for 2024.

The following chapters each lost one councillor for the 2024 Council meeting using the December 31, 2023, date: Alaska, California, Colorado, Government Services, Kansas, Louisiana, Missouri, South Carolina, Washington, and West Virginia. Using the average number of members would have resulted in California gaining one councillor compared to 2023 and Alaska and Colorado still losing one councillor. Government Services, Kansas, Louisiana, Missouri, South Carolina, Washington, and West Virginia would have maintained the same number of councillors as were allocated for 2023. Additionally, Florida, Michigan, New York, Ohio, Oklahoma, Pennsylvania, and Texas would have gained one councillor compared to the 2023 allocation. The total councillor allocation for chapters would have increased by 16 based on the average number of members, bringing the overall total councillor allocation,

including AACEM, CORD, EMRA, SAEM, and sections to 438 for a net gain of 11 compared to the total 2023 councillor allocation.

Attachment A provides an analysis of the councillor allocations for 2024 by chapter based on the membership as of December 31, 2023, compared to the average number of members by chapter for the 2023 calendar year. Councillor allocations for 2023 are also included in the chart.

ACEP Strategic Plan Reference

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

- Build up the leadership pipeline within ACEP and throughout emergency medicine spheres of influence.

Fiscal Impact

Budgeted staff resources to assess the number of members of each component body for councillor allocation based on the requirements in the Bylaws.

Prior Council Action

Resolution 4(86) Councillor Allocation adopted. Amended the Constitution to change the timing of councillor allocation determination based on the number of members of a chapter as shown by the membership rolls from 45 days prior to the annual meeting to December 31 each year.

Prior Board Action

Resolution 4(86) Councillor Allocation adopted.

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

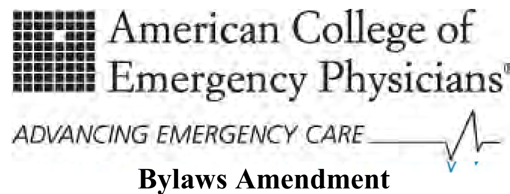
Mollie Pillman, MS, MBA, CAE
Associate Executive Director, Member Experience

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

Chapter	2023 Councillor Allocation	Membership as of 12/31/23	2024 Councillor Allocation	Average 2023 Membership	Councillor Allocation Based on Average Membership	Plus/Minus average 2023 vs. 12/31/23
Alabama	4	312	4	328	4	
Alaska	2	89	1	95	1	
Arizona	8	722	8	754	8	
Arkansas	2	194	2	196	2	
California	34	3254	33	3429	35	2
Colorado	7	594	6	596	6	
Connecticut	5	513	6	506	6	
Delaware	2	194	2	190	2	
District of Columbia	3	254	3	268	3	
Florida	21	2094	21	2118	22	1
Georgia	9	850	9	899	9	
Government Services	11	999	10	1037	11	1
Hawaii	2	168	2	166	2	
Idaho	2	207	3	206	3	
Illinois	13	1230	13	1284	13	
Indiana	6	558	6	541	6	
Iowa	2	181	2	189	2	
Kansas	3	194	2	210	3	1
Kentucky	3	313	4	321	4	
Louisiana	5	370	4	420	5	1
Maine	3	220	3	225	3	
Maryland	7	619	7	623	7	
Massachusetts	10	905	10	941	10	
Michigan	20	1905	20	2002	21	1
Minnesota	8	711	8	720	8	
Mississippi	3	242	3	252	3	
Missouri	7	583	6	621	7	1
Montana	1	88	1	88	1	
Nebraska	2	144	2	154	2	
Nevada	4	322	4	341	4	
New Hampshire	2	162	2	160	2	
New Jersey	10	991	10	959	10	
New Mexico	3	215	3	207	3	
New York	30	2920	30	3038	31	1
North Carolina	11	1048	11	1067	11	
North Dakota	1	52	1	54	1	
Ohio	15	1468	15	1534	16	1
Oklahoma	3	272	3	303	4	1
Oregon	5	475	5	440	5	
Pennsylvania	18	1784	18	1824	19	1
Puerto Rico	2	148	2	140	2	

Chapter	2023 Councillor Allocation	Membership as of 12/31/23	2024 Councillor Allocation	Average 2023 Membership	Councillor Allocation Based on Average Membership	Plus/Minus average 2023 vs. 12/31/23
Rhode Island	3	219	3	240	3	
South Carolina	6	489	5	532	6	1
South Dakota	1	56	1	60	1	
Tennessee	5	413	5	439	5	
Texas	21	2000	21	2103	22	1
Utah	4	349	4	357	4	
Vermont	2	117	2	117	2	
Virginia	9	875	9	891	9	
Washington	8	689	7	716	8	1
West Virginia	3	195	2	211	3	1
Wisconsin	6	500	6	517	6	
Wyoming	1	39	1	40	1	
Chapter Totals	**378**		**371**		**387**	**16**
AACEM	1		1		1	
CORD	1		1		1	
EMRA	8		8		8	
SAEM	1		1		1	
Sections	38		40		40	
Total Councillors	**427**		**422**		**438**	**16**

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



Bylaws Amendment

RESOLUTION: 14(24)

SUBMITTED BY: Bylaws Committee
Board of Directors
Council Steering Committee

SUBJECT: College Parliamentary Authority

PURPOSE: Amends the Bylaws to update ACEP's parliamentary authority.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, The College's current parliamentary authority, *The Standard Code of Parliamentary Procedure (Sturgis)* is no longer updated; therefore be it

RESOLVED, That the ACEP Bylaws, Article XIV –Miscellaneous, Section 3 – Parliamentary Authority, be amended to read:

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

Background

This resolution amends the Bylaws to update ACEP's parliamentary authority from *The Standard Code of Parliamentary Procedure (4th Edition)* to the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure.* There is also a companion Council Standing Rules resolution.

ACEP has used *The Standard Code of Parliamentary Procedure* and its subsequent updates as the parliamentary authority since 1975. The American Institute of Parliamentarians (AIP) published *The Standard Code of Parliamentary Procedure, Fourth Edition* (TSC) in 2001. ACEP has been aware since 2012, when AIP published the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (AIPSC), that a change to the parliamentary authority would eventually be necessary. The changes to the 2012 edition compared to the 4th edition released in 2001 were quite minor. Past Council officers and past members of the Bylaws Committee have consulted with ACEP's parliamentarian, Jim Slaughter, JD, over the past few years about the advisability of updating the parliamentary authority and when that should occur since TSC continues to be available for purchase and as a publish-on-demand book. Mr. Slaughter advised in 2022 that a new edition of the AIPSC was forthcoming and it was determined that considering a change to the parliamentary authority should be delayed until the new edition was released. The AIPSC 2nd edition was finally released in Fall 2023. Mr. Slaughter prepared a brief article about the book's purpose and updates: https://blog.lawfirmcarolinas.com/newly-released-aip-standard-code-of-parliamentary-procedure-second-edition/.

Updating ACEP's parliamentary authority from TSC to the AIPSC requires amendments to the Bylaws and the Council Standing Rules. Additional changes to the Council Standing Rules beyond updating the name of the parliamentary authority, are not required since the Council Standing Rules override the parliamentary authority as the higher authority, i.e., the Bylaws and the Council Standing Rules are higher authority governing documents.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

Resolution 9(75) Rules of Order adopted. Amended the Bylaws to change the parliamentary authority from *Robert's Rules of Order* to *The Standard Code of Parliamentary Procedure.*

Prior Board Action

June 2024, approved cosponsoring the resolution with the Council Steering Committee and the Bylaws Committee to update ACEP's parliamentary authority and submit it to the 2024 Council for consideration.

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

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

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

Council Standing Rules Amendment

RESOLUTION: 15(24)

SUBMITTED BY: Council Steering Committee

SUBJECT: College Parliamentary Authority

PURPOSE: Amends the Council Standing Rules to update ACEP's parliamentary authority with a proviso that the changes become effective after the 2024 Council meeting and only upon adoption of the companion Bylaws amendment.

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

WHEREAS, The College's current parliamentary authority, *The Standard Code of Parliamentary Procedure (aka "Sturgis")* is no longer updated; therefore be it

RESOLVED, That the ACEP Council Standing Rules, Parliamentary Procedure (paragraph one) be amended to read as follows with the proviso that the changes will become effective after the 2024 Council meeting and only upon adoption of the companion resolution College Parliamentary Authority – Bylaws Amendment:

Parliamentary Procedure

The ~~current~~ **most recent** edition of ~~*Sturgis, Standard Code of Parliamentary Procedure*~~ ***The American Institute of Parliamentarians 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.***

Background

This resolution amends the Council Standing Rules to update ACEP's parliamentary authority from *The Standard Code of Parliamentary Procedure (4th Edition)* to the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* with a proviso that the changes become effective after the 2024 Council meeting and only upon adoption of the companion Bylaws amendment.

ACEP has used *The Standard Code of Parliamentary Procedure* and its subsequent updates as the parliamentary authority since 1975. The American Institute of Parliamentarians (AIP) published *The Standard Code of Parliamentary Procedure, Fourth Edition* (TSC) in 2001. ACEP has been aware since 2012, when AIP published the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (AIPSC), that a change to the parliamentary authority would eventually be necessary. The changes to the 2012 edition compared to the 4th edition released in 2001 were quite minor. Past Council officers and past members of the Bylaws Committee have consulted with ACEP's parliamentarian, Jim Slaughter, JD, over the past few years about the advisability of updating the parliamentary authority and when that should occur since TSC continues to be available for purchase and as a publish-on-demand book. Mr. Slaughter advised in 2022 that a new edition of the AIPSC was forthcoming and it was determined that considering a change to the parliamentary authority should be delayed until the new edition was released. The AIPSC 2nd edition was finally released in Fall 2023. Mr. Slaughter prepared a brief article about the book's purpose and updates: https://blog.lawfirmcarolinas.com/newly-released-aip-standard-code-of-parliamentary-procedure-second-edition/.

Updating ACEP's parliamentary authority from TSC to the AIPSC requires amendments to the Bylaws and the

Updating ACEP's parliamentary authority from TSC to the AIPSC requires amendments to the Bylaws and the Council Standing Rules. Additional changes to the Council Standing Rules beyond updating the name of the parliamentary authority, are not required since the Council Standing Rules override the parliamentary authority as the higher authority, i.e., the Bylaws and the Council Standing Rules are higher authority governing documents.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 9(75) Rules of Order adopted. Amended the Bylaws to change the parliamentary authority from *Robert's Rules of Order* to *The Standard Code of Parliamentary Procedure.*

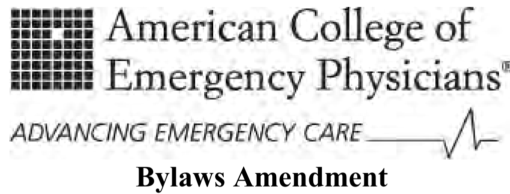
Prior Board Action

June 2024, approved cosponsoring the Bylaws resolution with the Council Steering Committee and the Bylaws Committee to update ACEP's parliamentary authority and submit it to the 2024 Council for consideration. The Board and the Bylaws Committee were not requested to cosponsor the Council Standing Rules amendment since this is a governing document of the Council.

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

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

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



Bylaws Amendment

RESOLUTION: 16(24)

SUBMITTED BY: Bylaws Committee
Board of Directors
Cruise Ship Medicine Section
International Emergency Medicine Section

SUBJECT: International Members Serving as Section Officers

PURPOSE: Amends the Bylaws to clarify the voting rights of international members and allows international members to serve as section officers except for the positions of councillor and alternate councillor.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

1 WHEREAS, Section officers must be elected by members of the section per the terms outlined in each section's
2 operational guidelines; and
3
4 WHEREAS, Section officers, as defined in section operational guidelines, typically include the positions of
5 chair, chair-elect or vice chair, immediate past chair, secretary or secretary/newsletter editor, and website editor and
6 some section operational guidelines include the councillor and alternate councillor positions; and
7
8 WHEREAS, International members of the College cannot currently serve as section officers based on the
9 restriction in the Bylaws that international members "may not hold office;" and
10
11 WHEREAS, "Holding office" is interpreted as having been elected to a position; and
12
13 WHEREAS, Some sections have international members and have expressed interest in serving as section
14 officers; and
15
16 WHEREAS, It is desirable to continue to the requirement that international members may not serve on the
17 Council; and
18
19 WHEREAS, It is desirable to continue to allow international members to vote in committees on which they
20 serve and participate as voting members in sections of membership; therefore be it
21
22 RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 2.4 – International Members, be
23 amended to read:
24
25 Any physician interested in emergency medicine who is not a resident of the United States or a possession
26 thereof, and who is licensed to practice medicine by the government within whose jurisdiction such physician resides
27 and practices, shall be eligible for international membership. All international members will be assigned by the Board
28 of Directors to either active or inactive status. Members who qualify will additionally be assigned to life status.
29
30 International members who are unable to engage in medical practice may, upon application to the Board of
31 Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable
32 annually upon re-application.
33
34 Any international member who has been a member of the College for a minimum of 30 years in any class shall
35 be assigned to life status. Any member previously designated as a life member under any prior definition shall retain

36 life status.
37
38 ~~International members may not hold office and may not serve on the Council. International members, with the~~
39 ~~exception of those in inactive status, may vote in committees on which they serve.~~
40
41 **International members may not seek election to or serve on the national Board of Directors, may not**
42 **seek election to or serve as Council Speaker or Council Vice Speaker, may not serve as a councillor or alternate**
43 **councillor, and may not serve on a Council committee. With the exception of those in inactive status,**
44 **international members may serve as voting members of College committees to which they are appointed but may**
45 **not serve as committee chairs, may participate as voting members in sections of membership, and may serve as a**
46 **section officer except for the positions of councillor and alternate councillor.**

Background

This resolution amends the Bylaws to clarify the voting rights of international members and allows international members to serve as section officers except for the positions of councillor and alternate councillor.

Some international members of sections have expressed a desire to serve as section officers. Section officers must be elected per the terms outlined in each section's operational guidelines. Section officers, as defined in section operational guidelines, typically include the positions of chair, chair-elect or vice chair, immediate past chair, secretary or secretary/newsletter editor, and website editor and some section operational guidelines include the councillor and alternate councillor positions as officer positions.

The current language in the Bylaws regarding "holding office" has been interpreted to exclude international members from serving as section officers because the positions are elected by the section and elected individuals are "holding office." ACEP's "Conflict of Interest" policy statement includes section chairs as key leaders having a fiduciary duty to the College.

The Bylaws Committee was assigned an objective to define "holding office" and determine whether a Bylaws amendment should be developed to provide clarification in the Bylaws regarding international members eligibility to serve as section chairs. Given that most sections would want a potential section chair to have served in other section leadership roles prior to being elected as chair-elect, it is desirable to expand the ability of international members to serve in those other leadership roles.

After careful review of the Bylaws and after researching various definitions of "holding office" the Bylaws Committee concluded that the term is overly broad and is difficult to define in a manner that fully resolves the potential conflict in the Bylaws. The proposed language in this Bylaws amendment specifically delineates the privileges the College extends or does not extend to international members, particularly regarding positions of leadership. The prior restrictions applied to international members who are in inactive status has been retained.

International membership in ACEP was added to the Bylaws in 1975. A Bylaws amendment was adopted in 1986 clarifying the voting rights for all classes of membership and specifically stated that international members cannot vote. In 1988, Bylaws language regarding the inability of inactive and international members to vote was amended to include "or hold office." Subsequent changes to the Bylaws have occurred over the years and have always maintained that international members cannot vote or hold office. A provision was added in 2014 allowing international members to vote in committees on which they serve.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

Amended Resolution 9(14) Membership Classification Restructure adopted. Changes to Article IV – Membership, Section 2.4 – International Members, explicitly defined the rights of international members and included language allowing international members the ability to "vote in committees in which they serve."

Amended Resolution 21(88) Housecleaning Changes to Constitution and Bylaws adopted. Several non-substantive and clarifying language changes were made to the Constitution and Bylaws. The "Voting Members and Holding Office" section was amended to include that inactive and international members shall not be entitled to vote **or hold office**.

Substitute Resolution 9(86) Voting Rights for Members adopted. The Bylaws amendment clarified the voting rights for all classes of membership and specifically stated that international members cannot vote.

Resolution 7(75) International Membership adopted. This Bylaws amendment created an international membership category.

Prior Board Action

June 2024, approved cosponsoring the Bylaws resolution with the Bylaws Committee to clarify the voting rights of international members and allows international members to serve as section officers except for the positions of councillor and alternate councillor and submit it to the 2024 Council for consideration.

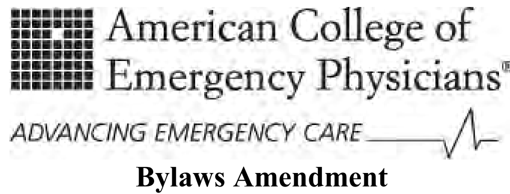
Amended Resolution 9(14) Membership Classification Restructure adopted.

The Board did not adopt Bylaws resolutions prior to 1991.

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

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

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



Bylaws Amendment

RESOLUTION: 17(24)

SUBMITTED BY: Jacob Altholz, MD
Scott Pasichow, MD, MPH, FACEP

SUBJECT: Removing Gendered Pronouns from ACEP's Bylaws

PURPOSE: Amends the Bylaws to remove gendered pronouns.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, ACEP's policy on Caring for Transgender and Gender Diverse Patients in the Emergency Department states: "EDs should foster and develop practices, policies, and accessible resources that provide a supportive and inclusive environment for TGD patients."[1]; and

WHEREAS, ACEP's values state: "The best interests of patients are served when emergency physicians practice in a fair, equitable, and supportive environment."[1]; and

WHEREAS, Our Bylaws are the legal foundation of the function of our College and its chapters, and that legal foundation should uphold the values and policies of the organization; and

WHEREAS, The U.S. Department of Commerce has issued a guide to gender inclusive language that includes not assuming the gender of another individual and avoid gendered nouns or pronouns[2]; and

WHEREAS, The European Union has published gender pronoun language that includes the use of "they" as a singular pronoun[3]; and

WHEREAS, ACEP's College and chapter bylaws have varying levels of adherence to the avoidance of gendered pronouns and nouns, including some chapters that simply state that using gendered pronouns is not intended to imply a gender bias or preference; and

WHEREAS, It would be clearer for ACEP to avoid the use of pronouns in bylaws to the individual and positions being referred to in a statement were clear and consistent; therefore be it

RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 3 – Qualifications be amended to read:

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.; and be it further

RESOLVED, That the ACEP Bylaws Article IX – Board of Directors, Section 2 – Composition and Election be amended to read:

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~~ **an** 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.; and be it further

RESOLVED, That the ACEP Bylaws Article X– Officers/Executive Director, Section 7 – Vice President be amended to read:

"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~~ **remains** 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"; and be it further

RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 9 – Secretary-Treasurer be amended to read:

A director shall be eligible for election to the position of secretary-treasurer if ~~he or she has~~ at least one year ~~remaining~~ **remains** 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.; and be it further

RESOLVED That the ACEP Bylaws Article XI – Committees, Section 5 – Finance Committee be amended to read:

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~~ **the speaker's** 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.; and be it further

RESOLVED, That the ACEP Bylaws Article XV – Mandatory Indemnification, Section 3 – Non-Exclusive; Continuation) be amended to read:

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~~ **the individual's** 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.

References
1. "Caring for Transgender and Gender Diverse Patients in the Emergency Department."
2. ACEP's Values Statements
3. "PROMISING PRACTICE GUIDE ON HOW TO USE GENDER-INCLUSIVE LANGUAGE AT THE U.S. DEPARTMENT OF COMMERCE." *US Departement of Commerece*. June 2024. Online.
4. *Gender Neutral Language in European Parliament.* 2018. Online.

Background

This resolution amends the Bylaws to remove gendered pronouns.

ACEP is committed to fostering diversity, equity, and inclusion in emergency medicine. This commitment is evidenced by the policy statements and Council resolutions that have been adopted as well as the creation of awards to recognize and honor individuals for their efforts to advance diversity, equity, and inclusion. Additionally, ACEP participated with nine other emergency medicine organizations to create the All EM DEI Vision Statement. Removing gendered pronouns and using gender-neutral or gender-inclusive in the Bylaws is consistent with ACEP's commitment.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

None pertaining to removing gendered pronouns from the Bylaws.

Prior Board Action

None pertaining to removing gendered pronouns from the Bylaws.

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

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

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

RESOLUTION: 18(24)

SUBMITTED BY: Alicia Mikolaycik Gonzalez, MD, FACEP
Aimee Moulin, MD, FACEP
David Terca, MD, FACEP
Randall Young, MD, FACEP
California Chapter
Nevada Chapter
New York Chapter

SUBJECT: ACEP Council and Scientific Assembly Meeting Location

PURPOSE: Survey members to obtain feedback on Scientific Assembly locations, including whether they would prefer a rotating or semi-permanent site, preferred and non-preferred cities, and provide input on other factors to consider when designating a conference location.

FISCAL IMPACT: Programs are budgeted so that net revenue exceeds expense. ACEP would incur significant fees to cancel meetings that are contracted through 2025. Potential estimated cost of $10,000 to conduct an all-member survey.

1 WHEREAS, Members of ACEP reside in all 50 states, which requires the majority of members to travel
2 annually to attend the Scientific Assembly and Council meeting; and
3
4 WHEREAS, Longer distance travel leads to higher costs incurred by the member/attendee; and
5
6 WHEREAS, Scientific Assembly locations located closer to the East or West coast impose significantly
7 increased cost and time associated with travel to members on the opposite coast, which can lead to decreased
8 attendance from those members; and
9
10 WHEREAS, Scientific Assembly meetings hosted in locations with multiple direct flight options, more central
11 location, and without significant weather-related travel disruptions, such as Las Vegas, can attract higher member
12 attendance for the Scientific Assembly and Council meetings; and
13
14 WHEREAS, Attendance at Scientific Assembly is an important fiscal as well as culture-building priority for
15 ACEP and having a single conference site could save money for the organization and be logistically simpler; therefore
16 be it
17
18 RESOLVED, That ACEP survey the membership to obtain robust, direct member feedback on Scientific
19 Assembly locations, including whether they would prefer a rotating or semi-permanent site, preferred and non-preferred
20 cities, and provide input on the other factors that the College should consider when designating a conference location.

Background

This resolution calls for ACEP to survey the members to obtain feedback on Scientific Assembly locations, including whether they would prefer a rotating or semi-permanent site, preferred and non-preferred cities, and provide input on other factors to consider when designating a conference location.

Scientific Assembly is the second largest single source of revenue for ACEP after membership dues and is approximately 38% of ACEP's overall budget. It is critically important that the annual meeting be held in locations

that maximize the likelihood of large attendance and financial success while providing all attendees with an exceptional experience.

The location of Scientific Assembly is traditionally placed in the most recognized first-tier cities such as Chicago, San Francisco, San Diego, Las Vegas, and Boston because of the size of the meeting and the rate of constant growth. In recent years, ACEP has been able to branch out into other lower cost cities such as Salt Lake City, Denver, and Dallas that may not be as recognized but offer ACEP financial incentives and lower costs to meet in those cities. The demand across all sectors for business meetings in these cities continues to increase as they prove to be extremely popular and have the capacity to accommodate large meetings and are attractive to registrants. Some cities will offer incentives to return to that location within a given time period, which can save ACEP significant costs.

Staff continue to explore all possibilities for cities that have the needed hotel rooms, meetings space, and easy flights to ensure ACEP is receiving the most beneficial financial package for the annual meeting, which is critical to the College's financial success each year. We must also select venues that ensure member/customer satisfaction and provide an exhilarating experience for attendees, attract exhibitors, and physically accommodate the large amount of function space ACEP requires at a reasonable cost. Data is gathered annually from the Scientific Assembly attendees about cities they would like to return to and potential new venues of interest from the overall evaluation sent to all attendees. Surveying attendees provides better data since all member surveys typically yield about a 2% response rate.

Given the continued growth of our meeting, accelerating competition for our preferred dates each year, a strong economy, and the loss of some previous options based on the growth in the size of our annual meeting, ACEP has been challenged with identifying venues that offer desirable dates, adequate function space, and hotel inventory. The competition for desirable dates in the most popular venues has increased, which makes it more challenging to find favorable date patterns with the required meeting space, reasonable hotel room rates, and availability, especially in the popular fall meeting timeframe.

Las Vegas is an attractive city for conventions but it is also known for having higher costs to host a meeting. Additionally, Las Vegas labor costs are higher because of union rules that govern labor usage. ACEP24 expenses in Las Vegas are significantly more than the previous meeting held in Las Vegas in 2016. The building rental has increased $100,000 and the food and beverage minimum has increased from $350,000 to $1 million. Our typical food and beverage minimum is around $500,000 and we have been successful in negotiating low or free building rentals for Philadelphia, Salt Lake City, and Dallas.

The history of attendance for Scientific Assembly the last ten years:

Year	Location	Final 4-day Registration
2023	Philadelphia, PA	4,780
2022	San Francisco, CA	4,791
2021	Boston, MA	3,022
2020	Virtual	4,811
2019	Denver, CO	6,644
2018	San Diego, CA	7,479
2017	Washington, DC	6,154
2016	Las Vegas, NV	7,461
2015	Boston, MA	6,508
2014	Chicago, IL	6,535

Future cities contracted for Scientific Assembly:

Year	Location	Amount to Cancel Contracted Meeting
2025	Salt Lake City, UT	100% of anticipated expenses at the convention center, hotel blocks total of 13,494 room nights, and vendor expenses incurred to date

2026	Chicago, IL	$82,500 center rental, hotel blocks currently contracted – total of 18,618 room nights
2027	Boston, MA	$284,700 center rental, hotel blocks currently contracted – total of 5,316 room nights
2028	Las Vegas, NV	n/a
2029	Philadelphia, PA	Hotel blocks currently contracted – total of 5,655 room nights
2030	San Francisco, CA	$198,540 center rental
2031	Chicago, IL	$50,000 center rental
2032	Dallas, TX	$25,000 center rental

ACEP Strategic Plan Reference

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

Fiscal Impact

Programs are budgeted so that net revenue exceeds expense. ACEP would incur significant fees to cancel meetings that are contracted through 2025. Potential estimated cost of $10,000 to conduct an all-member survey.

Prior Council Action

Substitute Resolution 17(22) Criteria for the Location of Future National ACEP Events adopted. Directed ACEP to consider whether the location of future national level ACEP events restricts access to reproductive health care.

Prior Board Action

The Board approves the dates and location of Scientific Assembly.

Substitute Resolution 17(22) Criteria for the Location of Future National ACEP Events adopted.

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

Toni McElhinney, CMP
Director, Conventions and Meetings

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

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

RESOLUTION: 19(24)

SUBMITTED BY: Diversity, Inclusion, Health Equity Section
Social Emergency Medicine Section

SUBJECT: Vetting Intended Speakers with Divisive Language or Ideologies for ACEP Events

PURPOSE: 1) Create and enforce guidelines to avoid selecting speakers who use or promote divisive language or ideologies that conflict with ACEP's commitment to diversity, equity, and inclusion; 2) Develop a vetting process for potential speakers to ensure their current language and ideologies align with ACEP's values and standards; and 3) Provide resources and education for members and event organizers on the importance of maintaining a professional and inclusive environment emphasizing the impact of divisive language and ideologies.

FISCAL IMPACT: Budgeted committee and staff resources to develop guidelines and educational resources for speaker vetting processes.

1 WHEREAS, ACEP is deeply committed to fostering a professional, respectful, and inclusive environment for
2 all its members and attendees of its events, valuing diversity, equity, and inclusion as fundamental principles
3
4 WHEREAS, Understanding that the use of divisive language or the promotion of divisive ideologies may
5 undermine the principles of diversity, equity, and inclusion, but also has the potential to create a hostile or
6 unwelcoming atmosphere; and
7
8 WHEREAS, ACEP is resolute in its stance against such practices setting precedence in the past with such
9 actions as the disinvite of Deepak Chopra; and
10
11 WHEREAS, ACEP has a firm commitment to upholding the highest standards of professionalism and respect
12 in all its activities, including its educational and professional development events; and
13
14 WHEREAS, ACEP takes a proactive approach in ensuring these standards are met; therefore be it
15
16 RESOLVED, That ACEP:
17
18 1. Establish, enforce, and periodically update guidelines that avoid the selection of speakers who use or
19 promote divisive language or ideologies that conflict with ACEP's commitment to diversity, equity, and
20 inclusion.
21 2. Develop a thorough vetting process for potential speakers to ensure their current language and ideologies
22 align with ACEP's values and standards.
23 3. Provide resources and education for members and event organizers on the importance of maintaining a
24 professional and inclusive environment emphasizing the impact of divisive language and ideologies.

Background

This resolution calls for the College to create and enforce guidelines to avoid selecting speakers who use or promote divisive language or ideologies that conflict with ACEP's commitment to diversity, equity, and inclusion; develop a vetting process for potential speakers to ensure their current language and ideologies align with ACEP's values and standards; and provide resources and education for members and event organizers on the importance of maintaining a professional and inclusive environment emphasizing the impact of divisive language and ideologies.

The planning and execution of ACEP's educational meetings are managed by the member-led Education Committee and various subcommittees. The committee is appointed by the ACEP president to ensure leadership and strategic direction align with ACEP's goals and priorities. Each committee is structured with three chairs, serving two-year terms across incoming, current, and outgoing roles. This structure allows for continuity and experienced leadership in the development and delivery of the educational programs. The General Session keynote speakers are recommended and vetted by the incoming ACEP president to ensure the speaker, and their message, align with ACEP's core values and the General Session annual theme.

The Education Committee has the following objective:

- Purposefully increase diversity, equity, inclusion, and belonging within ACEP education.
    - Recruit leading Under-Represented in Medicine (URM) educators to the Education Committee, subcommittees, and advisory group.

The Education Committee's *Scientific Assembly* Planning Subcommittee has the following objective:

- Increase diversity, equity, and inclusion within *Scientific Assembly*.
    - Recruit leading URM educators to the ACEP Scientific Assembly Planning.

In the ongoing commitment to enhance the diversity and inclusivity of educational offerings, ACEP has recently implemented a new speaker portal designed to improve the accuracy and reliability of data collection regarding speaker demographics. Historically, the process of tracking speaker ethnicity and gender involved assumptions, which often led to unreliable and inconsistent data. The new speaker portal facilitates self-reporting by speakers, allowing them to provide their own demographic information. This advancement in data collection provides the ability to track and analyze speaker diversity with greater precision and fostering a more inclusive and representative educational environment. The transition to self-reported data through the speaker portal marks a significant step towards improving transparency and inclusivity in our educational initiatives. Additionally, the transition to established term-limits for the Education Committee supports consistent and knowledgeable leadership in the planning and execution of educational programs while also ensuring there is a pipeline to new leadership with fresh perspectives.

Beginning with ACEP22, learning objectives pertaining to diversity, inclusion, and/or health care disparities have been added where appropriate. Each track for *Scientific Assembly* includes at least one didactic session with a learning objective related to systemic racism and social determinants of health. The annual "Leon L Haley, Jr Lecture" focuses on diversity, equity, and inclusion as well as professionalism, humanitarianism, and advocacy for the elimination of health care disparities.

In January 2025, a workgroup of the Board of Directors and staff was appointed to review and codify the process for planning the annual Leadership & Advocacy Conference (LAC) including the process for identification and approval of the educational program and speakers. A LAC Planning Workgroup will be appointed each year by the president and will be responsible, in collaboration with ACEP staff, for the overall planning of the LAC meeting. The keynote political speaker will be selected by the president. Staff will solicit input on potential administration speakers from the Board of Directors and the LAC Planning Workgroup and select the speakers based on the input from stakeholders and the availability of administration officials.

Rigorous guidelines and educational resources for speaker vetting processes are not currently developed. Completion of speaker/course evaluations from attendees is extremely helpful to the Education Committee, its subcommittees, and staff to help determine the effectiveness of speakers and usefulness of the topics presented. Additionally, the evaluations provide an opportunity for feedback about the presenters use of language or any controversial ideologies that may be mentioned.

This year ACEP24 features "off-track" (non-CME) courses that include innovative content beyond traditional CME and features fresh perspectives from new speakers and unique, thought-provoking topics, designed to challenge and expand knowledge outside of clinical topics. The speakers for the off-track courses feature the individual(s) that submitted the course proposal and, therefore, do not go through the usual *Scientific Assembly* Planning Subcommittee process.

All ACEP meeting attendees, including faculty, guests, and staff, are expected to adhere to ACEP's "Non-Discrimination and Harassment" policy statement and the "Meeting Conduct Policy" policy statement.

ACEP's "Non-Discrimination and Harassment" and policy statement includes the following information:

> "…ACEP acknowledges that implicit and explicit biases, attitudes, or stereotypes affect our understanding, actions, and decisions."
>
> "ACEP advocates for the respect and dignity of each individual, opposes all forms of discrimination and harassment, and supports anti-discrimination and anti-harassment practices protected by local, state, or federal law. Discrimination and harassment may be based on, but are not limited to, an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military, or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, or sexual orientation."

ACEP's "Meeting Conduct Policy" policy statement includes the following information:

> "ACEP promotes equal opportunities and treatment for all participants. All participants are expected to treat others with respect and consideration, follow venue rules, and alert staff or security when they have knowledge of dangerous situations, violations of this Meeting Conduct Policy, or individuals in distress."

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

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

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

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

Fiscal Impact

Budgeted committee and staff resources to develop guidelines and educational resources for speaker vetting processes.

Prior Council Action

Resolution 81(21) Leon L. Haley, Jr., Award adopted. The resolution directed ACEP to create a national award to or champions of diversity, inclusion, and health equity in honor of one of the emergency medicine leaders who promoted diversity, inclusion, health equity and eliminating health disparities throughout his career; and create the "Leon L Haley Jr Lecture" to be held at the annual *Scientific Assembly* that focuses on diversity, equity, and inclusion.

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

Prior Board Action

The Board has consistently supported initiatives to enhance diversity, equity, and inclusion within the organization.

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

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

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

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

June 2018, approved the "Meeting Conduct Policy" policy statement.

Background Information Prepared by: Ansley Colbeck
Senior Manager, Conference Education

Robert Heard, MBA, CAE
Chief Operating Officer

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

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

RESOLUTION: 20(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Advisory Council for All of Emergency Medicine

PURPOSE: Work with emergency medicine organizations to develop an ongoing advisory council to address issues pertaining to the direction of emergency medicine as a specialty.

FISCAL IMPACT: Unbudgeted and unknown costs to develop a formal structure to create an ongoing advisory council comprising all emergency medicine organizations.

1 WHEREAS, Emergency Medicine is one of few specialties with numerous governing organizations: ACEP,
2 AAEM, CORD, SAEM, ACOEP, EMRA, other resident/student organizations (SAEM-RAMS, AAEM-RSA);
3
4 WHEREAS, The presence of numerous organizations leads to a lack of one authority for our specialty, and
5 occasional discord between organizations; and
6
7 WHEREAS, Other specialties may have one primary governing organization that guides major specialty-wide
8 decisions, such as ACOG's decisions to split from the AAMC/ERAS and utilize a new application platform for all
9 OB/Gyn residency programs for the 2024-2025 academic year[1]; and
10
11 WHEREAS, The lack of overall governance and advising for all of the specialty of emergency medicine has
12 been demonstrated by events such as when the Accreditation Council for Graduate Medical Education (ACGME)
13 Residency Review Committee stated it is not their role to take action in preventing new EM residency programs from
14 forming if they meet the ACGME requirements for initial accreditation[2]; therefore be it
15
16 RESOLVED, That ACEP collaborate with other stakeholder organizations in emergency medicine to develop a
17 working advisory council to determine and adjudicate issues as they pertain to the direction of emergency medicine as a
18 specialty, such as but not limited to, residency program growth.

References:

1. New Residency Application Platform for Obstetrics and Gynecology https://apgo.org/page/rrrapplicationplatform
2. ACGME RRC Updates, CORD Business Meeting, CORD Academic Assembly, March 2023, Las Vegas, NV

Background

This resolution requests that ACEP work with emergency medicine organizations to develop an ongoing advisory council to address issues pertaining to the direction of emergency medicine as a specialty.

ACEP routinely works with other national emergency medicine organizations to collaborate on issues of mutual interest and agreement such as the workforce study, policy statements, and most recently diversity, equity, and inclusion in emergency medicine:

- American Academy of Emergency Medicine (AAEM)
- AAEM-Resident and Student Association (AAEM-RSA)
- American Academy of Emergency Nurse Practitioners (AAENP)
- Association of Academic Chairs of Emergency Medicine (AACEM)
- American Board of Emergency Medicine (ABEM)
- American College of Osteopathic Emergency Physicians (ACOEP)

- American Osteopathic Board of Emergency Medicine (AOBEM)
- Council of Residency Directors in Emergency Medicine (CORD)
- Emergency Medicine Residents' Association (EMRA)
- Emergency Nurses Association (ENA)
- National Association of EMS Physicians (NAEMSP)
- Society for Academic Emergency Medicine (SAEM)
- SAEM-Residents and Medical Students (SAEM-RAMS)
- Society of Emergency Medicine Physician Assistants (SEMPA)

The idea of an emergency medicine advisory council is not new. Such an organization was attempted by SAEM in the late 1990s. The group had difficulties from its inception and eventually disbanded. This effort was replaced by creating the All EM Organizations group and convening regular meetings. Meetings are held during the SAEM annual meeting and ACEP's annual Scientific Assembly and are an opportunity for each organization to provide updates about their major initiatives and to identify potential areas of collaboration. The meetings are primarily for information distribution in the hopes that duplicate efforts among the organization can be recognized.

Each organization has its own strategic vision and there are often challenges for all organizations to reach consensus on issues and do so in a timely manner, particularly on social issues, social media responses, and legislative actions. Each organization serves different constituencies and has their own policies and procedures. One issue that arose over time was the definition of a stakeholder organization. The initial invitation list of organizations was limited to ACEP, SAEM, AACEM, AAEM, ABEM, ACOEP, AOBEM, CORD, EMRA and early on the group was expanded to include AAEM-RSA and SAEM-RAMS. Over time the list of organizations has grown to include 21 groups, which significantly limits time for reporting on primary projects and discussion of cooperation on projects.

While other specialties often have a single organization that represents the voice of the specialty, that is a different model where the large specialty-wide group is acknowledged as the leading voice as opposed to the collaborative model in emergency medicine where some organizations provide a unique voice for each segment of the specialty. For example AACEM, CORD, and SAEM represent the specialty at the Council of Faculty and Academic Societies, which represents academic medicine faculty and academic societies within the American Association of Medical Colleges. ACEP represents emergency medicine at the Council of Medical Specialty Societies, which is a broader group representing all 24 members of the American Board of Medical Specialties.

About 10 years ago, the All EM Organization group agreed to work together on wellness. A summit was held and ideas for many possible projects were generated. However, issues were encountered over leadership of initiatives, funding for in person meetings and resources, and organizational responsibility for action items. It became obvious that each of the organizations had different resources and interests that led to the perception that some organizations dominated and others contributed too little. When the pandemic ensued, each organization led the way.

Other mulit-organizational activities have been tried with varying levels of success. Seven emergency medicine organizations participated in the latest workforce study, with ACEP in the lead. This effort was largely effective, but we learned the need for detailed planning and handling expectations. Additionally, even when consensus/compromise was reached within the taskforce, those statements did not always coincide with the priorities of the individual organization.

The Council of Board Certified Emergency Physicians (COBCEP), led by ABEM, has worked very well in part because it has a narrow focus on merit badge requirements and also perhaps because it is led by what is perceived to be a truly neutral organization.

Ten of the above listed emergency medicine organizations developed the All EM DEI Vision Statement. Additionally, nine emergency medicine organizations issued a Joint Statement from Emergency Medicine Organizations on Efforts to Diversify Health Care Professionals in the United States was issued after the U.S. Supreme Court decisions on the consideration of an applicant's racial or ethnic background in the higher education admissions process.

Six of the organizations worked together on creating recommendations for the new Accreditation Council for Graduate Medical Education (ACGME) requirements. This was a long and difficult process of achieving consensus and approval from all constituent boards. Several areas of contention were either not addressed or left open in the recommendations because agreement could not be achieved.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

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

Fiscal Impact

Unbudgeted and unknown costs to develop a formal structure to create an ongoing advisory council comprising all emergency medicine organizations.

Prior Council Action

None

Prior Board Action

None

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

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

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

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

RESOLUTION: 21(24)

SUBMITTED BY: Alecia Gende, DO, FACEP
Sarah Hoper, MD, FACEP
AAWEP Section

SUBJECT: Printable Volunteer Recognition Certificate

PURPOSE: Develop a volunteer recognition certificate for ACEP physician volunteers and leaders that can be printed and proudly displayed for interested parties.

FISCAL IMPACT: Budgeted staff resources for some volunteer recognition during National Volunteer Appreciation Week. Unbudgeted staff resources and unknown costs depending on the scope of an expanded volunteer recognition program.

1 WHEREAS, The health and success of the American College of Emergency Physicians is dependent upon
2 physician volunteers; and
3
4 WHEREAS, The retention of membership and voluntary physician leaders within ACEP is necessary for the
5 persistence of ACEP; and
6
7 WHEREAS, Diversity amongst volunteers, and leaders will bring a larger range of lived experiences and
8 overall strengthen ACEP; and
9
10 WHEREAS, Physician volunteers serving ACEP utilize hard-earned vacation days, personal funding, and many
11 hours of precious free time to fulfill the responsibilities of their various leadership roles within ACEP; and
12
13 WHEREAS, Hospital administration, emergency department administration, and other organizations are likely
14 to encourage emergency physician involvement in ACEP and recognize emergency physicians who volunteer and serve
15 ACEP if ACEP provides an incentive certificate; and
16
17 WHEREAS, An incentive certificate recognizes the physician's volunteered time and leadership position(s)
18 within ACEP to recognize both the employer/hospital and the physician volunteer; therefore, be it
19
20 RESOLVED, That ACEP develop a volunteer recognition certificate for ACEP physician volunteers and
21 leaders that can be printed and proudly displayed for interested parties.

Background

This resolution asks ACEP to develop a volunteer recognition certificate for ACEP physician volunteers and leaders that can be printed and proudly displayed for interested parties.

Volunteer leadership is critical to accomplishing the work of the College and addressing issues that are important to members. ACEP has many volunteer leadership opportunities, including but not limited to:

- Board of Directors
- Chapter Board of Directors
- Council (2 Council Officers, 422 councillors, approximately 200 alternate councillors)
- 5 Council committees

- 31 ACEP committees (approximately 1,100 members)
- Task Forces (2 current task forces with 48 members)
- 40 sections of membership with volunteer section officers
- Member Interest Groups
- Emergency Medicine Foundation Board of Trustees
- *ACEP Now* Editorial Board
- *Annals of Emergency Medicine* Editorial Board
- *JACEP Open* Editorial Board
- *Critical Decisions in Emergency Medicine* Editorial Board
- PEER Editorial Board
- National Emergency Medicine Political Action Committee Board of Trustees
- Clinical Ultrasound Accreditation Program Board of Governors
- Emergency Department Accreditation Program Board of Governors
- Geriatric Emergency Department Accreditation Program Board of Governors
- Pain and Addiction Care in the ED Board of Governors
- Emergency Medicine Data Institute Board of Governors
- AMA Section Council on Emergency Medicine
- Faculty for Scientific Assembly and other ACEP meetings
- Liaison representatives to other organizations and for special projects
- International Emergency Medicine Ambassadors
- Volunteers working on grant-funded projects
- Members of the 911 Grassroots Network

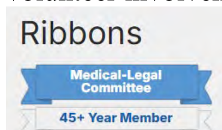
Many of ACEP's volunteers are featured on the ACEP website along with the member's name, photo, and bio information, such as the *Annals of Emergency Medicine* Editorial Board.

This resolution envisions developing customized certificates of appreciation annually for each ACEP volunteer and emailing it for the member to print on demand. Many members serve in multiple leadership positions and multiple certificates would be needed for some members to include all of their volunteer leadership positions. ACEP's current membership system, i.e., Association Management System (AMS), is limited in its ease of use to accomplish what is requested in this resolution. ACEP has had a cross-functional team working on the requirements and vetting options for a new AMS system for more than a year. The cost for the new AMS is $2 – $3 million and ACEP will move forward as soon as we are able to start planning for the budgetary impact. One goal for the new AMS is the ability to create a volunteer profile as part of MyACEP that tracks each member's volunteer activity for the College, which will assist in developing a service recognition program.

The last Whereas statement mentions recognizing both the employer/hospital and the physician volunteer, however, recognition of the employer/hospital is not included in the Resolved statement. ACEP does not currently require members to provide their employer or hospital information in their membership profile and that data would need to be collected.

ACEP has participated in National Volunteer Appreciation Week the past two years to recognize and thank volunteers who lend their time, talent, voice and support to causes they care about. ACEP's campaign has focused on:

- Sending handwritten postcards to committee members, section officers, and the Board of Directors.
- Profiling some member volunteers on the ACEP website.
- Emailing a "thank you" letter to volunteers from the ACEP president.
- Using engagED communities to highlight volunteer activity with "ribbons" displaying the member's volunteer involvement.



A series of content was posted on the All Member engagED community during National Volunteer Appreciation Week:

- Sunday – Start 🌟 Happy National Volunteer Week! 🌟
- Monday – Board of Directors and Past Presidents of ACEP
- Tuesday – Chapter Leaders
- Wednesday – Committees*
- Thursday – Sections Leaders*
- Friday – Member Interest Group Leaders*
- Saturday – Close/Call to action (reminder) on how to get involved (e.g. Committee Application)

Social media posts were developed for each day and for *EM Today/Weekend Review* posts:

- Sunday – social post announcing week, celebrating volunteers
- Monday – social spotlight post on a member volunteer with link to web article/*EM Today* announcing week, celebrating volunteers, link to article
- Tuesday – social spotlight post on member volunteer with link to web article
- Wednesday – social spotlight post on member volunteer with link to web article/*EM Today* item celebrating volunteers, link to article
- Thursday – social spotlight post on member volunteer with link to web article
- Friday – social spotlight post on member volunteer h link to web article/*EM Today* item celebrating volunteers, link to article
- Saturday – social video of all member volunteer features/*Weekend Review* item celebrating volunteers, link to webpage with video and all articles

ACEP presents committee chairs with a framed certificate of appreciation for their committee service when their term is completed. Committee members receive a letter of appreciation from the ACEP president when their committee term ends. Section chairs receive a commemorative plaque when their term is completed.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources for volunteer recognition during National Volunteer Appreciation Week. Unbudgeted staff resources and unknown costs depending on the scope of an expanded volunteer recognition program.

Prior Council Action

None

Prior Board Action

None

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

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

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RESOLUTION: 22(24)

SUBMITTED BY: Wellness Section
Arizona College of Emergency Physicians
Colorado Chapter
District of Columbia Chapter
South Carolina Chapter

SUBJECT: Support for the "Well Workplace" Policy Statement

PURPOSE: Promote, advertise, and support the best practices as defined in the "Well Workplace" policy statement and develop and support a system to track adherence to the "Well Workplace" policy statement to create a wellness certification mechanism or incorporate adherence into the ED Accreditation Program.

FISCAL IMPACT: Budgeted committee, section, and staff resources for some aspects of promotion. Unbudgeted costs estimated at $73,500 – $81,000 to develop a formal compliance program with estimated ongoing costs of $81,000 – $90,500+ annually. Grant funding could potentially be secured to support the project's direct costs and additional staff time required.

1 WHEREAS, ACEP believes in the wellbeing of all those who work in healthcare and are supportive of efforts
2 that result in a well workplace and has adopted a "Well Workplace" policy statement; and
3
4 WHEREAS, The evolution of health care in a post COVID 19 era has significantly affected the landscape of
5 Emergency Departments (EDs) around the world, with an exodus of professionals who are seeking improvement in and
6 protection of their own wellbeing; and
7
8 WHEREAS, The clinicians within the ED encounter frequent and significant challenges to the provision of care
9 for the often-increasing volumes of patients with diminishing resources for care; and
10
11 WHEREAS, A well workplace is prioritized by organizational leaders and personnel working together to
12 promote, build, and sustain personal and professional health and wellbeing; and
13
14 WHEREAS, ACEP recognizes that the attributes of a well workplace may vary depending on location
15 (academic medical center, community program, urban, suburban, rural, or critical access) and regardless of the setting,
16 it is incumbent upon individual organizations to cultivate wellness, keeping it at the forefront of every decision and
17 initiative; and
18
19 WHEREAS, ACEP has been the leader in developing policies that set the standard for the practice of
20 emergency medicine and support the emergency physician, emergency patients, and the entire emergency team; and
21
22 WHEREAS, A system of standards and accountability are important to ensure that a well workplace is
23 supported across EDs; and
24
25 WHEREAS, Although the individual has responsibility for personal wellness, the primary emphasis should be
26 on how the organization impacts the wellbeing of physicians, therefore be it
27
28 RESOLVED, That ACEP promote, advertise, and support the best practices as defined in the "Well
29 Workplace" policy statement; and be it further

30 RESOLVED, That ACEP develop and comprehensively support a system to track adherence to the "Well
31 Workplace" policy statement in an effort to create a wellness certification mechanism or incorporate adherence to this
32 well workplace policy into the ED Accreditation Program.

Background

This resolution calls for ACEP to promote, advertise, and support the best practices as defined in the "Well Workplace" policy statement and develop and support a system to track adherence to the "Well Workplace" policy statement to create a wellness certification mechanism or incorporate adherence into the ED Accreditation Program

ACEP is committed to improving the well-being of emergency physicians. This work is led by the Well-Being Committee and Wellness Section and supported by the Board of Directors.

The Well-Being Committee collaborates closely with the Wellness Section. Its primary focus is to address the tough issues that hinder wellness and career satisfaction for emergency physicians using evidenced-based tactics to solve these challenges and support well workplaces for all emergency physicians. The committee's objectives for the 2024-25 committee are:

Well Workplace

1. Create a process for recognizing organizations that adhere to the ACEP "Well Workplace" policy statement.
2. Solicit nominations for the 2025 Emergency Medicine Wellness Center of Excellence Award and recommend a recipient to the Board of Directors.
3. Provide subject matter expertise in promoting ACEP's work on addressing workplace violence.

Physician Wellness

4. Partner with National Association of Mental Illness (NAMI) to pilot at least three training sessions for peer-to-peer physician wellness, report on the results and evaluate the best strategy for peer support.
5. Create and curate wellness content for emergency physicians and providers to encourage personal and professional wellness strategies to be released throughout the year. Provide subject matter experts during development of ACEP meetings and educational offerings.

The Wellness Section aims to provide a forum for ACEP members with special interests in wellness and physician well-being to develop a knowledge base, share information, receive and give counsel, and serve as a resource to others interested in this area of emergency medicine. The Wellness Section's objectives are:

- To promote wellness for physicians practicing the specialty of emergency medicine.
- To promote collegiality and cooperation among the physicians who practice emergency medicine and to foster a lexicon for personal as well as professional well-being.
- To provide an opportunity for physicians interested in well-being to meet, interact, and network.
- To develop, present, and recommend educational programs on the many facets of wellness for physicians practicing emergency medicine.
- To prepare and distribute an interesting, educational, and informative newsletter for members of the section.
- To serve as a resource to the College president, Board of Directors, College committees, and ACEP members on issues relating to the well-being of those who practice emergency medicine.
- To coordinate activities with other organizations involved in emergency medicine at the invitation of the president and/or Board of Directors.
- To provide a pathway for professional leadership development within the organization.

The section has advised on a wide array of ACEP policies and published guiding documents to empower and improve the mental health of emergency physicians in their daily practice. These include:

- Emergency Department Planning and Resource Guidelines

- Model of the Clinical Practice of Emergency Medicine
- Boarding of Admitted and Intensive Care Patients in the Emergency Department
- From Self to System: Being Well in Emergency Medicine
- Emergency Physician Rights and Responsibilities
- Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department
- Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided

The "Well Workplace" policy statement was developed by the Well-Being Committee and approved by the Board of Directors in April 2024. ACEP policy statements follow a standard process after they are approved by the Board. This ensures fair and equitable promotion of the work products of sections, committees, and other groups of ACEP volunteers. That process includes:

- Placement of the policy statement on the ACEP website and publication in *Annals of Emergency Medicine*.
- Promotion of the new policy through standard ACEP channels such as *EM Today*, *Weekend Review*, and in specialized forums such as engagED or other areas that pertain to the subject matter.

The "Well Workplace" policy statement was promoted strategically in May during Mental Health Awareness Month and leading up to Emergency Medicine Wellness Week during the first week of June 2024. It was also promoted in the June issue of *ACEP Now* as part of a summary of activities from the April 2024 Board meeting. *ACEP Now* is a print publication that is sent to all ACEP members and about 3,000 additional physicians who identify as emergency physicians to the American Medical Association (AMA) but are not currently ACEP members.

The Well-Being Committee has an objective for the coming year to create a recognition program for emergency departments / employers that adhere to the "Well Workplace" policy statement. There are a number of ways that this could be accomplished, including use of a self-reporting / attestation form or modeling after similar initiatives such as the AMA Joy in Medicine Health System Recognition Program, which is designed to guide organizations interested or already engaged in improving physician satisfaction and reducing burnout.

Another program to reference is The Charter on Physician Well-Being, which was created by the Collaborative for Healing and Renewal in Medicine (CHARM), a group of leading medical centers and organizations that includes the AMA. The Charter helps health systems, organizations and individuals advance and promote physician well-being. This project was supported by a grant from the Arnold P. Gold Foundation.

Using self-reporting and or self-attestation as the method of verifying compliance is less costly and quicker to implement than more formal mechanisms that mirror accreditation programs. However, the absence of a formal verification or follow-up process could mean that the information collected is incorrect or incomplete. Incentives might be required to encourage emergency departments to submit this information until recognition on its own becomes meaningful to physicians and administrators.

ACEP is piloting its tiered Emergency Department Accreditation Program to establish transparency by recognizing hospitals with EDs that meet several key criteria and provide the best patient care possible. The ED Accreditation Board of Governors oversees the standards for each tier of ED Accreditation, which are based on ACEP policies, and approved by the Board of Directors. The program has begun accepting pilot applications, with early pilot sites able to provide feedback of suggested improvements for future consideration.

The criteria for all ACEP accreditation programs are reviewed annually. Proposed changes to the accreditation criteria must be submitted to the ED Accreditation Board of Governors for consideration. The Board of Governors will review the request and if appropriate, submit a recommendation to the ACEP Board of Directors to revise the criteria. Once approved, a notice period of at least 120 days must be provided to accredited sites prior to action being taken to enforce the new criteria.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

Recognition programs can vary widely in both the direct cost and staff labor required to implement.

- For a self-attestation program that collects information via an online form for review by ACEP volunteer leaders, with subsequent online publication of those that adhere to the policy, costs would be negligible, and the staff work required could be absorbed into current allocated time and processes.
- Adding requirements related to the "Well Workplace" policy statement to the ED Accreditation Criteria could also be low/no cost, but would have a longer time horizon to implement.
- Formal compliance programs that collect information and require verification (i.e., site visits, interviews, etc.) are more costly to implement and require dedicated staff time to operate. Grant funding could potentially be secured to support the project's direct costs and additional staff time required above what is allocated annually to support committee and section work. ACEP's grants staff team could assist with applying to the right opportunities as they are identified by ACEP leaders.
    - Several factors need to be considered to estimate the cost and targeted grant funding required to implement a formal compliance program that involves information collection and verification (e.g., site visits, interviews). These include staff salaries, operational costs, travel expenses, and any technology or resources needed for the program. Additionally, it is important to recognize that once the program is implemented, it will require continued funding. This commitment will likely grow over time as the program expands.
        - Implementing a formal compliance program is estimated to cost between $73,500 – $81,000.
            - Travel for in-person verification: 5 sites/year with two volunteers – $25,000 (this assumes we audit/verify 5, the rest would have to be Zoom interviews)
            - Program operations: Part time staff dedicated 15 hours/week – $37,500 up to 18 hours/week – $45,000 as the program is implemented
            - Software support: $1,000
            - Promotion: $10,000
        - Ongoing Costs: To ensure the program is fully supported, ongoing costs are estimated to cost between $81,000 – $90,500+* annually.
            - Travel for in-person verification: At 5 sites/year with two volunteers – $25,000 (this assumes auditing/verifying 5 and the remaining interviews conducted virtually)
                - *Up to $25,000+ if the program decides they want to visit all of the sites that apply for compliance or recognition rather than just five per year (at ~$5,000 per site visit)
            - Program operations: Increased workload may be necessary to maintain program effectiveness as the program scales; part time staff dedicated 18 hours/week – $45,000 up to 20 hours/week – $52,500 as the program scales//
            - Software support:, There may be a need for enhanced technology, which could increase costs $1,000 – $3,000 if the program grows significantly.
            - Promotion: $10,000

Prior Council Action

None

Prior Board Action

April 2024, approved the policy statement "Well Workplace."

April 2024, approved the revised ED Accreditation Program Criteria and approved the Blue Ribbon Recognition "in concept;" revised and approved January 2024; originally approved October 2023 with requests to revise Blue Ribbon category.

June 2021, approved creation of the Emergency Medicine Wellness Center of Excellence Award.

Background Information Prepared by: Amanda Pairitz-Campo
Community and Engagement Manager

Mollie Pillman, MS, MBA, CAE
Associate Executive Director, Member Engagement

Nicole Tidwell
Senior Accreditation Manager

Nancy Calaway
Managing Director, Communications

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

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RESOLUTION: 23(24)

SUBMITTED BY: Diversity, Inclusion & Health Equity Section
Social Emergency Medicine Section

SUBJECT: Supporting a Statement Affirming Diversity, Equity, and Inclusion in Emergency Medicine

PURPOSE: Develop a statement affirming diversity, equity, and inclusion in emergency medicine that is specifically from ACEP.

FISCAL IMPACT: Budgeted committee and staff resources for development and distribution of policy statements.

1 WHEREAS, The American College of Emergency Physicians (ACEP) is committed to fostering an inclusive
2 and equitable healthcare environment for all individuals; and
3
4 WHEREAS, Diversity within the College is essential to reflect the varied backgrounds and experiences of the
5 patients we serve, enhancing the cultural competence and effectiveness of our care and ACEP is already committed to a
6 diverse workforce in healthcare settings and recognizes the shortage of minority professionals healthcare; and
7
8 WHEREAS, Emergency medicine, being at the epicenter of health equity, serves as the frontline for patients
9 from all walks of life, including those from underserved and marginalized communities, and it underscores our
10 commitment to ensuring equitable healthcare for all; and
11
12 WHEREAS, Embracing diversity, equity, and inclusion within the emergency medicine community will
13 improve patient outcomes, reduce health disparities, and foster a more just health care system; and
14
15 WHEREAS, ACEP is already invested in a joint statement from emergency medicine organizations on efforts
16 to diversify health care professionals in the United States; therefore be it
17
18 RESOLVED, That ACEP develop a statement affirming its commitment to the prioritization of diversity and
19 inclusion, the promotion of cultural competency, the support of health equity, the promotion of transparency, and the
20 fostering of a collaborative environment; and be it further
21
22 RESOLVED, That ACEP continue to evaluate and adapt strategies to ensure they meet the evolving needs of
23 our diverse patient population and our commitment to excellence in emergency medicine.

Background

This resolution asks for the College to establish its own unique diversity, equity, and inclusion (DEI) statement. ACEP is a signatory to the All-EM DEI Vision Statement that outlines broad principles for diversity, equity, and inclusion within emergency medicine, however, it lacks a distinct DEI statement that reflects the specific values and commitments of ACEP as an organization. ACEP has previously addressed DEI and diversity, inclusion, and health equity (DIHE) through several policy statements (see prior Board Action).

Through affirmation by the Board of Directors, policy statements, and participation in EM-specific work, ACEP acknowledges the importance of DEI initiatives in fostering an inclusive environment within emergency medicine. This is reinforced by its participation in the all-EM organizations working group on DEI that is aimed at aligning efforts, particularly in promoting DEI across the specialty of emergency medicine and by participating in the development of the All-EM DEI Vision Statement and the joint statement from emergency medicine organizations on

efforts to diversity health care professionals in the U.S. that was issued on July 20, 2023, with nine other emergency medicine organizations following the July 2023 U.S. Supreme Court decision regarding the consideration of an applicant's racial or ethnic background in higher education admissions.

This resolution provides the framework and rationale for the College to:

- Establish a unique identity: ACEP represents emergency physicians across the United States and globally. A unique DEI statement could articulate the specific values and commitments of ACEP regarding DEI within the emergency medicine community.
- Provide members and staff guidance: A distinct ACEP DEI statement will provide clear guidance to ACEP members and staff on the organization's stance and actions regarding DEI. This will ensure alignment with organizational goals and foster a sense of ownership among stakeholders.
- Align with best practices: Many other medical specialty societies have developed their own DEI statements tailored to their unique missions and membership. These statements serve as benchmarks and demonstrate best practices in addressing DEI within their respective fields.
- Establish leadership commitment: By establishing its own DEI statement, ACEP will demonstrate leadership within emergency medicine by setting specific goals, metrics, and action plans to promote DEI within the specialty.

Examples of DEI statements from other emergency medicine organizations:

American Academy of Emergency Medicine (AAEM)
AAEM's DEI statement focuses on advocating for diversity, equity, and inclusion in emergency medicine practice, education, and policy. It highlights their dedication to addressing systemic barriers and promoting cultural competency among emergency physicians.

American Board of Emergency Medicine (ABEM)
ABEM's DEI statement outlines their commitment to diversity, equity, and inclusion in board certification processes and ongoing certification maintenance. It emphasizes efforts to ensure fairness and inclusivity in evaluating emergency medicine practitioners' qualifications and competencies.

Emergency Medicine Foundation
EMF's DEI statement emphasizes its commitment to diversity, health equity, and inclusion by increasing representation of underrepresented racial and ethnic groups in biomedical research and addressing related health inequities. EMF also promotes geographic and institutional diversity, including partnerships with historically Black colleges and Hispanic-serving institutions.

National Association of EMS Physicians (NAEMSP)
NAEMSP's DEI statement focuses on promoting diversity, equity, and inclusion within Emergency Medical Services (EMS). It outlines their commitment to supporting diversity among EMS providers, addressing disparities in prehospital care, and advocating for inclusive policies and practices.

Society for Academic Emergency Medicine (SAEM)
SAEM's DEI statement emphasizes their commitment to promoting diversity, equity, and inclusion within academic emergency medicine. It outlines principles to foster an inclusive environment for all members and support efforts to address disparities in emergency care and research.

Examples of DEI statements from other medical specialty societies:

American Academy of Pediatrics (AAP)
AAP's DEI statement emphasizes creating an inclusive environment where all children, families, and pediatricians feel valued and respected. It commits to addressing health disparities, promoting cultural competence, and advocating for policies that support diversity, equity, and inclusion in pediatric care.

American College of Surgeons (ACS)
ACS's DEI statement outlines its commitment to promoting diversity among surgeons and ensuring equitable access to surgical care for all patients. It emphasizes creating an inclusive surgical community, addressing barriers faced by underrepresented groups, and supporting diversity in surgical leadership.

American Psychiatric Association (APA)
APA's DEI statement focuses on advancing diversity, equity, and inclusion in psychiatry. It pledges to support a diverse workforce, eliminate disparities in mental health care, and foster an inclusive environment for patients and providers of diverse backgrounds.

Developing a robust DEI statement for ACEP that reflects the unique identity and values of ACEP while aligning with best practices could further formalize the commitment to diversity, equity, and inclusion within emergency medicine.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.
- Focus resources, education and networks to assist members in identifying career opportunities and having career fulfillment across different professional interests or life stages.
- Remain diligent in addressing workforce solutions to ensure emergency physicians set the course for the future.

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

- Leverage personalization and opportunities for issue/interest-based participation to make a member's connection to ACEP more personally meaningful.
- Measure and showcase the diversity and character of ACEP leaders and members.
- Enhance ACEP's brand positioning and communication strategies.

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

- Implement a systematic program evaluation process that considers new and on-going needs, return on investment/member value and ACEP's strategic plan.
- Be more transparent and timelier in communicating College policies, processes, and initiatives.

Fiscal Impact

Budgeted committee and staff resources for development and distribution of policy statements.

Prior Council Action

Amended Resolution 56(21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted. Directed ACEP to issue a statement to the membership denouncing the validity of the use of race-based science and its detrimental impact in the care of diverse populations, commit to educating ACEP members by denouncing the use of race-based calculators in clinical policies, and commit to not support research studies that utilize race-based calculations that are not supported by sound scientific evidence.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted. Directed ACEP to: 1) Promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED; 2) compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the ED; 3) encourage hospitals to provide adequate and appropriate education, training, and

resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients; and 4) encourage EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

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

Resolution 21(21) Diversity, Equity, and Inclusion adopted. Directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion within the next year; create a road map to promote diversity, equity, and inclusion; embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and report to the 2022 Council the outcome of the summit and have a roadmap created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted. The resolution directed ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism as it pertains to emergency care; continue to explore models of health care that would make equitable health care accessible to all; and continue to use its voice as an organization and support its members who seek to reform discriminatory systems and advocate for policies promoting the social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

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

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

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

Prior Board Action

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

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

April 2023, reviewed the Policy Resource & Education Paper "Caring for Transfer and Gender Diverse Patients in the Emergency Department."

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

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

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

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

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

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

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

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

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted.

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

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

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

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

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

Background Information Prepared by: Tony Vellucci
Director of Advancement

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

2024 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 24-42

Torree M. McGowan, MD, FACEP (GS) – Chair
Blake Bailey, DO, MBA, FACEP (PA)
Lisa M. Bundy, MD, FACEP (MS)
Joshua R. Frank, MD, FACEP (WA)
George RJ Sontag, MD, FACEP (OH)
James C. Mitchner, MD, MPH, FACEP (MI)

Erin Grossmann
Ryan McBride, MPP

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

RESOLUTION: 24(24)

SUBMITTED BY: James Humble, MD
Virginia College of Emergency Physicians
Dual Training Section
Observation Medicine Section
Young Physicians Section

SUBJECT: Address ED Boarding and the Medicare Three-Midnight Rule for Post-Acute Rehabilitation

PURPOSE: Prioritize advocacy to remove the 3-midnight rule for skilled nursing placement.

FISCAL IMPACT: Budgeted staff resources as this is already an ongoing initiative of the College.

1 WHEREAS, Emergency Department boarding (ED Boarding) is an ongoing and serious issue[1,2]; and
2
3 WHEREAS, The boarding crisis is a major issue for ACEP at this time[1,2]; and
4
5 WHEREAS, This rule adversely affects patient care and physician wellness[3]; and
6
7 WHEREAS, The Medicare three-midnight rule (3MN rule) is outdated and unnecessary[4]; and
8
9 WHEREAS, Waiving the 3MN rule led to shorter hospital lengths of stay and was specifically implemented to
10 prevent hospital crowding and ED boarding[5,6]; therefore be it
11
12 RESOLVED, That the American College of Emergency Physicians prioritize advocacy to have the Medicare
13 three-midnight rule for skilled nursing placement removed.

References
1. https://www.acep.org/news/acep-newsroom-articles/acep-to-cms-consider-the-boarding-crisis-in-reporting-measures
2. https://www.acep.org/news/acep-newsroom-articles/new-poll-alarming-number-of-patients-would-avoid-emergency-care-because-of-boarding-concerns
3. https://www.jointcommission.org/resources/news-and-multimedia/news/2023/11/ed-boarding-impact-on-patient-care-and-clinician-well-being/
4. Halawi MJ, Vovos TJ, Green CL, Wellman SS, Attarian DE, Bolognesi MP. Medicare's 3-Day Rule: Time for a Rethink. J Arthroplasty. 2015 Sep;30(9):1483-4. doi: 10.1016/j.arth.2015.03.038. Epub 2015 Apr 8. PMID: 25922314.
5. Sheehy AM, Locke CF, Kaiksow FA, Powell WR, Bykovskyi AG, Kind AJ. Improving Healthcare Value: COVID-19 Emergency Regulatory Relief and Implications for Post-Acute Skilled Nursing Facility Care. J Hosp Med. 2020 Aug;15(8):495-497. doi: 10.12788/jhm.3482. PMID: 32804613; PMCID: PMC7518138.
6. https://www.mcknights.com/news/waiver-of-3-day-stay-didnt-increase-costs-or-lower-outcomes-in-cms-study/#:~:text=center%20published%20the-,February%20analysis,-%2C%20which%20showed%20that

Background

This resolution calls for the College to prioritize advocacy for the removal of the three-midnight rule (or 3-Day Rule), a Medicare policy that requires a Medicare approved 3-day hospital stay before a patient is eligible for Medicare coverage in a skilled nursing facility (SNF), due because of the compounding effects on the boarding crisis and its obsolescence.

The requirement for a Medicare approved 3-day hospital stay before a patient is eligible for Medicare coverage in a SNF has been part of Medicare since its inception. Since Medicare only covers "skilled nursing care," the intent of Congress was to allow ongoing acute medical care in a less expensive setting limited to 120 days. However, since

Medicare's inception in 1965, medical care of the elderly, as well as treatment centers, have changed significantly. Acute and chronic medical care previously rendered almost exclusively in the inpatient hospital setting is now often being delivered in SNFs, rehabilitation hospitals, or even at home.

The Centers for Medicare & Medicaid Services (CMS) already provides 3-Day Rule waivers for certain Accountable Care Organizations (ACOs) that participate in or have applied to certain Shared Savings Program performance-based risk tracks, wherein health care providers can admit a beneficiary to a SNF directly from the community or after only 1-2 days in a hospital. A Center for Medicare & Medicaid Innovation Center (CMMI)-published report found that average SNF length of stay for direct and 1-2-day stays was consistently lower than non-waiver SNF stays, and that adverse outcome rates for direct waiver stays and 1-2-day stays were consistently lower than or similar to 3-day non-waiver stays and non-waiver stays overall.

Elimination of the 3-Day Rule has been a priority on ACEP's legislative and regulatory agenda for about 20 years. ACEP has supported every Congressional proposal and related regulatory action or proposal to rescind or ameliorate the rule's effects by at least counting time in observation toward the 3-day requirement. During the COVID-19 public health emergency, CMS provided a temporary waiver for the three-day stay rule. Legislators and advocates had hoped that CMS would make this waiver permanent and could potentially obviate the need for a legislative fix, but CMS indicated they did not have the authority to make the policy permanent and the waiver expired with the end of the public health emergency declaration in May 2023.

Specifically, ACEP supports the Improving Access to Medicare Coverage Act (H.R. 5138/S. 4137) to count time spent under observation status towards the three-day hospital stay for coverage of skilled nursing care, and establish a 90-day appeal period following passage for those that have a qualifying hospital stay and have been denied skilled nursing care after January 1, 2024. This bipartisan, bicameral legislation was introduced in the current 118th Congress by U.S. Representatives Joe Courtney (D-CT), Glenn Thompson (R-PA), and others, and Senators Sherrod Brown (D-OH), Susan Collins (R-ME), and Sheldon Whitehouse (D-RI). The legislation remains a priority for ACEP's federal advocacy. ACEP is also a member of a larger coalition solely focused on addressing this issue. While there is significant industry and stakeholder support for changing this policy, Congress has not yet acted on this legislation. However, as there is now a greater body of evidence from the pandemic experience that revising the three-day stay rule leads to better outcomes for patients without increasing costs, ACEP and coalition advocates have renewed the push for Congress to take up and pass this legislation.

Regulatory Activity
ACEP has also advocated for rescission and/or counting observation in countless regulatory comments, including in response to the "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success" proposed rule, the 2021 Outpatient Prospective Payment System (OPPS) proposed rule, and the 2023 OPPS.

ACEP also identified removal of the three-midnight rule as a key policy solution for addressing ED boarding in the Policy Solutions to ED Boarding document, a document that guides ACEP advocacy strategies.

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

Budgeted staff resources as this is already an ongoing initiative of the College.

Prior Council Action

Resolution 25(15) Medicare 3-Day Rule not adopted. Requested that ACEP develop a paper describing the barriers of

the Medical 3- Day Rule, the costs it creates for the health care system and costs that are often transferred to patients; partner with the AMA and other organizations to develop the paper and work together to eliminate the rule and make elimination of the rule a top legislative priority.

Amended Resolution 36(05) Medicare Requirement of Three-Night Hospital Stay referred to the Board of Directors.

Prior Board Action

The Board of Directors approves the legislative and regulatory priorities each year.

March 2024, February 2023, January 2022, and January 2021, approved supporting legislation to rescind the Medicare 3-day inpatient stay before becoming eligible for Skilled Nursing Facility (SNF) services and encourage the use of waivers to restrictive payment policies such as telehealth and the 3-day SNF rule, as appropriate, based on experience from waivers granted during the COVID-19 public health emergency.

February 2020, approved supporting legislation to rescind the Medicare 3-day inpatient stay before becoming eligible for Skilled Nursing Facility (SNF) services and encourage the use of waivers to restrictive payment policies such as telehealth and the 3-day SNF rule.

January 2019, approved supporting waivers to the 3-day Skilled Nursing Facility (SNF) rule that are included in Medicare payment models.

February 2018, January 2017, and February 2016, approved supporting expanded exemption for integrated payment models regarding Medicare policy that requires 3-day inpatient stay before becoming eligible for Skilled Nursing Facility (SNF) services.

January 2015, January 2014, and February 2013, approved supporting legislation to rescind the Medicare 3-day inpatient stay and supporting regulatory efforts for an exemption for integrated payment models.

January 2012, approved continuing advocacy efforts to count time in observation toward the Medicare 3-day stay rule, and/or waiving the rule for ACOs.

January 2011, approved continuing advocacy efforts to count time in observation toward the Medicare 3-day stay rule.

September 2008, approved continuing efforts with key stakeholders, such as AARP, nursing homes, and beneficiary groups to advocate for a change in the Medicare 3-day rule.

August 2007, supported continuing state and federal advocacy efforts to rescind the Medicare 3-day stay rule.

Background Information Prepared by: Erin Grossmann
Regulatory and External Affairs Manager

Ryan McBride, MPP
Congressional Affairs Director

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

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

RESOLUTION: 25(24)

SUBMITTED BY: John Bibb, MD, FACEP
Fred Dennis, MD, FACEP
New Mexico Chapter
Exploring Retirement Section

SUBJECT: Boarding – Follow the Money

PURPOSE: Collaborate with relevant stakeholders including the AMA, hospital associations, nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the ED to hospital discharge and chronic care facility placement if necessary for all patients admitted to observation and inpatient status from the ED.

FISCAL IMPACT: Budgeted committee and staff resources for ongoing federal and state advocacy initiatives.

1 WHEREAS, President George W. Bush said in 2007, "I mean, people have access to health care in America.
2 After all, you just go to an emergency room."; and
3
4 WHEREAS, There have been 69 billion ACEP resolutions about boarding over the last several decades and the
5 problem has only gotten worse; and
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7 WHEREAS, The adverse outcomes of boarding have been documented ad nauseam; and
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9 WHEREAS, Boarding has forced the development of new subspecialties of emergency medicine including
10 Hallway Medicine, Waiting Room Medicine, and Tent/Parking Lot Medicine that patients are forced to endure; and
11
12 WHEREAS, When they say it is not about the money, it is always about the money; and
13
14 WHEREAS, It is, at best, partially effective, in our capitalist system, to force businesses to engage in
15 nonprofitable lines of work through regulation, legislation, bureaucracy begging, pleading, and accusations; and
16
17 WHEREAS, When admitting sick patients to the hospital from all economic strata is profitable (economically
18 viable?), this business line will be pursued fervently, and many of our problems with boarding will be ameliorated;
19 therefore be it
20
21 RESOLVED, That ACEP collaborate with relevant stakeholders including the AMA, hospital associations,
22 nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the
23 emergency department to hospital discharge and chronic care facility placement if necessary for all patients admitted to
24 observation and inpatient status from the emergency department.

Background

The resolution calls for ACEP to collaborate with relevant stakeholders including the AMA, hospital associations, nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the emergency department to hospital discharge and chronic care facility placement if necessary for all patients admitted to observation and inpatient status from the ED.

The resolution aims to address the foundational economic incentives that have led to the current emergency

department boarding crisis. Emergency department boarding is a scenario where patients are kept in the ED for extended periods of time because of a lack of available inpatient beds or space in other facilities where they could be transferred. Shortages of physicians, nurses, and other health care providers across the health care continuum have significantly contributed to the growing issue of boarding.

Recent reports, including a May 2024 report issued by the American Hospital Association, suggest that hospitals and health systems throughout the country are facing dire financial outlooks, despite the stabilization of operating costs and margins as the COVID-19 pandemic subsided. The AHA report states that increasing demand for higher acuity care, persistent workforce shortages, supply chain issues for drugs and supplies, and high levels of inflation, are contributing to growing costs while reimbursement rates from government payers and bad commercial insurer practices are exacerbating the financial distress facing hospitals. As the resolution notes, given our current system of health care financing, regulatory and legislative environments, and growing administrative and bureaucratic burdens, hospitals and health systems are required to provide nonprofitable lines of business and are thus incentivized to pursue lines of business that are profitable, often at the expense of efficiencies or most appropriate care for patients.

Empirical studies have shown boarding contributes to worse patient outcomes and increased mortality related to downstream delays of treatment for both high- and low-acuity patients. In addition to disrupting the ED workflow and creating operational inefficiencies, it often also creates additional dangers, such as ambulance diversion, increased adverse events, preventable medical errors, more walkouts by patients, lower patient satisfaction, violent episodes in the ED, and higher overall health costs. This problem is only worsening as ED volumes return to normal levels after a substantial drop in visits during the early stages of the COVID-19 pandemic. Boarding and ED crowding are not caused by ED operational issues or inefficiency; rather, they stem from misaligned economic drivers and broader health system dysfunction.

ACEP has been working on a study of ED boarding with the Emergency Department Benchmarking Alliance (EDBA). Preliminary results of this 2022 EDBA performance measures survey "…found a significant deterioration in patient processing due to inpatient boarding." ACEP issued a report in 2016, developed by the Emergency Medicine Practice Committee, "Emergency Department Crowding: High Impact Solutions." The report was developed to identify and disseminate proven ways to decrease input, as well as novel approaches to increase throughput and increase output. This document is available on ACEP's resource page, "Crowding & Boarding," along with links to other relevant information papers, policy statements, resources regarding state approaches, and others.

Overall, addressing boarding and crowding have been longstanding priorities of the College There is active policy development, committee work, liaison work, and media outreach that is ongoing on this issue. Federal legislative and regulatory advocacy efforts continue as well. ACEP federal advocacy has focused on raising awareness of the ED boarding crisis and developing both legislative and regulatory solutions to help ease this multifactorial challenge. In November 2022, ACEP led a coalition letter to President Biden, laying out the ED boarding crisis as a public health emergency and asking the Administration to establish an ED Boarding Task Force. Then, in May 2023, ACEP developed and helped secure signatories during the 2023 Leadership and Advocacy Conference (LAC) for a bipartisan "Dear Colleague" letter led by Representatives Debbie Dingell (D-MI) and Brian Fitzpatrick (R-PA), along with 42 other Representatives, urging U.S. Department of Health and Human Services Secretary Xavier Becerra to convene a stakeholder task force to address the boarding crisis and develop and implement immediate and long-term solutions.

As part of this continued initiative, in September 2023, ACEP organized and led a summit of stakeholders across health care to discuss the factors contributing to the boarding crisis and strategies to pursue collaborative solutions. Participating medical societies, state and federal government leaders, hospital, nursing home, and patient group representatives came to the ACEP DC office for a candid and crucial conversation, including the Agency for Healthcare Research and Quality (AHRQ), the American Hospital Association, American Nurses Association, America's Essential Hospitals, among others. A full report of the Summit's proceedings was published on October 20, 2023. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue. And in December 2023, Secretary Becerra responded to the Dingell-Fitzpatrick Dear Colleague letter and announced the convening of stakeholders through AHRQ to address ED boarding. ACEP has worked closely with AHRQ since this announcement to help inform the AHRQ Directors' Roundtable and its continued efforts on the topic.

Additionally, the Centers for Medicare and Medicaid Services (CMS) finalized the adoption of the Age-Friendly Hospital Measure as part of the Hospital IQR Program. The measure, developed by ACEP in partnership with the American College of Surgeons (ACS) and Institute for Healthcare Improvement, seeks to enhance care for older patients by focusing on key areas like medication management and frailty screening. This measure aims to redefine how hospital systems approach geriatric care, calling for hospitals to have protocols in place to move older patients out of the emergency department within eight hours of arrival or three hours of the decision to admit. ACEP encouraged CMS to include attestations to reduce boarding in the emergency department and screen for risk factors related to social determinants of health, among others. The inclusion of the measure in the hospital IQR program gives hospitals a financial incentive to address boarding in geriatric populations.

In July 2024, ACEP leadership and staff met with CMS asking them to potentially modify the Emergency Services Condition of Participation (CoP) as a lever to help address boarding. There is a recent precedence for this, as in the Calendar Year 2025 Outpatient Prospective Payment System (OPPS) proposed rule, CMS proposes to revise the Emergency Services CoP related to emergency readiness for hospitals and CAHs that provide emergency services and create a new CoP for obstetrical services.

Addressing boarding and crowding have also been key priorities for federal advocacy during the 118th Congress. ACEP helped develop and supports the bipartisan Improving Mental Health Access from the Emergency Department Act (S.1346), which creates a grant program aimed at assisting emergency departments and communities in implementing innovative strategies to ensure continuity of care for patients who have presented with acute mental health conditions.

ACEP also supports:

- The bipartisan Helping Kids Cope Act (H.R. 2412), introduced by Representatives Lisa Blunt Rochester (D-DE) and Brian Fitzpatrick (R-PA) which would provide funding to support necessary staffing, capacity increases, and infrastructure adjustments needed to alleviate pediatric boarding; maintaining initiatives to allow more children to access care outside of emergency departments; and addressing gaps in the continuum of care for children.
- The Mental Health Infrastructure Improvement Act (H.R. 5804), introduced by Representatives Derek Kilmer (D-WA) and Don Bacon (R-NE). Helps expand mental health infrastructure by establishing a new loan and loan guarantee program to fund the construction or renovation of mental health or SUD treatment facilities that provide inpatient care, partial hospitalization, intensive outpatient, and/or crisis stabilization; sets aside at least 25% of the funding for pediatric-serving facilities; provides priority for facilities that are located in high-need, underserved, or rural areas, are able to provide integrated care for complex patients, and will provide multiple services along the continuum of care.
- The Providing Access to Treatment and Housing (PATH) Act (H.R. 4941) introduced by Representatives Adam Schiff (D-CA), Nancy Pelosi (D-CA), Yvette Clarke (D-NY), and others. Expands access to mental health and behavioral health services, including substance use disorder treatment, for individuals experiencing homelessness or housing insecurity. Establishes a $2 billion grant program to expand access to services, overdose prevention, workforce training, care coordination, housing programs, and training for non-health care professionals interacting with those experiencing homelessness or housing insecurity.

ACEP staff continue to discuss potential solutions with legislators in both chambers and inform additional legislative efforts in development, including legislation to help improve bed tracking and capacity management systems that is expected to be introduced in the near future. Additionally, ED boarding, ED crowding, and mental health have been the central themes of the face-to-face advocacy efforts by our members who attend the ACEP Annual Leadership and Advocacy Conference for the last several years.

Emergency Department Boarding and Crowding resources are available on the ACEP website, including Policy Solutions to Emergency Department Boarding. These policy solutions point to some of these financial drivers and potential ways to realign financial incentives, such as establishing reimbursement incentives for hospital systems to transfer patients outside of their system in limited cases of extreme boarding, tying additional financial incentive es and penalties to measures of crowding and boarding, developing incentives to enable skilled nursing facilities and long-term care facilities to expand capacity and accept patients from the ED outside of core business hours (as well as

possible penalties for refusing patients without documentation of legitimate reasons for doing so), among others.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources for ongoing federal and state advocacy initiatives.

Prior Council Action

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted. Directed ACEP to work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA and support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs referred to the Board of Directors. Directed ACEP to work with state and federal agencies to advocate for state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems and to report their activities publicly; advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not available at the referring hospital; advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined as patient catchment areas rather than jurisdictional boundaries; and, support research to strengthen the evidence base regarding rural hospital transfer processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes and experience and include investigation of common challenges experienced by all small, non-networked hospitals.

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted. Directed ACEP to use legislative venues and lobbying efforts, focus regulatory bodies to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve ED capacity; and define criteria to determine when an ED is considered over capacity and hospital action plans are triggered to activate

Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted. Directed the College to study financial and other incentives that might be used to reduce Boarding of admitted patients in the emergency department.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted. Directed ACEP to work with the U.S. Department of Health and Human Services, the U.S. Public Health Service, The Joint Commission, and other appropriate stakeholders to determine action steps to reduce ED crowding and boarding.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend

discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Resolution 28(08) Nationwide ED Crowding Crisis not adopted. The resolution directed ACEP members to work with state medical associations and/or health departments to encourage hospitals and health care organizations to develop mechanisms to increase availability of inpatient beds. Salient provisions of this resolution were included in Substitute Resolution 25(08) State Department of Health Crowding Surveys.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted. Directed ACEP to investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding, encourage members to work with their state medical associations and/or state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients, identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. Directed ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate crowding and treatment delays affecting ED and other hospital patients.

Amended Resolution 26(07) Hallway Beds adopted. The resolution directed ACEP to revise the policy statement "Boarding of Admitted and Intensive Care Patients in the ED," work with state and national organizations to promote the adoption of such policies, and to distribute information to the membership and other organizations related to patient safety outcomes caused by the boarding of admitted patients in the ED.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will reduce crowding by placing the burden on hospitals to manage their resources more effectively.

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted. Directed ACEP to endorse the concept that overcrowding is a hospital-wide problem and the most effective care of admitted patients is provided in an inpatient unit, and in the event of emergency department boarding conditions, ACEP recommends that hospitals allocate staff so that staffing ratios are balanced throughout the hospital to avoid overburdening emergency department staff while maintaining patient safety.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted. Directed ACEP to develop a specific strategy to coordinate all activities related to emergency department and hospital crowding to support state efforts, analyze information and experiences to develop a resource tool to assist chapters in efforts to seek solutions to emergency department and hospital crowding at the local level.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. The resolution called for ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards that are consistent with ACEP's policy "Boarding of Admitted and Intensive Care Patients in the Emergency Department." The standard should address the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision.

Amended Resolution 50(88) Hospital Bed Availability and Methodology adopted. It called for ACEP to develop policies to ensure that emergency patients receive the highest priority in hospital admission systems.

Prior Board Action

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted.

February 2023, approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department;" revised and approved June 2017, April 2011, April 2008, January 2007; originally approved October 2000.

January 2022, approved the revised policy statement, "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with current title; revised and approved February 2009, February 2002, June 1997, September 1992 titled, "Appropriate Inter-hospital Patient Transfer;" originally approved September 1989 as position statement "Principles of Appropriate Patient Transfer."

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted.

Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted.

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

June 2016, reviewed the updated information paper "Emergency Department Crowding High-Impact Solutions"

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper "Crowding and Surge Capacity Resources for EDs."

October 2006, reviewed the information paper "Approaching Full Capacity in the Emergency Department."

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Amended Resolution 50(88) Hospital Bed Availability and Methodology adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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

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

RESOLUTION: 26(24)

SUBMITTED BY: Erik Blutinger MD FACEP
Elaine Rabin MD FACEP
Nicholas Stark, MD, MBA
Arjun Venkatesh, MD, FACEP
New York Chapter
Quality Improvement & Patient Safety Section
Young Physicians Section

SUBJECT: Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events

PURPOSE: 1) Advocate for and support the development of policies that take ED boarding and overcrowding into consideration when analyzing adverse patient safety events and patient safety procedures; 2) Commit resources for establishing best practices for hospitals to consider ED boarding/overcrowding in developing corrective action plans in response to medical errors; 3) Work with stakeholders to require that Root Cause Analyses performed in response to adverse patient safety events specifically list boarding and/or overcrowding as benchmarks in analysis questions and root cause types.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives and potential unbudgeted expenses of $5,000-$10,000 if an in-person meeting (depending on the number of participants) is necessary or for third-party development and dissemination of best practices materials.

1 WHEREAS, Inpatient boarding in emergency departments and hospital crowding was declared a national
2 epidemic in 2007 by the Institute of Medicine[1]; and
3
4 WHEREAS, The issue has not been resolved and likely worsened after COVID[2]; and
5
6 WHEREAS, Boarding and crowding have been demonstrated to compromise patient safety, with dire effects on
7 morbidity and mortality[3]; and
8
9 WHEREAS, The Joint Commission mandates that hospitals employ a Root Cause Analysis (RCA) process or
10 similar activity to identify and address systemic contributors to patient safety issues[4]; and
11
12 WHEREAS, RCAs often deliberately focus only on the care of one patient without consideration of other
13 activity in a department at the time, thus by design not necessarily accounting for contributions of boarding and
14 crowding to any adverse events; and
15
16 WHEREAS, There is no widely accepted, universal approach to performing an RCA used by health systems to
17 account for boarding in Emergency Departments and hospital crowding; and
18
19 WHEREAS, Federal data often fails to capture a comprehensive review of resource limitations inclusive of ED
20 strain, staffing variability, and local outbreak burden; therefore be it
21
22 RESOLVED, That ACEP advocate for and support the development of policies that will ensure appropriate
23 consideration of context of contemporaneous boarding and overcrowding during Root Cause Analysis and related
24 patient safety processes in hospitals; and be it further
25
26 RESOLVED, That ACEP commit resources for establishing best practices and assisting hospitals with
27 considering relevant corrective actions for medical errors committed as a result of ED overcrowding; and be it further

28 RESOLVED, That ACEP work with other organizations to require that Root Cause Analysis and corrective
29 actions include hospital capacity constraints and overcrowding as benchmarks in "analysis questions" and "root cause
30 types" when analyzing an event and organizing next steps.

References

1. Institute of Medicine. 2007. *Hospital-Based Emergency Care: At the Breaking Point*. Washington, DC: The National Academies Press. https://doi.org/10.17226/11621.
2. Janke AT, Melnick ER, Venkatesh AK. Hospital Occupancy and Emergency Department Boarding During the COVID-19 Pandemic. JAMA Netw Open. 2022 Sep 1;5(9):e2233964. doi: 10.1001/jamanetworkopen.2022.33964. PMID: 36178691; PMCID: PMC9526134
3. Kelen GD, Wolfe R, D'Onofrio G, et al. Emergency Department Crowding: the canary in the healthcare system. NEJM Catalyst. September 28, 2021.
4. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/camh_se_20230906_155314.pdf. Accessed June 24, 2024.

Background

This resolution calls for the College to work with other organizations to add emergency department (ED) boarding and crowding as a factor when conducting Root Causes Analysis (RCA) and determining corrective action plans in response to medical errors and adverse patient safety events. Additionally, the resolution asks the College to create resources to establish best practices in engaging and assisting hospitals in consideration of ED boarding and crowding when those hospitals conduct analyses of such incidents.

The resolution also asks the College to advocate for requiring that RCA include ED boarding and/or overcrowding as benchmarks in "analysis questions" and "root cause types" but does not specifically mention TJC. the College would need to engage with TJC, state regulatory bodies, the Centers for Medicare & Medicaid Services (CMS), and/or other appropriate policymaking bodies that can enforce a requirement to include these benchmarks,

RCA is a structured method used to analyze serious adverse events and is the method mandated by The Joint Commission (TJC) when hospitals experience and report a sentinel event. Though hospitals and accredited organizations are not required to report sentinel events – a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm) – TJC encourages self-reporting of such events for health care organizations. Self-reporting allows hospitals and health care organizations to identify opportunities to change their culture, systems, and processes to prevent unintended harm; help health care organizations that have experienced a sentinel event determine and understand contributing factors (including underlying causes, latent conditions, and active failures) and develop strategies to prevent or reduce such events in the future; and maintain the confidence of the public, clinical staff, and health care organizations in the priority of patient safety in TJC–accredited health care organizations. Though specifically mandated by TJC in response to a sentinel event, RCA is also widely used internally as a response to medical errors and adverse patient safety incidents.

In TJC's Framework for Root Cause Analysis and Action Plan, which provides a template for analyzing an event and helps to organize the steps and information in an RCA in preparation for submitting an analysis to TJC (but can be used to guide analysis of non-TJC-reported events), boarding and/or overcrowding is not listed as one of the root cause types or referenced as a causal factor. However, multiple studies have shown that boarding and/or overcrowding is associated with a reduction in quality of care, resulting in unfavorable clinical outcomes and adverse events (Rocha et al.; Loke et al.).

In June 2024, ACEP leadership and staff engaged in a discussion with TJC in which we advocated for the consideration of boarding and/or overcrowding-related adverse incidents as sentinel events. Further, in July 2024, ACEP leadership and staff met with CMS asking them to potentially modify the Emergency Services Condition of Participation (CoP) as a lever to help address boarding. There is a recent precedence for this, as in the Calendar Year 2025 Outpatient Prospective Payment System (OPPS) proposed rule, CMS proposes to revise the Emergency Services CoP related to emergency readiness for hospitals and CAHs that provide emergency services and create a new CoP for obstetrical services.

Addressing boarding and crowding has been a longstanding priority of the College, with continuing federal legislative and regulatory advocacy efforts. In September 2023, ACEP organized and led a summit of stakeholders across health care to discuss the factors contributing to the boarding crisis and strategies to pursue collaborative solutions. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue. Addressing boarding and crowding has also been key priorities in ACEP's advocacy to Congress. Specifically, ACEP's Boarding Policy Recommendations include several recommendations for hospital contributions:

- Creation of reimbursement incentives for hospital systems to transfer patients outside of their system in limited cases of extreme boarding.
- Tie additional financial incentives and penalties to measures of crowding and boarding such as CMS measure OP-18 (Median Time from ED Arrival to ED Departure for Discharged ED Patients) and ED-2 (Admit Decision Time to ED Departure Time for Admitted Patients).
- Creation of "holding for discharge rooms" elsewhere in hospital that allow patients who are near discharge to receive final discharge instructions—thereby freeing up ED beds.
- New CMS Condition of Participation requiring hospitals to develop contingency plans when inpatient occupancy exceeds 85 percent [or similar threshold], including a load balancing plan and an identification and utilization plan of alternative space and staffing for inpatients when greater than a certain percentage of ED licensed bed capacity is occupied.
- Expansion of surgical and procedural schedules to seven days, thereby spreading out elective procedures and smoothing out the availability of inpatient beds within hospitals.

Boarding was a key issue that ACEP member advocates brought to Congressional offices during the last two Leadership & Advocacy Conferences. ACEP staff continue to work on developing legislative proposals and it is hoped the proposals will be introduced this fall in both chambers of Congress. Lastly, boarding is also part of ACEP's recess toolkit for ACEP members to advocate to their Congressional leaders during the August break while legislators are back in their home districts.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

Fiscal Impact

Budgeted staff resources for advocacy initiatives and potential unbudgeted expenses of $5,000-$10,000 if an in-person meeting (depending on the number of participants) is necessary or for third-party development and dissemination of best practices materials.

Prior Council Action

The Council has discussed and adopted many resolutions related to boarding in the ED, but none that are specific to adding ED boarding and crowding as a factor when conducting Root Causes Analysis (RCA) and determining corrective action plans in response to medical errors and adverse patient safety events.

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted. It directed the College to use legislative and regulatory venues to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve emergency department capacity; and define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

Amended Resolution 13(16) ED Boarding and Overcrowding is a Public Health Emergency adopted. It directed the College to work with regulatory agencies and the Joint Commission 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.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted. Directed ACEP to investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding, encourage members to work with their state medical associations and/or state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients, identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. The resolution directed ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate crowding and treatment delays affecting ED and other hospital patients.

Amended Resolution 26(07) Hallway Beds adopted. The resolution directed ACEP to revise the policy statement "Boarding of Admitted and Intensive Care Patients in the ED," work with state and national organizations to promote the adoption of such policies, and to distribute information to the membership and other organizations related to patient safety outcomes caused by the boarding of admitted patients in the ED.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will reduce ED crowding by placing the burden on hospitals to manage their resources more effectively.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted. Directed ACEP to develop a specific strategy to coordinate all activities related to emergency department and hospital crowding to support state efforts, analyze information and experiences to develop a resource tool to assist chapters in efforts to seek solutions to emergency department and hospital crowding at the local level.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. The resolution called for ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards that are consistent with ACEP's policy "Boarding of Admitted and Intensive Care Patients in the Emergency Department."

Prior Board Action

February 2023, approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department;" revised and approved June 2017, April 2011, April 2008, January 2007; originally approved October 2000.

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted.

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

April 2017, approved the revised policy statement "Disclosure of Medical Errors;" revised and approved April 2010; originally approved September 2003.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper "Crowding and Surge Capacity Resources for EDs."

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Background Information Prepared by: Erin Grossmann
Regulatory and External Affairs Manager

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

RESOLUTION: 27(24)

SUBMITTED BY: Rural Emergency Medicine Section
Social Emergency Medicine Section
Oklahoma Chapter
Michigan College of Emergency Physicians
Virginia College of Emergency Physicians

SUBJECT: Continuous Physician Staffing for Rural Emergency Departments

PURPOSE: Collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician be required to be on-site and available for care of emergency department patients at all times.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives.

1 WHEREAS, Rural emergency department patients deserve access to physician-led teams to the same degree as
2 their urban counterparts; and
3
4 WHEREAS, There is variability in the required training and supervision of non-physician practitioners (NPs,
5 PAs,) working in emergency departments which can lead to a lower degree or complete absence of physician
6 involvement in emergency care; and
7
8 WHEREAS, The states of Virginia and Indiana have set a precedent with legislation requiring continuous on-
9 site physician staffing in all emergency departments; and
10
11 WHEREAS, The ACEP Council adopted Amended Resolution 42(23) which resolved to "encourage and
12 support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency
13 departments"; and
14
15 WHEREAS, The American Medical Association (AMA) in 2024 adopted resolution 204 that the AMA seek
16 federal legislation or regulation that would require all emergency departments to be staffed 24/7 by a qualified
17 physician; therefore be it
18
19 RESOLVED, That ACEP collaborate with the American Medical Association to advocate that the Centers for
20 Medicare and Medicaid Services (CMS) modify the "Staff and Staffing Responsibilities" Conditions of Participation
21 for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician be
22 required to be on-site and available for care of emergency department patients at all times.

Background

This resolution requests ACEP to collaborate with the American Medical Association to advocate that the Centers for Medicare and Medicaid Services (CMS) modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician be required to be on-site and available for care of emergency department patients at all times.

ACEP has consistently advocated for physician-led care teams in the emergency department at both the national and state level. The Advocacy and Practice Affairs Division has also advocated for this standard to the Centers for

Medicare and Medicaid Services as well as Health and Human Services and the U.S. Congress.

Indiana ACEP successfully passed legislation in 2023 (HOUSE BILL No. 1199) that requires a physician be on-site, on-duty, and responsible for the emergency department at all times. This new legislation complements state regulations in place in California and New Jersey that also require a physician on-site in a hospital emergency department.

The State Legislative/Regulatory Committee (SLRC) developed a toolkit after the successful passage of the Indiana legislation and used the language from that legislation along with other model provisions, drafting notes and definitions, as well as current regulatory language to consider. The toolkit was distributed to ACEP chapters in time for the 2023-24 state legislative season.

Virginia ACEP used the model legislation developed by ACEP to pass legislation (HB 392) updating an existing law to include a requirement for a physician to be on site and responsible for the emergency department at all times. Nearly a dozen other states are considering introducing the ACEP model legislation in their 2025 legislative session.

ACEP advocated at the AMA House of Delegates for a resolution that adopts much of the model legislation used in Indiana and Virginia. The AMA adopted resolution 204 in June 2024 that compels the AMA to seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and that the AMA seek federal legislation or regulation that would require all emergency departments to be staffed 24/7 by a qualified physician.

CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet to begin and continue participating in Medicare and Medicaid. This action would have the effect of creating a federal mandate that EDs in Critical Access Hospitals (CAH) and Rural Emergency Hospitals (REH) be staffed 24/7 by a qualified physician. This would parallel the requirement in Indiana, Virginia, and ACEP's model legislation, but does not require a board certified emergency physician in the rural setting.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states:

> "Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety. Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

ACEP has continually promoted the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians and advocated for this standard to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, and the U.S. Congress.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

- Expand and strengthen the role, approach, and impact of state-level advocacy.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives.

Prior Council Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the

independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing two policy statements. "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments.

Background Information Prepared by: Adam Krushinskie
Senior Director, State Legislative and Reimbursement

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

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

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

RESOLUTION: 28(24)

SUBMITTED BY: Utah Chapter

SUBJECT: Data Gathering on Free Standing EDs: Examining Regulations, Services Offered, and Staffing Policies

PURPOSE: Collect data on free standing emergency department-type facilities at the national and state level, including current services and equipment offered at FSEDs, state regulations, and other policies that might assist chapters addressing issues with FSEDs.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Significant staff resources would be required to identify existing FSEDs and the contact information for each one. An outside consultant would likely be necessary and the cost is estimated at $250,000 or more. As the possible use of the data is unknown, this estimate could increase depending on the amount of detail required and the analysis needed. A data system would require ongoing staff resources to ensure the data remains current. This project would require diverting budgeted staff resources from other initiatives to support this effort.

1 WHEREAS, Across the nation there is significant variation both in number and location of free standing
2 emergency departments (FSEDs) as well as regulation of staffing or clinical capabilities at these facilities; and
3
4 WHEREAS, One study demonstrated that state requirements for FSEDs vary from "thorough and well defined
5 to vague or non-existent, a range that likely contributes to the wide variation in the services available at FSEDs"[1]; and
6
7 WHEREAS**,** ACEP has recommended core policies that FSEDs should adopt, as well as a formal accreditation
8 process for FSEDs,[2] but that has not come to fruition and this has allowed hospital corporations and individuals to open
9 and operate FSEDs without nationally standardized, formal safety regulations related to staffing, equipment, or
10 capabilities; and
11
12 WHEREAS**,** Patients may be likely to assume that a FSED can provide the same services as a hospital-based
13 ED and seek care from a facility that may not be capable of adequately providing definitive care and this could result in
14 treatment delays or inability to prevent death or severe disability; and
15
16 WHEREAS, In addition, patients may confuse FSEDs for urgent care centers, receiving evaluation and
17 treatment for lower acuity issues, but receiving a bill on par with that of a hospital-based emergency department due to
18 similar facility fees[3]; therefore be it
19
20 RESOLVED**,** That ACEP collect data on free standing emergency department-type facilities (FSEDs)
21 nationally, and any state regulations specifically pertaining to them, and this may include a survey of current services
22 and equipment offered at FSEDs in each state as well as staffing and other pertinent policies that might be helpful to
23 ACEP chapters who may be addressing issues with these facilities.

References

1. Gutierrez, C et al. State Regulation of Freestanding Emergency Departments Varies Widely, Affecting Location, Growth, and Services Provided. *Health Affairs* 35, No. 10 (2016): 1857-1866.
2. Dayton, J et al. Freestanding Emergency Center Accreditation Task Force Recommendations. ACEP 2018.
3. Alexander, A and Dark, C. Freestanding Emergency Departments: What is Their Role in Emergency Care? *Annals of Emergency Medicine.* Volume 74, No. 3: September 2019. 325-330.

Background

This resolution requests ACEP to gather data on free standing emergency department-type facilities (FSEDs) at the national and state level to assist ACEP chapters addressing issues with FSEDs.

The number and location of FSEDs, and regulation of these facilities vary greatly. Patients might confuse am FSED with a hospital ED and seek care from a facility that is not equipped to provide definitive care, potentially causing treatment delays or exacerbating the patient's condition. Conversely, patients might confuse a FSED with an urgent care center and could lead to unexpected medical bill totals.

The ability to gather sufficient data about FSEDs will first require a determination about the purpose and possible uses of the data. It will also be necessary to determine contact information for each FSED. There is no repository that identifies FSEDs in the U.S. or the contact information for each one. Additionally, there will need to be an incentive for an FSED to complete a survey to provide the information.

ACEP's "Freestanding Emergency Departments" policy statement maintains that states are encouraged to develop regulations regarding FSEDs in partnership with the applicable ACEP state chapter. The policy statement addresses appropriate staffing by qualified emergency physician and adequate medical and nursing personnel, and affirms that FSEDs should receive the same level of reimbursement for physician and technical component services as a hospital-based ED.

ACEP endorses the Center for Improvement in Healthcare Quality Free-Standing Emergency Center Accreditation Program. The accreditation survey process includes a review of facility policies and procedures, a tour of the facility and care areas, review of physician credentials and medical records, and observation of care services. This is a voluntary program that facilities can choose to utilize for accreditation.

ACEP's Freestanding Emergency Centers Section has an objective focused on collaborating with ACEP leadership to establish a national set of standards that could be referred to as a unified national resource for legislatures, physicians, and the medical community.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Significant staff resources would be required to identify existing FSEDs and the contact information for each one. An outside consultant would likely be necessary and the cost is estimated at $250,000 or more. As the possible use of the data is unknown, this estimate could increase depending on the amount of detail required and the analysis needed. A data system would require ongoing staff resources to ensure the data remains current. This project would require diverting budgeted staff resources from other initiatives to support this effort.

Prior Council Action

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency

Care in Underserved and Rural Areas of the U.S. adopted. Called for the College to develop a report or information paper supporting the use of freestanding emergency centers as a replacement for EDs in critical access and rural hospitals that are closing or at-risk of closing.

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted. Called for ACEP to explore the possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers and the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where allowed by state law.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted. Directed ACEP to study the emergence and proliferation of free-standing EDs and facilities including: applicable federal and state regulatory and accreditation issues; the potential impact on the emergency medicine workforce; the potential fiscal impact on hospital-based EDs; and provide informational resources to the membership.

Resolution 15(98) Certifying Emergency Departments adopted. Directed the Board to appoint a task force to study the advisability of regionalization of care, developing a strategy to consolidate certifying agencies, and consider development of an ACEP certifying agency to replace as many other certifying agencies as possible.

Substitute Resolution 51(84) Advertising and Public Education of Free-standing Facilities adopted. Called for ACEP to encourage physicians and health care providers and health care facilities to emphasize in advertising their own positive attributes rather than to denigrate the capabilities of other providers or facilities.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted. Instructed ACEP to reaffirm the Emergency Care Guidelines and develop definitions of various forms of ambulatory care facilities and emergency care facilities to be included in future Emergency Care Guidelines.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted. Called for ACEP to set standards of care for facilities that present themselves to be sources of emergency care.

Prior Board Action

April 2020, approved the revised policy statement "Freestanding Emergency Departments;" originally approved June 2014.

April 2019, approved partnering with the Center of Improvement in Healthcare Quality (CIHQ) to provide accreditation services for freestanding emergency centers.

September 2018, directed the Freestanding Emergency Centers Task Force to explore models and develop a business plan to develop for freestanding emergency center accreditation.

May 2018, reviewed the Freestanding Emergency Centers Task Force report.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2016 and April 2016, discussed a certification program for Freestanding Emergency Centers created by the Society of Cardiovascular Patient Care (SCPC), which merged with the American College of Cardiology (ACC), and offers certification in Freestanding ED cardiac care. ACEP notified SCPC that it does not support certification of this type. SCPC formally launched the certification program in May 2016.

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted.

November 2015, reviewed the information paper Freestanding Emergency Departments and Urgent Care Centers.

June 2014, approved the policy statement, "Freestanding Emergency Departments."

July 2013, reviewed the revised information paper "Freestanding Emergency Departments;" originally developed August 2009.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted.

Resolution 15(98) Certifying Emergency Departments adopted.

Substitute Resolution 51(84) Advertising and Public Education of Free-standing Facilities adopted.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted.

Background Information Prepared by: Jessica Adams
Reimbursement Director

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

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

RESOLUTION: 29(24)

SUBMITTED BY: Utah Chapter

SUBJECT: Minimum Standards for Freestanding Emergency Departments

PURPOSE: Promote and advocate that all FSEDs meet minimum standards of: 24/7 staffing by a board-certified/board-eligible emergency physician; x-ray, CT, and ultrasound capabilities at all times, trained technicians dedicated to those tasks; two registered nurses experienced in emergency medicine onsite at all times; laboratory services capable of performing low and moderate complexity tests available at all times; a certified respiratory therapist onsite at all times; a trained security officer present at all hours of operation; at least two units of packed red blood cells at all times.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

1 WHEREAS**,** Freestanding emergency departments (FSEDs) were created in the 1970s in the hopes they would
2 provide high-quality emergency care to people in medically underserved areas, provide convenient services and
3 treatments with shorter wait times, and relieve overburdened hospital emergency departments (EDs); and
4
5 WHEREAS, FSEDs are a rapidly expanding alternative to traditional hospital-based EDs. However, when
6 advertised as an emergency center/department/room, the general public may reasonably expect that a FSED will be able
7 to provide emergency services on par with that of a hospital ED, including care for strokes, heart attacks, and traumatic
8 injuries, when the reality is that some FSEDs may not be capable of providing all of these services; and
9
10 WHEREAS**,** FSEDs should provide services that reflect the current evidence-based standard of emergency
11 medical care as well as provide adequate staffing and capabilities to ensure patient safety and to reduce physician and
12 other provider liability; therefore be it
13
14 RESOLVED**:** That ACEP promote and advocate that all free standing emergency departments (FSEDs)
15 maintain the following minimum standards:
16
17 1. All facilities advertised or promoted as free standing emergency departments (FSEDs) or similar titles implying
18 services comparable to a hospital-based emergency department should be staffed by at least one board-certified
19 or board-eligible emergency physician 24 hours a day, 7 days a week. All FSEDs should be physician-led.
20 Nurse practitioners and physician assistants providers may be allowed to supplement staff at FSEDs, but a
21 physician must be present on site at all times.
22 2. FSEDs must have x-ray, CT, and ultrasound capabilities at all times with trained technicians dedicated to those
23 tasks. Ultrasound technicians may be on call if they can arrive within 30 minutes when needed.
24 3. There should be at least two registered nurses with experience in emergency medicine services with the ability
25 to flex up nursing staff as needed if--in the opinion of the on-duty physician-- patient census, acuity level, or
26 length of stay requires more nursing staff for safe and optimal patient care.
27 4. All FSEDs must maintain on the premises during all hours of operation laboratory services capable of
28 performing low and moderate complexity laboratory tests that can be completed in a timely manner so that
29 results are readily available for the on-site physician to make decisions regarding appropriate patient care and
30 disposition. This may include but not be limited to only use of point of care tests at any hour of operation. The
31 facility must be staffed by a certified technician or dedicated staff member for laboratory services who is
32 trained to process labs on site. Facility lab capability should include, at a minimum, tests such as CBC, CMP
33 and BMP, troponins (preferably high sensitivity), d-dimers, pregnancy tests including a Beta-hCG quantitative
34 level, and basic toxicology screens.

35 5. A trained and certified respiratory therapist (RT) should be on site at all times of operation. The RT can be
36 trained to do additional tasks including ECGs, IV access, clerical duties, and other tasks as needed.
37 6. The FSED should have a trained security officer present at all hours of operation. The security guard may also
38 be assigned clerical duties or other tasks as needed.
39 7. FSEDs should have at least two units of packed red blood cells on site and immediately available for
40 emergency use at all times.

Background

This resolution asks the College to promote and advocate that all freestanding emergency departments meet minimum standards of: 24/7 staffing by a board-certified/board-eligible emergency physician; x-ray, CT, and ultrasound capabilities at all times, trained technicians dedicated to those tasks; two registered nurses experienced in emergency medicine onsite at all times; laboratory services capable of performing low and moderate complexity tests available at all times; a certified respiratory therapist onsite at all times; a trained security officer present at all hours of operation; at least two units of packed red blood cells at all times.

ACEP's "Freestanding Emergency Departments" policy statement addresses some of the standards requested in this resolution, including staffing by appropriately qualified emergency physicians, adequate medical and nursing personnel, and provision of stabilizing treatment by any FSED that presents itself as an ED. The policy statement could be updated to include the minimum standards requested in this resolution. ACEP has resources available on FECs on the web site, including an information paper and the Freestanding Emergency Centers Section newsroom.

ACEP created, in response to Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers, and now endorses the Center for Improvement in Healthcare Quality Free-Standing Emergency Center Accreditation Program. The accreditation survey process includes a review of facility policies and procedures, a tour of the facility and care areas, review of physician credentials and medical records, and observation of care services. This is a voluntary program that facilities can choose to utilize for accreditation.

ACEP's Freestanding Emergency Centers Section has an objective focused on collaborating with ACEP leadership to establish a national set of standards that could be referred to as a unified national resource for legislatures, physicians, and the medical community.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted. Directed ACEP to explore possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers and the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where allowed by state law.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted. Instructed ACEP to study the emergence and proliferation of free-standing EDs and facilities including: applicable federal and state regulatory and accreditation issues; the potential impact on the emergency medicine workforce; the potential fiscal impact on hospital-based EDs; and provide informational resources to membership.

Resolution 15(98) Certifying Emergency Departments adopted. Directed the Board to appoint a task force to study the advisability of regionalization of care, developing a strategy to consolidate certifying agencies, and consider development of an ACEP certifying agency to replace as many other certifying agencies as possible.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted. Instructed ACEP to reaffirm the Emergency Care Guidelines and develop definitions of various forms of ambulatory care facilities and emergency care facilities to be included in future Emergency Care Guidelines.

Substitute Resolution 51(84) Advertising and Public Education of Free-standing Facilities adopted. Called for ACEP to encourage physicians and health care providers and health care facilities to emphasize in advertising their own positive attributes rather than to denigrate the capabilities of other providers or facilities.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted. Called for ACEP to set standards of care for facilities that present themselves to be sources of emergency care.

Prior Board Action

September 2020, approved revised policy statement "Freestanding Emergency Departments" with the current title; originally approved June 2014.

October 2016, Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted.

November 2015, reviewed the information paper Freestanding Emergency Departments and Urgent Care Centers.

June 2014, approved the policy statement, "Freestanding Emergency Departments."

July 2013, reviewed the revised information paper "Freestanding Emergency Departments;" originally developed in August 2009.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted.

Substitute Resolution 51(84) Advertising and Public Education of Free-standing Facilities adopted.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted.

Background Information Prepared by: Jessica Adams, Reimbursement Director

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

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

RESOLUTION: 30(24)

SUBMITTED BY: Elisabeth Giblin, MD
Paul Kivela, MD, FACEP
Bing Pao, MD, FACEP
Thomas Sugarman, MD, FACEP
California Chapter

SUBJECT: Hospital Network Requirements for Emergency Physicians

PURPOSE: ACEP to formally request appropriate federal government agencies investigate whether health insurers and hospitals violate antitrust or other laws by requiring emergency physicians be in-network as a condition for an emergency professional service contract.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

1 WHEREAS**,** The American College of Emergency Physicians (ACEP) is committed to ensuring that patients
2 have access to high-quality emergency care; and
3
4 WHEREAS**,** Emergency physician practices provide professional services to hospitals through service
5 agreements; and
6
7 WHEREAS**,** Hospitals and health systems may require emergency physicians to be in-network with specified
8 health insurers as a condition of a professional service contract; and
9
10 WHEREAS**,** Hospitals may receive financial inducements from health insurers to force emergency physicians
11 into accepting in-network contracts with unfavorable terms or below-market rates; and
12
13 WHEREAS**,** Following the passage of the No Surprises Act, several health insurers have demanded drastic
14 reductions in long standing contracted emergency physician in network rates; and
15
16 WHEREAS**,** These practices reduce the ability of emergency physicians to adequately staff emergency
17 departments with high quality emergency physicians, particularly in underserved areas, and compromise the ability of
18 emergency physicians to provide necessary care; and
19
20 WHEREAS**,** There is concern that such contractual practices by health insurers and hospitals may violate
21 antitrust laws and result in monopolistic practices that harm both healthcare providers and patients; therefore be it
22
23 RESOLVED, That ACEP formally request that appropriate federal government agencies investigate whether
24 health insurers and hospitals violate antitrust or other laws by requiring emergency physicians to be in-network as a
25 condition for an emergency professional service contract.

Background

This resolution seeks for ACEP to formally request that appropriate federal government agencies investigate whether health insurers and hospitals violate antitrust or other laws by requiring emergency physicians be in-network as a condition for an emergency professional service contract.

Emergency physician service agreements with hospitals that require physicians to contract with insurer networks are

not uncommon. In the past decade, roughly 90% of emergency physician groups have reported insurers deliberately selling policies to patients that cover very little while forcing hospitals to ensure all physicians in their facilities join their network.

The No Surprises Act (NSA) limited out-of-network for physician groups and requiring insurers and physicians to abide by an independent dispute resolution process. While the result of the NSA was largely positive for patients, taking them out of the middle of disputes, physician groups have felt pressure to join insurer networks. Insurer consolidation and narrowing of networks has increasingly forced hospitals to agree to in-network demands by insurers.[1]

Federal and state antitrust agencies play a role in challenging anticompetitive practices of health care providers and other businesses. At the federal level, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) share responsibility for enforcing federal antitrust laws, including the Sherman Act, the Clayton Act, and the FTC Act. State attorneys general (AG) offices also have the authority to bring action under federal antitrust law, as well as under state statutes, which sometimes expand upon federal law.[2]

While hospitals cannot force physicians to be in network with insurers because hospitals and physicians negotiate contracts with insurers independently, there are some exceptions, such as Health Maintenance Organizations (HMOs), which require patients to use physician groups in their network. Physician groups negotiating directly with hospital administration for a contract are at a disadvantage if they do not contract with the major health insurers in the local area. As physician groups find themselves at a disadvantage, hospitals also risk their reputation if physicians accept a lower rate of reimbursement which does not meet the financial needs of the group.

Insurer anticompetitive behavior has made a significant impact on competition and physician groups. There have been very few settlements after a federal investigation. Recently, in a class-action suit, plaintiffs successfully alleged that Blue Cross Blue Shield “violated antitrust laws by entering into an agreement not to compete with each other and to limit competition among themselves in selling health insurance and administrative services for health insurance.” The plaintiffs argued that Blue Cross was able to charge higher rates for plans through the practice of limiting competition. Despite these serious charges and the resulting settlement, neither federal antitrust agency has given any indication that it intends to investigate or take any action to deal with the lack of competition and increase in prices.

ACEP supported the bipartisan 2021 Competitive Health Insurance Reform Act (CHIRA), which protects consumers and physicians by repealing a long-outdated antitrust exemption for the health insurance industry. To date, neither the FTC nor the DOJ has announced major steps to exercise their expanded antitrust enforcement authority under the new law. ACEP has called on the agencies to provide information on any enforcement actions, guidelines, rulemaking, or other actions taken to extend antitrust enforcement to the health insurance industry.

In December 2023, ACEP leaders and staff met with Jonathan Kanter, the United States Assistant Attorney General for Antitrust and other key Department of Justice (DOJ) staff to discuss the growing negative impact of insurer consolidation on emergency physicians and the patients seeking care in the ED. In the meeting, ACEP raised concerns about the impact on clinical decision making and physician autonomy that vertical consolidation by insurers who directly employ physicians can bring. Also on the agenda was the rapidly diminishing leverage that emergency physician groups have during contract negotiations as insurance companies are acquiring more and more market share via consolidation. ACEP continues to work with the DOJ on these and other related issues.

Background References
[1]Anticompetitive Conduct by Commercial Health Insurance Companies, American Hospital Association, 2023.
[2]Issue Brief: Understanding the Role of the FTC, DOJ, and States in Challenging Anticompetitive Practices Of Hospitals and Other Health Care Providers, Kaiser Family Foundation, 2023.

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Resolution 25(20): Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement & Optimal Patient Coverage. Directed ACEP to: 1) Create a task force and commission an independent study on the financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and withholding appropriate reimbursement against emergency physicians. 2) Engage with an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care. 3) Advocate for higher standards and additional scrutiny of health insurer spending. 4) Work with other professional organizations, consumer advocacy groups, and the AMA to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

Resolution 26(13) Repeal of McCarran-Ferguson Act referred to the Board of Directors. Requested that ACEP support the repeal of the McCarran-Ferguson Act of 1945 and ask the American Medical Association via resolution to work legislatively for the repeal of the McCarran-Ferguson Act of 1945. The AMA did not take action to pursue repeal of the McCarran-Ferguson Act.

Prior Board Action

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement & Optimal Patient Coverage adopted.

October 2013 referred to the Board Council Resolution 26(13): Repeal of McCarran-Ferguson Act which asks ACEP to work with the American Medical Association in pursuit of legislation to repeal the 1945 McCarran-Ferguson Act. The resolution states that repeal would lead to substantial savings to insurance consumers.

Background Information Prepared by: Adam Krushinskie
Senior Director, State Legislative and Reimbursement

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

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

RESOLUTION: 31(24)

SUBMITTED BY: Diversity, Inclusion & Health Equity Section
Social Emergency Medicine Section

SUBJECT: NEMPAC Contributions Transparency and Ethical Standards

PURPOSE: Asks NEMPAC to implement measures to provide clear and detailed reports on how NEMPAC contributions are distributed and ensure easy access and understanding by members; discourage supporting candidates who discriminate or promote discrimination based on race, gender, sexual orientation, age, disability, nationality, or religion; and encourage the support of policies, candidates, and initiatives that are grounded in evidence-based practices further suggesting that decisions to support will be achieved through rigorous vetting processes and consultations with medical experts, devaluing non-evidence-based ideologies that could undermine the quality of emergency care.

FISCAL IMPACT: Budgeted resources for ongoing management and administration of NEMPAC.

1 WHEREAS, ACEP is committed to transparency, ethical standards, and evidence-based practices in
2 all its endeavors; and
3
4 WHEREAS, The National Emergency Medicine Political Action Committee (NEMPAC) plays a pivotal and
5 indispensable role in advocating for policies and candidates that support emergency medicine and the patients we serve;
6 and
7
8 WHEEREAS, NEMPAC's contributions must be distributed in a manner that aligns with ACEP's values and
9 commitment to diversity, equity, inclusion, and evidence-based medicine; therefore, be it.
10
11 RESOLVED, That ACEP:
12
13 1. Create expectations that NEMPAC implement measures to provide clear and detailed reports on how
14 NEMPAC contributions are distributed, ensuring that ACEP members can easily access and understand this
15 information.
16 2. Discourage NEMPAC to support candidates who discriminate or promote discrimination based on race,
17 gender, sexual orientation, age, disability, nationality, or religion, thereby maintaining the integrity and
18 inclusiveness of ACEP's mission.
19 3. Encourage NEMPAC to support policies, candidates, and initiatives that are grounded in evidence-based
20 practices. This will be achieved through rigorous vetting processes and consultations with medical experts,
21 devaluing non-evidence-based ideologies that could undermine the quality of emergency care.

Background

This resolution asks the National Emergency Medicine PAC (NEMPAC) to implement measures to provide clear and detailed reports on how NEMPAC contributions are distributed and ensure easy access and understanding by members; discourage supporting candidates who discriminate or promote discrimination based on race, gender, sexual orientation, age, disability, nationality, or religion, thereby maintaining the integrity and inclusiveness of ACEP's mission; and encourage the support of policies, candidates, and initiatives that are grounded in evidence-based practices further suggesting that decisions to support will be achieved through rigorous vetting processes and consultations with medical experts, devaluing non-evidence-based ideologies that could undermine the quality of emergency care.

NEMPAC Organization, Purpose, and Governance:
The ACEP Board of Directors initially approved the National Emergency Medicine Political Action Committee (NEMPAC) Articles of Association on November 5, 1987. The Articles of Association were last approved by the ACEP Board of Directors in January 2023.

The NEMPAC Articles of Association Article IV – Purposes and Powers, Section 1 states:

> "The purpose of NEMPAC is to provide the opportunity for individuals interested in the future of emergency medicine to contribute to the support of worthy candidates for federal offices who believe, and have demonstrated their beliefs, in the principles to which emergency medicine is dedicated. To further these purposes, NEMPAC is empowered to solicit, directly or indirectly, and accept voluntary personal contributions, and to make expenditures in connection with the attempt to influence the selection, nomination, or election of any individual to any elective federal office."

Article VIII – Trustees, Section 1 states:

> "Subject to the ultimate authority of the National ACEP Board of Directors, the governing body of NEMPAC shall be a Board of Trustees, composed of the ACEP Immediate Past President, ACEP President-elect, fourteen (14) individuals, and one ACEP Resident."

Article VIII – Trustees, Section 2 states:

> "Subject to review and approval of the National ACEP Board of Directors, the Board of Trustees shall set basic policies with respect to the collection and disbursement of NEMPAC funds, including but not limited to protecting the property and affairs, and carrying out the purposes of the NEMPAC. In particular, the Board of Trustees shall determine, with assistance and advice of the Treasurer, the procedures for solicitation and collection of contributions and subsequent distribution of funds to candidates in accordance with the Act(s) and Regulations(s) of the Federal Election Commission, and other applicable laws and regulations."

NEMPAC has served a vital role in advancing ACEP's legislative agenda and in broadening ACEP's visibility with Congress since its inception in 1987. NEMPAC raised $1.75 million and contributed $1.6 million to candidates, party committees, leadership PACs, and independent expenditure campaigns during the 2022 election cycle. Approximately 19% of ACEP members donate to NEMPAC.

The NEMPAC Board of Trustees, composed of the ACEP Immediate Past President, ACEP President-Elect, fourteen (14) individual ACEP members, and one Resident Liaison, develops the NEMPAC Contribution Guidelines and budget at the beginning of each two-year election cycle. The 2024 Election Cycle Guidelines are modified throughout the election cycle per majority vote of the NEMPAC Board of Trustees. The Guidelines were last amended on March 7, 2024, are provided as Attachment A. The NEMPAC Board of Trustees meets in person or virtually each month and the minutes of these meetings are available upon request.

The NEMPAC website is updated continually to reflect any changes to the guidelines established by the NEMPAC Board of Trustees. All active ACEP members can access the NEMPAC website. The website also includes a list of all candidates supported in the current election as well as election reports from prior election cycles. Criteria for support is clearly outlined. The 2024 Election Cycle Guidelines follow past NEMPAC practice of focusing on a candidate's support and co-sponsorship of ACEP's key legislative and regulatory initiatives, committee assignments, leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions. Incumbents and new candidates seeking NEMPAC support that meet criteria in several categories are eligible for more support. Additionally, a list of NEMPAC Champions and Investment candidates are identified by the NEMPAC Board and staff. The Champions receive maximum financial support and additional resources from NEMPAC as determined by the NEMPAC Board. NEMPAC produces an Election Report at the end of each cycle that contains this information. In 2022, the report was included as an insert with the March 2023 issue of ACEPNow.

An internal spreadsheet is maintained by NEMPAC staff and tracks criteria for every seated member of Congress and includes recommended budget amounts for each member. This document is reviewed and modified throughout the election cycle to reflect movement on legislation considered by Congress, campaign activity, election ratings, and ACEP staff and member interactions with legislators. The internal document includes voting/sponsorship records of key ACEP legislation for that Congress and votes and sponsorships of key legislation in prior Congressional sessions if applicable. The decision to track specific votes and co-sponsorships is based on the legislative priorities established by the ACEP Federal Government Affairs (FGA) Committee at the beginning of each Congress. Although ACEP may track multiple issues and bills in any given congressional session, only those that are determined by the ACEP FGA Committee and the ACEP Board of Directors to be key issues for emergency medicine that are moving through the congressional process either by accumulating co-sponsors, consideration by congressional committees, or inclusion in House or Senate floor votes, for example, are tracked.

The votes and co-sponsorships records of all members of Congress are available to the public on https://www.congress.gov/ and disbursement information from federally registered PACs to federal candidates is available to the public on www.Fec.gov.

The 2024 NEMPAC Contribution Guidelines include the following language:

> "Candidates and incumbents who receive NEMPAC support are expected to exhibit behavior and actions consistent with the mission, vision and values of the American College of Emergency Physicians and uphold the principles of our democratic process and orderly governance. We believe NEMPAC supported candidates should affirm science, evidence and fact in their words and actions.
>
> The integrity and character of the candidate will be assessed on an ongoing basis and NEMPAC may consider ceasing contributions to a candidate or committee if credible, specific, and serious allegations about the candidate's behavior arise.
>
> NEMPAC will also continue our commitment to inclusiveness and respect for diversity."

The guidelines also state: "Each legislator and candidate will be looked at individually for their past and current conduct and actions and none of the metrics outlined are meant to be a litmus test."

NEMPAC tracks our federal expenditures by diversification (Attachment B). In the 2024 election cycle, our donation percentage to diverse candidates stands at 47.4 percent. In the 2022 election cycle, NEMPAC's diversity percentage was 45.66 while the make-up of Congress was 43.33 percent.

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

- Identify, test, and adopt new fundraising strategies to support advocacy initiatives.

Fiscal Impact

Budgeted resources for ongoing management and administration of NEMPAC.

Prior Council Action

Resolution 15(19) Increased Transparency in NEMPAC contributions not adopted. Requested the College to support increased NEMPAC transparency by making available online to ACEP members the voting/sponsorship record of key ACEP legislation for federal candidates supported by NEMPAC.

Prior Board Action

January 2024, , approved the amended NEMPAC Articles of Association; amended and approved October 2020 and April 2008; originally approved November 1987.

Background Information Prepared by: Jeanne Slade
Senior Director, Political Affairs and Grassroots Advocacy

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

Attachment A

NEMPAC Contribution Guidelines/Strategic Plan and Budget for 2024 Cycle

(last revised and approved by the NEMPAC BOT on March 7, 2024)

Background

NEMPAC serves a vital role in advancing ACEP's legislative agenda and in broadening emergency medicine's visibility with Congress. In the 2022 election cycle, despite the challenges of emerging from a global pandemic, national political unrest and divisiveness, and economic and professional concerns unique to emergency medicine, NEMPAC raised $1,751,328 and contributed more than $1.6 million to candidates, party committees, leadership PACs, and independent expenditure campaigns.

In the 2024 election cycle, the NEMPAC Board of Trustees adopted the following strategies which are to be continued from the 2022 cycle:

- Identify and assist candidates and incumbents who support ACEP's mission, vision, and values.
- Support candidates in both major political parties who will work to advance ACEP's issues or can influence positions important to the specialty of emergency medicine.
- Identify "Champions" of emergency medicine who would receive maximum funding for their re-election campaigns ($10,000) and for the Leadership PACs (if applicable) of $5000 per year, in addition to other benefits identified below.
- Continue to fund independent expenditure campaigns as warranted with hard dollars.
- Authorize a minimum contribution ($1000) to Senators and Representatives from the states and districts of members of the ACEP Board of Directors and the NEMPAC Board of Trustees. This strategy is designed to enhance the contacts between these two Boards and their Congressional representatives by giving the Board members the opportunity to attend virtual and local events for their Members of Congress.

The following strategies will be continued from the 2022 cycle with stronger emphasis in the 2024 cycle:

- Prioritize checking deliveries and attendance in person by ACEP members ACEP leaders, Chapter leaders, and NEMPAC VIP Donors.
- Prioritize contribution to members of key congressional committees (House Ways and Means, House Energy and Commerce, Senate Finance and Senate HELP) utilizing NEMPAC donations and interactions due to NEMPAC to educate committee members, particularly those new to the committees.

The NEMPAC budget will guide NEMPAC's contributions through the election cycle and will be subject to modification as the election cycle progresses and the congressional agenda takes shape. The budget may be amended to reflect projections of NEMPAC fundraising efforts in 2023 and 2024.

Evaluation Criteria

Candidates and incumbents who receive NEMPAC support are expected to exhibit behavior and actions consistent with the mission, vision and values of the American College of Emergency Physicians and uphold the principles of our democratic process and orderly governance. We believe NEMPAC supported candidates should affirm science, evidence and fact in their words and actions.

The integrity and character of the candidate will be assessed on an ongoing basis and NEMPAC may consider ceasing contributions to a candidate or committee if credible, specific, and serious allegations about the candidate's behavior arise.

NEMPAC will also continue our commitment to inclusiveness and respect for diversity.

2024 evaluation criteria follow past NEMPAC practice of focusing on a candidate's support of ACEP's key legislative and regulatory initiatives, co-sponsorship of ACEP legislation, committee assignments (with an emphasis as noted above), leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions.

As we look at incumbents and new candidates for NEMPAC support, those that meet criteria in several categories would be eligible for more support.

Although a candidate may be budgeted a specific amount, the candidate will not necessarily receive the full amount for which he or she is budgeted. A notable change in the legislative/political climate may dictate that we reach as many candidates as possible (rather than a targeted focus on candidates on a committee). Ongoing assessments will enable us to determine which overall approach is most compatible with ACEP's legislative and regulatory agenda.

Each legislator and candidate will be looked at individually for their past and current conduct and actions and none of the metrics outlined below are meant to be a litmus test.

2024 Senate Budget Spreadsheet Categories (as of March 1, 2024)

- Committee Assignments and Leadership Positions
  - Finance, HELP, Appropriations Health Subcommittee
- Emergency Department Visit back home, or district meeting with Senator or staff
- Dine-around participant at Leadership and Advocacy Conference in DC
- Senator or staff participated in meeting with ACEP members during the Hill Days at LAC in 2023/2024

Workplace Violence

- Co-sponsor of S.1176, Workplace Violence Prevention for Health Care and Social Service Workers Act (OSHA)
- Co-sponsor of S.2768, Safety from Violence for Healthcare Employees (SAVE) Act

Boarding

- Co-sponsor of S.1346, Improving Mental Health Access from the Emergency Department Act (MH Boarding)

Firearm Safety and Research

- Co-sponsor of S. 494, Background Check Expansion Act

SUD

- Co-sponsor of S.1080, Opioid Reporting - establishes requirements for electronic communication service providers and remote computing service providers to report knowledge of various drug-related offenses to the DEA.

Other

- Co-sponsor of S. 220 to ban non-compete clauses.
- Co-sponsor of S.1653, Prevent Bleeding Act - grants to make available anti-blood loss supplies (e.g., tourniquets, wound-packing materials, and gloves) in high-traffic and other specified areas for use in medical emergencies.
- Co-sponsor of S.1447, Bipartisan Solution to Cyclical Violence Act of 2023
- Co-sponsor S.704, REDI Act – allows borrowers in medical or dental internships or residency programs to defer student loan payments until the completion of their programs.
- Co-sponsor S. 2364 MAPS Act to provide a mapping system for essential drugs and an FDA essential drugs list (Peters, Lankford, Braun)
- Co-sponsor S. 3765 to reauthorize the Emergency Medical Services for Children (EMSC) program.
- Co-sponsor of S. 3679, the Dr. Lorna Breen Health Care Provider Protection Act Reauthorization
- Co-signed Boozman/Welch Medicare Cuts letter (2/23/2024)
- Support of efforts to fund appropriations requests for trauma programs, EMSC, Dr. Lorna Breen Act, grants for programs to assist with OUD and mental health disorders in the ED, etc.
- Signing on to letters asking for Congress to act on pending Medicare cuts.
- Historical and ongoing support for fair and reasonable implementation of the No Surprises Act, and other legislation impacting physician payment.
- Support of peaceful democracy and election certification.

Overall background/knowledge in health care with emphasis on physician candidates.

2024 House Budget Spreadsheet Categories (as of March 1, 2024)

- Committee Assignments and Leadership Positions
  - Ways and Means, Energy and Commerce, Education and Labor, Appropriations including health subcmt assignments.
- Attended district meeting, Emergency Department Visit or fundraiser with ACEP member back home.
- Met with ACEP members during 2024 LAC Hill Days (not including 2023 because House not in session)
- Dine-around participant at LAC meetings in Washington DC

Workplace Violence

- Co-sponsor of H.R. 2584, Safety from Violence for Healthcare Employees (SAVE) Act
- Co-sponsor of or vote for H.R. 2663, Workplace Violence Prevention for Health Care and Social Service Workers (OSHA)

Boarding

- Co-signed letter asking Administration to convene a boarding summit
- Co-sponsor of and/or vote for H.R. 5414, Improving Mental Health Access from the Emergency Department Act (to assist with mental health patient boarding)
- Co-sponsor of H.R. 2412, Helping Kids Cope Act (Blunt Rochester, Fitzpatrick)
- Co-sponsor of H.R. 5804, The Mental Health Infrastructure Improvement Act (Kilmer, Bacon)

Medicare Payment Reform

- Co-sponsor for H.R. 6683, to prevent across-the-board Medicare spending cuts
- Co-sponsor H.R. 2474, Strengthening Medicare for Patients and Providers Act (MEI update for Medicare physician reimbursements)
- Co-sponsor H.R. 6371, Provider Reimbursement Stability Act (Doc Caucus budget neutrality proposal)
- Co-sponsor H.R. 6545, Physician Fee Schedule Update and Improvements Act (GPCI work floor extension, 1.25% fix for PFS, APM bonus extension, budget neutrality threshold update, etc.)
- Stop Medicare cuts "Dear Colleague" letter signer (12/13/23)
- Bera/Bucshon Stop Medicare Cuts letter signer.

Other Issues

- Co-sponsor of H.R.731 to ban non-compete clauses.
- Co-sponsor H.R. 1694 to provide Medicare payments to freestanding EDs.
- Co-sponsor H.R. 2416, the Mission Zero Act - reauthorize a military and civilian partnership for trauma readiness grant program.
- Co-sponsor H.R. 1202, REDI Act – allows borrowers in medical or dental internships or residency programs to defer student loan payments until the completion of their programs
- H.R. 5506, HANDS Act to support the distribution of naloxone (Pettersen)
- H.R. 6251, Helping Educators Respond to Overdoses Act (HERO) (Schiff, Ruiz, Kuster, Sanchez, Tokuda, Trone, Watson Coleman)
- H.R. 7251, To amend the Public Health Service Act to reauthorize certain poison control programs (Reps. Chavez-DeRemer, D. Joyce, Davis, and Cherfilus-McCormick)
- H.R. 7153, To reauthorize the Dr. Lorna Breen Health Care Provider Protection Act, and for other purposes (Reps. Wild and Kiggans)
- H.R. 6960, Emergency Medical Services for Children Reauthorization Act of 2024 (Reps. Carter and Castor)
- Cosponsor H.R 6992, MAPS Act to provide a mapping system for essential drugs and an FDA essential drugs list. (Matsui, Bucshon)
- Support of efforts to fund appropriations requests for trauma programs, EMSC, Dr. Lorna Breen Act, grants for programs to assist with OUD and mental health disorders in the ED, etc.
- Historical and ongoing support for fair and reasonable implementation of the No Surprises Act, and other legislation impacting physician payment.
- Support of peaceful democracy and election certification.
- Background/knowledge in health care with emphasis on physician candidates

The Board will maintain flexibility throughout the election cycle in assessing the importance of these issues. All will be considered when determining a candidate's level of support from NEMPAC without assigning a score or weight to each one.

Committee Assignments

As stated earlier, NEMPAC contributions should be directed to those candidates who serve on committees with jurisdiction over healthcare issues. Contribution amounts are based on which committee a Member serves, his or her leadership position on the committee, and whether the Member also serves on the healthcare subcommittee of the committee.

Key committees in the House are:

- Ways and Means
- Energy and Commerce
- Appropriations

Key committees in the Senate are:
- Finance
- Health, Education, Labor, and Pensions (HELP)
- Appropriations

Members of Congress on a key committee are eligible to receive a minimum of $2500 and/or $5000 if on the health subcommittee without Board approval. Additional funds for these members would require Board approval.

Relationship to ACEP

The relationship that a candidate (Member of Congress) has with ACEP leadership, ACEP Advocacy Leaders and 911 members, staff and other ACEP members is another factor to consider when evaluating contribution requests. If a candidate has a good working relationship with someone associated with ACEP, he or she is more likely to take the time to listen to ACEP's position on an issue. Although NEMPAC will direct most contributions to members of Congress who have shown concrete support for ACEP's priorities, a special relationship with ACEP can be a key factor in considering a contribution request.

Co-Sponsorship of ACEP Legislation

Members of Congress who do not serve on a key or secondary committee but who support ACEP's legislative agenda by co-sponsoring key legislation would be eligible for $2,500 - $5,000 during the election cycle. Also, Members of Congress who participate in press conferences, co-sign letters of support for an ACEP legislative priority, or host meetings for ACEP members, etc., would be considered for a NEMPAC contribution on a case-by-case basis in the same contribution range.

Difficulty of Race

As we move through the election cycle, the difficulty of a candidate's race or Members re-election campaign will become a key factor in determining if NEMPAC contributes to or increases the amount budgeted to a candidate. NEMPAC can have a greater impact by making contributions to candidates who face a difficult election.

"Friendly Incumbent" Guidelines

NEMPAC will continue to follow "friendly incumbent" guidelines for contributions used in past election cycles. These guidelines recommend that NEMPAC should not contribute campaign funds to a candidate running against an incumbent determined to be friendly or supportive to ACEP. In situations where physicians, members of ACEP, or other candidates strongly supported by an ACEP state chapter run against a "friendly incumbent," the NEMPAC Board may vote to modify this guideline after careful consideration of factors such as electability, support of ACEP's legislative and regulatory agenda and relationship to ACEP members in the district or state.

In an "open seat" situation, where neither candidate is an incumbent, each candidate will be evaluated to determine if the candidates' positions on important healthcare issues are consistent with ACEP policy.
Responses to the NEMPAC Candidate Questionnaire, input from the state chapters, local ACEP leaders, and 911 Network members will also be considered. All open seat and challenger candidate contributions must be approved by the NEMPAC Board of Trustees or the NEMPAC Executive Committee if time is of the essence.

Endorsement Requests by Candidates
NEMPAC/ACEP does not endorse candidates for office outside of or in addition to our financial contributions to federal campaigns. A NEMPAC contribution or financial expenditure through other means such as a SuperPAC or independent expenditure serves as our means for "supporting" candidates and under no circumstances do we permit the name of our PAC (NEMPAC) or supporting organization (ACEP) to be listed as an "endorsing" organization on a candidate's campaign materials and website.

NEMPAC Candidate Questionnaire

For each election cycle, NEMPAC will develop a candidate questionnaire that highlights ACEP core legislative and regulatory principles and requests information from the candidate about their background and campaign operation. Open

seat and challenger candidates will be strongly urged to complete and return the survey for consideration of NEMPAC support. Exceptions may be permitted if time constraints are present if the NEMPAC Board of Trustees or Executive Committee are made aware of the circumstances, and they are documented, as to why the survey was not completed prior to making and/or approving a donation.

Contributing to Two Candidates Running for the Same Congressional or Senate Seat

NEMPAC will maintain the practice of supporting only one candidate in a race. In instances where the candidate supported by NEMPAC loses a primary election, the NEMPAC Board may consider supporting another candidate in the general election since the original candidate supported would be out of the race.
In rare circumstances and after careful consideration by the NEMPAC Board of Trustees, there may be flexibility in this practice so that an exception could be made for NEMPAC to donate to two different candidates running for the same office.

Independent Expenditures

NEMPAC will continue to consider independent expenditures as an option for support of candidates in key races if funds are available for this allocation. Independent expenditure can be made for communications expressly advocating the election or defeat of a candidate that are not made in cooperation or consultation with or at the request or suggestion of, a candidate's campaign or representatives. These expenditures allow NEMPAC to go beyond the limits of $5,000 per primary and $5,000 per general to individual candidates' campaigns and can provide significant and much appreciated campaign support to candidates while enhancing ACEP's and NEMPAC's political influence.

National Party Committees

Prior to 2015, the maximum allowable annual donation from a PAC to a party committee was $15,000. NEMPAC consistently donated $15,000 to the NRSC, NRCC, DSCC and DCCC over the years to maintain parity and bipartisanship in our giving strategy.
In 2015, three new types of political funds for national party committees went into effect.

- A **party convention fund** for the Republican National Committee and Democratic National Committee that may accept up to $45,000 per year from a multicandidate PAC.
- A **building fund** that may accept up to $45,000 per year from a multicandidate PAC. The RNC, NRSC, NRCC, DNC, DSCC and DCCC are eligible to accept these funds.
- A **recount & legal proceedings fund** that may accept up to $45,000 per year from a multicandidate PAC. The above committees are also eligible for these types of funds.

Contributing to these Committees allows ACEP leadership (i.e., Board members, FGA Committee members, etc.) and staff to participate in special briefings, roundtables and out of town events throughout the year held specifically for donors to the campaign committees. These events allow for greater access to Congressional leaders and will help establish ACEP as an important player on the political scene, and the travel expenses for ACEP members and staff participating in these and other candidate-related activities can be reimbursed by NEMPAC's administrative fund or hard dollars if needed.

Going forward in the 2024 cycle, it is recommended that NEMPAC continue to make a minimum $15,000 annual contribution to each of these four committees. Because the amount allowable from PACs to these committees has dramatically increased, the possibility of exceeding the status quo should be considered by the NEMPAC Board on a case-by-case basis. The contribution amount should be maintained consistent over all four committees with no preference to any of the four.

This committee also allow PACs to "tally" their contributions to specific members of congress which is another way to increase support to NEMPAC champions. The decisions to tally will be made on a case-by-case basis by ACEP staff in consultation with the NEMPAC Board of Trustees.

Leadership PACs

Leadership PACs (LPACs) are separate funds established by Members of Congress that have separate and distinct limits from their campaign committees. Leadership PACs can accept up to $5,000 per year from other PACs. Legislators often use their leadership PACs to support the campaigns of other federal candidates who may not have the ability to raise

significant or adequate funds on their own. When considering a contribution to a Member's leadership PAC, NEMPAC will observe the same criteria as for contributions to that member's campaign committee.

NEMPAC will budget $5,000 annually to the leadership PACs of NEMPAC "Champions" and consider other requests on an ad hoc basis, prioritizing the LPACs of members on key committees. Leadership PAC contributions should be looked at carefully and not be given if there is the potential to reduce the amount available for other approved candidate's re-election campaigns. Priority should be given to re-election committees contributions first since NEMPAC cannot control where/how a contribution to a Leadership PAC is used and may not agree with or be aware of other members of congress that the LPAC is supporting.

Post Election/Debt Retirement

Some Members of Congress request contributions following a general election to help retire debts from the previous campaign. Debt retirement can offer ACEP the opportunity to establish relationships with Members of Congress that NEMPAC did not contribute to in the general election, to forge relationships with newly elected Members of Congress, and to maintain strong relationships with Members of Congress who have been supportive of ACEP's legislative agenda.

NEMPAC will continue its policy of contributing to Members' debt retirement account on a case-by-case basis. These contributions will be considered only to victorious candidates, will not count towards a Member's total NEMPAC eligibility for the upcoming election cycle, and will not exceed the contribution level the candidate was eligible for under NEMPAC criteria in the just completed election cycle.

NEMPAC also reserves the right to request a refund of a contribution made to a candidate in good faith, if immediately or soon after requesting and receiving support from NEMPAC, the candidate decides to retire or leave congress for other reasons.

NEMPAC "Champions"

The NEMPAC Board with the consultation of ACEP staff will develop a list of "NEMPAC Champions" not to exceed a total of 20 incumbent Senators or Representatives and candidates. These champions would be eligible to receive the following financial support and other benefits from NEMPAC if available:

- Maximum donation to primary and general election campaign ($5K to each)
- Maximum donation to leadership PAC if applicable ($5K)
- Campaign highlighted in NEMPAC newsletter during the cycle with link to campaign website.
- Campaign highlighted on NEMPAC website.
- NEMPAC would host or co-host a MADPAC event for the Member during the election cycle.
- NEMPAC staff or ACEP members would attend one out of town event for the Member per cycle.
- NEMPAC staff would serve on the Member's fundraising steering committee.
- NEMPAC would "tally" part of our party committee donation to that member.
- NEMPAC would conduct a dine-around event for the members during LAC or invite to participate in a Virtual Happy Hour.
- NEMPAC would fund or co-fund an independent expenditure for the members.
- NEMPAC would contribute to a "SuperPAC" formed to positively support the member or candidate.

Delivery of NEMPAC Contributions

When delivering contributions, we will give priority to participating in smaller healthcare-specific meetings and fundraisers. The smaller events allow the candidates to focus solely on healthcare issues and to hear ACEP's concerns and priorities in the current Congress.

Funds will also be set aside for "dine-around" at future Leadership and Advocacy Conferences and virtual happy hour events for targeted members.

In the 2024 cycle as most legislators and candidates have fully returned to in-person events, NEMPAC will place emphasis on events and meetings back home in the state and district where ACEP members can deliver a NEMPAC check personally to their Member of Congress. NEMPAC will attempt to target contributions to Members of Congress who

represent the states and congressional districts of ACEP Board of Directors members and members of the NEMPAC Board of Trustees. This strategy will enhance the contacts between these ACEP leaders and their federal legislators.

The NEMPAC Board, ACEP Board and Council will be provided with regular updates of check deliveries and fundraisers attended by ACEP members.

NEMPAC Board and ACEP Board Involvement

To show ACEP members the strength of support for NEMPAC and its activities by the leadership of ACEP, all members of both the ACEP Board of Directors and the NEMPAC Board of Directors should make significant contributions to NEMPAC each year.

Members of both Boards will be encouraged to "Give-a-Shift" ($1,200) each year to NEMPAC and maintain this giving level throughout their tenures. They will also be encouraged to attend and contribute to NEMPAC dine-around events at LAC annually.

Members of both Boards will be encouraged to attend at least one fundraiser or other event for their Representative and Senators in the next two years to enhance contacts between these ACEP leaders and their Members of Congress. NEMPAC will contribute to the federal representatives of Board members to allow those Board members to attend the event. A minimum amount will be contributed to each Board member' Representative and Senators, even if that Representative or Senator is not a strong supporter of ACEP's legislative priorities. This minimum contribution is simply designed to foster improved contacts between Board members and their Members of Congress.

Attachment B

Federal Expenditure Diversification Breakdown
All PACs

Election Year	Net Contribution Amount*	Funds Given to Diverse** Candidates	% of Funds Given to Diverse Candidates	% of Diversity in Congress
2014	$1,618,582	$406,000	25.08%	31.10%
2015	$2,500		0.00%	
2016	$1,506,900	$397,500	26.38%	32.00%
2017	$1,000		0.00%	
2018	$1,652,187	$472,188	28.58%	34.90%
2019	$3,000	$1,000	33.33%	
2020	$1,227,000	$513,500	41.85%	38.80%
2021	$4,500	$4,500	100.00%	
2022	$1,187,891	$542,391	45.66%	43.30%
2024	$1,157,000	$548,500	47.41%	
2026	$5,500	$2,500	45.45%	
2028	$2,500		0.00%	

*Federal candidates/leadership PACS only

**Diverse candidates are defined as women and non-white/Caucasian

Election Year	Net Contribution Amount*	Male	Female	% of Women in Congress
2014	$1,618,582	86.72%	13.28%	19.00%
2015	$2,500	100.00%	0.00%	
2016	$1,506,900	85.04%	14.96%	20.00%
2017	$1,000	100.00%	0.00%	
2018	$1,652,187	81.35%	18.53%	21.30%
2019	$3,000	100.00%	0.00%	
2020	$1,227,000	75.14%	24.74%	24.20%
2021	$4,500	44.44%	55.56%	
2022	$1,187,891	68.22%	31.78%	27.50%
2024	$1,157,000	67.42%	32.58%	
2026	$5,500	100.00%	0.00%	
2028	$2,500	100.00%	0.00%	

*Federal candidates/leadership PACS only

Election Year	% Given to Asian / Pacific American	% Given to Black / African American	% Given to Hawaiian / Pac. Islander	% Given to Hispanic / Latino	% Given to Indian / Native American	% Given to Other	% Given to Two or More Ethnicities	Total % Given to Minorities	% Given to White / Caucasian	% of Minorities in Congress
2014	1.05%	1.33%	0.00%	6.83%	0.31%	4.82%	0.00%	14.33%	85.67%	17.90%
2015	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	
2016	0.83%	1.56%	0.00%	6.27%	0.23%	4.05%	0.33%	13.27%	86.73%	18.90%
2017	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	
2018	1.82%	1.57%	0.00%	4.75%	0.67%	3.42%	0.48%	12.71%	87.29%	21.80%
2019	0.00%	0.00%	0.00%	0.00%	0.00%	33.33%	0.00%	33.33%	66.67%	
2020	1.59%	4.93%	0.00%	5.91%	0.73%	9.70%	1.34%	24.21%	75.79%	24.20%
2021	0.00%	44.44%	0.00%	0.00%	0.00%	0.00%	0.00%	44.44%	55.56%	
2022	1.85%	3.03%	0.00%	6.52%	1.14%	8.75%	0.84%	22.13%	77.87%	25.90%
2024	1.90%	5.66%	0.00%	5.79%	0.13%	8.99%	1.08%	23.55%	76.45%	
2026	0.00%	0.00%	0.00%	0.00%	45.45%	0.00%	0.00%	45.45%	54.55%	
2028	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	

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

RESOLUTION: 32(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Preventing Harmful Health Care Deals

PURPOSE: Advocate for legislation to require health systems to notify regulatory agencies prior to entering into an agreement or transaction that reduces competition or increases costs for health care consumers to help maintain competitive markets.

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

1 WHEREAS, The Federal Trade Commission (FTC) and the Department of Justice (DOJ) have shown increased
2 interest in scrutinizing private equity firms' acquisitions in the health care sector due to concerns about the negative
3 impact on competition and the value of health systems[1,2]; and
4
5 WHEREAS, Transactions such as sale-leaseback agreements, purchases or sales of health system facilities or
6 real estate, dividend recapitalization, private practice roll-ups, and changes in majority owner equity stakes have been
7 identified as contributing factors to these concerns; and
8
9 WHEREAS, Many of these harmful health care deals drain value from health systems and often portend
10 hospital closures and a loss of health care access to communities; and
11
12 WHEREAS, Pennsylvania Senate Bill 548, introduced by Senator Tim Kearney (D-Delaware County), is
13 model legislation that aims to address these issues by requiring health systems to file notice and documentation to the
14 Office of the Attorney General before completing critical transactions[3]; and
15
16 WHEREAS, Similar legislative measures have been considered or implemented in other states to ensure
17 transparency and oversight of such transactions, including but not limited to Massachusetts, New York, and California[4];
18 and
19
20 WHEREAS, It is essential for the ACEP to advocate for its members by supporting national legislation that
21 aligns with the objectives of Pennsylvania Senate Bill 548; therefore be it
22
23 RESOLVED, That ACEP advocate for legislation that would require health systems to file notice with
24 regulatory agencies before completing critical transactions, to protect the integrity of health systems and maintain
25 competitive markets.

References

1. FTC News Release https://www.ftc.gov/news-events/news/press-releases/2024/03/federal-trade-commission-department-justice-department-health-human-services-launch-cross-government
2. DOJ Polsinelli Publication https://www.polsinelli.com/publications/ftc-and-doj-signal-greatly-increased-scrutiny-of-private-equity-firms-acquisitions-in-health-care
3. Pennsylvania Senate Bill 548, introduced by Sen. Tim Kearney (D-Delaware). https://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2023&sInd=0&body=S&type=B&bn=0548
4. Massachusetts legislation: https://malegislature.gov/PressRoom/Detail?pressReleaseId=84

Background

This resolution asks ACEP to advocate for legislation to require health systems to file notice with regulatory agencies

prior to entering into an agreement or transaction that reduces competition or increases costs for health care consumers to help protect the integrity of health systems and maintain competitive markets.

The Federal Trade Commission (FTC) and the Department of Justice (DOJ) have shown increased interest in scrutinizing private equity firms' acquisitions in the health care sector due to concerns about the negative impact on competition and the value of health systems. The agencies jointly launched a cross-government public inquiry into private-equity and other corporations' increasing control over health care in March 2024. The agencies wish to understand how specific transactions may increase consolidation and generate profits for firms and pose potential risks to quality of care and affordable health care for patients and taxpayers. Officials at Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services share these concerns.

There is increased interest in these purchases at the state level, as well. New York state passed a law in August 2023 requiring health care entities involved in material transaction(s) to provide written notice to the state Department of Health a minimum of 30 days prior to the closing of the transaction. Material transactions include mergers, acquisitions, affiliation agreements, and partnerships that increase a healthcare entity's total gross in-state revenues by $25 million.

In Pennsylvania, Senator Tim Kearney (D-Delaware County) introduced Senate Bill 548 that would allow for intervention in large financial transaction involving health systems that could pose a threat to public. The bill would require for-profit health systems to file notice and documentation with the Office of the Attorney General before completing transactions such as, sale-leaseback agreements, purchase or sale of health system facilities or real estate, private practice roll-ups, and changes in majority owner equity stakes. The Office of the Attorney General could then challenge those transactions that threaten patient access to care for violating the defined public interest.

The Massachusetts House of Representatives recently passed legislation intended to increase accountability across the healthcare industry and curb healthcare spending to ensure patient access to quality, affordable healthcare. The Bill empowers the Massachusetts Health Policy Commission to scrutinize transactions for anti-competitive effects, such as equity investments that would result in a change of hospital or practice ownership, conversion of a hospital to a for-profit entity, and significant transfer of a hospital's assets.

ACEP carefully monitors how increased acquisitions of emergency medicine practices have affected emergency physicians and the patients they serve. There have been numerous assessments conducted across the house of medicine to determine the effect consolidation on both health care costs and quality of patient care. In 2022, ACEP utilized the opportunity of the FTC and DOJ's request for information to ask members a series of structured and open-ended questions about their experiences with mergers and acquisitions in emergency medicine. Responses indicated that consolidation in EM detrimentally affects physicians' interests and well-being, and therefore, might impact their ability to serve their patients. ACEP shared our findings with the FTC and DOJ and called upon the agencies to address potentially anti-competitive labor-related effects of mergers and acquisitions.

Based upon feedback from ACEP and other stakeholders, the FTC and DOJ issued Draft Merger Guidelines in July 2023. The Draft Guidelines included thirteen principles that the agencies determine whether a merger is unlawfully anticompetitive under antitrust laws. ACEP sent a formal letter commenting on the proposed updates to guidelines used to assess health care mergers. ACEP supported the proposal to more closely examine the labor impacts of health care mergers as well as lowered thresholds for identifying potentially monopolistic market share. In December, ACEP leaders met with Jonathan Kanter, the U.S. Assistant Attorney General for Antitrust, and other key Department of Justice staff to discuss the growing negative impact of insurer consolidation on emergency physicians and the patients they care for.

ACEP remains committed to our overall goal of supporting emergency physicians and ensuring that they are treated fairly by their employer and practice in an environment where they can serve their patients to the best of their abilities. This resolution asks for investment of ACEP resources in advocating for national legislation that requires health systems to provide regulatory agencies with notice before completing acquisition or merger transactions to preserve health systems and competitive markets. There is not a specific ask related to emergency medicine.

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

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

Prior Council Action

Resolution 23(23) Opposing Sale-Leaseback Transactions by Health Systems referred to the Board of Directors. The resolution asked ACEP to advocate for regulatory agencies and other entities, as appropriate, to closely monitor, discourage, and oppose sale-leaseback transactions involving health systems, ensuring transparency, accountability, and consideration of the long-term impact on patient care and health care infrastructure.

Amended Resolution 56(22) Policy Statement on the Corporate Practice of Medicine. "ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine." The resolution directed ACEP to work with relevant experts to develop a policy statement opposing the corporate practice of medicine.

Amended Resolution 52(20) The Corporate Practice of Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) prepare a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine and fee splitting in each state and the results of this review will be compiled into a resource and announced to members as an available electronic download; 2) adopt as policy: "ACEP, in concert with its relevant component state chapter, in those states where there are existing prohibitions on the corporate practice of medicine, will provide assistance to physician owned groups who are threatened with contract loss to a corporate entity or to hospital employed physicians whose site will be taken over by a corporate entity by providing, upon request, a written review of the legality of the corporation obtaining the contract for emergency services."; 3) in those states that are found to have existing prohibitions on the corporate practice of medicine, along with the relevant state chapter, petition the appropriate authorities in that state to examine the corporate practice of emergency medicine if such is believed to occur within that state and ACEP will reach out to the state professional societies to solicit the support of the state medical society; and 4) work with the American Medical Association to convene a meeting with representatives of physician professional associations representing specialties and other stakeholders affected by the corporate practice of medicine, to ensure the autonomy of physician owned groups or hospital employed physicians contracting with corporately-owned management service organizations.

Amended Resolution 58(19) Role of Private Equity in Emergency Medicine adopted. The resolution called for ACEP to study and report annually the market penetration of non-physician ownership of emergency medicine groups and the effects that these groups have on physicians and ACEP advocacy efforts. It further directed the College to advocate to preserve access to emergency care for patients and protect the careers of emergency physicians in the event of contract transitions, bankruptcies, or other adverse events of their employer/management company. Additionally, ACEP was directed to partner with other medical societies to determine the circumstances under which corporate or private equity investment could lead to market effects that increase the cost of care without a commensurate increase in access or quality and to advocate for corrections to the market if such market effects should occur.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted. Directed ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and to continue to promote the adoption of the principles outlined in the "Emergency Physician Rights and Responsibilities" policy statement by the various emergency medicine contract management groups, the American Hospital Association and other pertinent organizations.

Prior Board Action

April 2022, approved the ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine.

September 2021, approved actions regarding Referred Amended Resolution 52(20) The Corporate Practice of Medicine.

October 2019, Amended Resolutions 58(19) Role of Private Equity in Emergency Medicine adopted.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted.

Background Information Prepared by: Jessica Adams
Reimbursement Director

Laura Wooster, MPH
Associate Executive Director, Advocacy and Practice Affairs

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

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

RESOLUTION: 33(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Promotion of Nursing in Emergency Medicine

PURPOSE: Collaborate with relevant organizations and stakeholders to look at models, such as incentivized pay structures, to recruit and maintain nursing staff in emergency medicine, in alignment with ACEP's beliefs and policies, to maintain a safe standard of care for patients.

FISCAL IMPACT: Budgeted staff resources for some components of advocacy work. Studying models to alleviate the nursing shortage is not a current initiative of the College, is unbudgeted, and would require diverting current budgeted staff resources from other advocacy work to support this effort.

1 WHEREAS, The April 2021 ACEP-approved policy statement "Emergency Department Planning and
2 Resource Guidelines" states that "Appropriately educated and qualified emergency physicians, NPs, PAs, registered
3 nurses and ancillary staff should staff the ED during all hours of operation"[1]' and
4
5 WHEREAS, The April 2021 ACEP-approved policy statement "Emergency Department Planning and
6 Resource Guidelines" states that, "Each nurse working in the ED should: Provide evidence of adequate previous ED or
7 critical care experience or have completed an emergency care education program. The CEN credential is an excellent
8 benchmark. Demonstrate evidence of the knowledge and skills necessary to deliver nursing care in accordance with the
9 Standards of Emergency Nursing Practice"[1]; and
10
11 WHEREAS, The April 2022 ACEP-approved policy statement "Emergency Department Nurse Staffing" states
12 that "The American College of Emergency Physicians (ACEP) supports emergency department (ED) nurse staffing
13 systems that provide adequate numbers of registered nurses who are trained and experienced in the practice of
14 emergency nursing"[2]; and
15
16 WHEREAS, The January 2024 ACEP-approved policy statement "Advocating for Certified Emergency Nurses
17 (CENs) in Departments of Emergency Medicine" states that "The American College of Emergency Physicians supports
18 the efforts of the Emergency Nurses Association (ENA) and the Board of Certification for Emergency Nursing (BCEN)
19 regarding defining standards of emergency nursing care and the provision of resources, support, and incentives for
20 emergency nurses to be able to readily attain Certified Emergency Nurses (CEN) certification"[3]; and
21
22 WHEREAS, The Nursing Community Coalition provided testimony to both the U.S. House and U.S. Senate
23 Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, U.S.
24 Department of Health and Human Services, Health Resources and Services Administration (HRSA) & National
25 Institutes of Health (NIH), requesting support for, "at least $530 million for the Nursing Workforce Development
26 programs (authorized under Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.] and administered by
27 HRSA)"[4,5]; and
28
29 WHEREAS, Emergency departments have always served as the "safety net" of the health care system; and
30
31 WHEREAS, The ED nursing shortage is not a new phenomenon and it has affected care delivery in emergency
32 departments for most of the 21st century and the COVID-19 pandemic, however, has dramatically increased nursing
33 turnover rates[6]; and
34
35 WHEREAS, The exodus of health care staff continues despite the resolution of the COVID-19 pandemic and
36 multiple studies have demonstrated an increased prevalence of anxiety, depression, and insomnia during the pandemic,

37 and nursing burnout can be traced to "occupational psychological trauma;" and
38
39 WHEREAS, Many nurses report the emergence of new sleep disturbances and decreased quality of life; and
40
41 WHEREAS, Psychological trauma combined with the current pressures of working through the pandemic have
42 contributed significantly to workforce shortages as nurses leave the emergency department and/or field altogether and
43 in addition, a large cohort of aging "baby boomer" nurses are now retiring, thus adding to the problem[6]; therefore be it
44
45 RESOLVED, That ACEP collaborate with relevant organizations and stakeholders to look at models, such as
46 incentivized pay structures, to recruit and maintain nursing staff in emergency medicine, in alignment with our
47 organization's beliefs and policies, to maintain a safe standard of care for our patients.

References

1. https://www.acep.org/siteassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf
2. https://www.acep.org/patient-care/policy-statements/emergency-department-nurse-staffing/
3. https://www.acep.org/siteassets/new-pdfs/policy-statements/advocating-for-certified-emergency-nurses-cens-in-departments-of-emergency-medicine.pdf
4. https://www.ena.org/docs/default-source/government-relations/federal-news/2-fy2025-senate-appropriations-committee-coalition-testimony.pdf?sfvrsn=b553ee5c_1
5. https://www.ena.org/docs/default-source/government-relations/federal-news/3-fy-2025-house-appropriations-committee-coalition-testimony.pdf?sfvrsn=d670e59_1
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10116161/..

Background

This resolution calls for the College to collaborate with relevant organizations and stakeholders to look at models, such as incentivized pay structures, to recruit and maintain nursing staff in emergency medicine, in alignment with ACEP's beliefs and policies, to maintain a safe standard of care for patients. Essentially, the resolution asks for ACEP to develop a plan for identifying appropriate emergency department staffing levels for nursing and support personnel and to identify alternative staffing patterns for a variety of emergency departments.

Emergency departments (EDs) are facing challenges related to staffing, which impacts the quality of care provided to patients. The health care workforce, particularly in emergency medicine, continues to experience high levels of burnout, workplace violence, mental health challenges, and emergency department boarding. According to a 2020 survey by the American Nurses Association (ANA), almost two-thirds of nurses (62%) experience burnout, with this rate being even higher (69%) among nurses under 25. Burnout is driven by several factors, including the inherent demands of nursing, such as providing compassionate care, working long hours, changing shift schedules, and the physical strain of being on one's feet for extended periods. Systemic challenges, such as the increasing demand for nursing professionals due to an aging population and the COVID-19 pandemic, have exacerbated these issues. The pandemic also added emotional stress, with nurses often providing moral and emotional support for patients dying without their families and dealing with public skepticism about the pandemic's severity. A study published in the *Journal of Nursing Management* found that burnout and turnover rates among emergency nurses are alarmingly high, driven by factors such as workload, emotional demands, and workplace violence. In May 2022, the Center for American Progress published a report on the nursing shortage, recommending policy efforts to enhance recruitment and retention, improve workplace conditions, and collect data on staffing levels, nurse interventions, and patient outcomes. A Government Accountability Office (GAO) report highlighted emerging nurse shortages and the need for better data to describe nurse workforce availability. The American Hospital Association (AHA) has published reports addressing strategies for increasing recruitment, retention, and development of hospital caregivers. These reports include fostering educational opportunities, broadening the applicant pool, and reviewing compensation strategies.

ACEP submitted a statement for the record for an Energy and Commerce Health Subcommittee hearing in May 2023 on the health care workforce where ACEP noted the importance of addressing the ongoing nursing shortage. ACEP partnered with EMRA in 2022 to submit a statement for the record for a Senate HELP Committee hearing on workforce shortages. The statement highlighted how ongoing workforce shortages affect emergency care, reiterating the importance of maintaining the physician-led, team-based emergency care model, while also raising the persistent

issues of providing emergency care in rural and underserved areas, nurse staffing firm practices during the COVID-19 pandemic, and how these workforce shortages contribute to ED boarding.

Regarding the issue of mental health, depression, and burnout in emergency medicine, nursing, and other health care professions, ACEP developed and led the efforts to enact the Dr. Lorna Breen Health Care Provider Protection Act that was signed into law on March 18, 2022. This landmark first-of-its-kind law includes provisions that have supported increased access to mental health services and supports for health care workers, research into the mental health challenges faced by health care workers, and initiatives to reduce stigma and encourage health care workers to seek mental health support, among other things. ACEP is currently working to reauthorize this critical law through fiscal year 2029 and secure continued federal appropriations to fully fund its programs. ACEP also continues to partner with the Emergency Nurses Association (ENA) and ANA on legislation to address and reduce workplace violence as part of the effort to help reduce burnout, in addition to both psychological and physical harm.

ACEP's September 2023 Summit on ED Boarding, among numerous factors, identified inadequate nurse staffing ratios as a contributing factor to boarding and overcrowding. A range of strategies, including data collection, surveys, legislative and regulatory advocacy have been initiated to address these issues. In February 2022, ACEP submitted a response to a request for information (RFI) to the US Department of Health and Human Services on preparedness and response that highlighted efforts to reduce nursing burnout such as regulatory waivers and flexibility around documentation requirements. Several states, including CT, IL, NV, NY, OH, OR, TX, WA, and MN, participate in Hospital-Based Staffing Committees, where a team of hospital stakeholders collaborates to review staffing challenges. CA and MA are the two states that have a limit for nurses to one patient in the intensive care unit. ACEP does not support mandated staffing ratios out of concern that these policies would not allow flexibility during mass trauma or other common occurrences in busy suburban and urban EDs. If hospitals lack enough nurses to comply with a mandated ratio in an inpatient unit, they may keep additional patients in the ED to comply with the law, contributing to ED crowding. ACEP supports hospitals staffing more nurses on inpatient units to alleviate ED boarding but has strong concerns that mandated staffing ratios could worsen the situation.

An ACEP article published in *Annals of Emergency Medicine* in December 2023 studied the deteriorating conditions at Ascension Via Christi St. Francis Hospital in Wichita where staffing shortages and cost-cutting measures have led to high nurse-to-patient ratios and long wait times. This situation prompted 66% of the staff to unionize with the National Nurses United (NNU). The article references a University of Pennsylvania survey that attributes high nurse turnover rates to poor working conditions rather than a shortage of nurses. The study noted that financially-driven understaffing, especially in emergency departments, has worsened the crisis.

The American Nurses Association (ANA) has also been involved in legislative initiatives to address nurse shortages, including funding for nursing education and restricting mandatory overtime. The Emergency Nurses Association (ENA) has developed position statements on staffing and productivity in emergency care settings. Americans for Nursing Shortage Relief (ANSR) Alliance, comprising 29 nursing organizations, advocates for increased funding for nursing education and comprehensive initiatives to address nurse shortages. Nurses for a Healthier Tomorrow (NHT), a coalition of 43 nursing and health care organizations, initiated a national campaign to attract people to the nursing profession.

ACEP worked with leaders of ENA during the pandemic (2022) to identify traditional nursing tasks that could be performed by other health care professionals. In these discussions, our nursing colleagues identified the nursing assessment as the primary task that required an individual with nursing training and experience. Many other tasks could be completed by alternative staff including preclinical medical students, nursing students, LPNs, paramedics, pharmacists and even specially trained volunteers. It was suggested that locally a team of nurses, physicians, and others in health care should meet to identify the appropriate tasks and available staff as these vary by location. It was also suggested to initiate team nursing and additional training sessions, especially for less experienced nurses. Nursing documentation is time consuming, just as it is with physicians, and the use of scribes, dictation, and perhaps AI in the near future, should be extended to nurses as well. Finally, they identified that care of boarders as their major pain point and suggested the use of floor nurses or LPNs for the care of these patients when possible.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted staff resources for some components of advocacy work. Studying models to alleviate the nursing shortage is not a current initiative of the College, is unbudgeted, and would require diverting current budgeted staff resources from other advocacy work to support this effort.

Prior Council Action

Resolution 17(01) Staffing Levels not adopted. It directed ACEP to identify appropriate staffing levels in the ED.

Amended Resolution 38(00) Professional Staffing adopted. It called for ACEP to investigate optimal staffing models for emergency department professional nurses with appropriate entities such as the Emergency Nurses Association, American Hospital Association, and the American Nurses Association, develop specific recommendations to address the manpower needs that exist and that are anticipated in the future to ensure continued access to quality emergency care, and submit a resolution to the AMA House of Delegates to investigate hospital wide staffing shortages.

Prior Board Action

January 2024, reaffirmed the policy statement "Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine;" reaffirmed February 2018 and April 2012; originally approved October 2006.

April 2022, approved the revised policy statement "Emergency Department Nurse Staffing;" revised and approved October 2005; reaffirmed September 2005; originally approved June 1999.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, and June 2001 with the current title; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

Amended Resolution 38(00) Professional Staffing adopted.

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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

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

RESOLUTION: 34(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Reimbursement for Emergency Physician Services Provided Out-of-Hospital

PURPOSE: Collaborate with other stakeholders to investigate ways to establish EMS physician reimbursement pathways.

FISCAL IMPACT: Budgeted staff resources.

1 WHEREAS, Emergency Medical Services (EMS) is the largest and a rapidly growing board certified sub-
2 specialty of emergency medicine; and
3
4 WHEREAS, EMS Physicians have a specialized skill set that can improve patient outcomes in the out-of-
5 hospital environment, both in the emergent and non-emergent settings; and
6
7 WHEREAS, EMS Physicians currently are unable to bill for clinical services provided in the out-of-hospital
8 environment, limiting the expansion of the specialty; therefore be it
9
10 RESOLVED, That ACEP collaborate with other stakeholders to investigate ways to establish EMS physician
11 reimbursement pathways.

Resolution References

1. Medical Claims processing manual: Chapter 15 Ambulance https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c15.pdf

Background

This resolution directs ACEP to collaborate with other stakeholders to investigate ways to establish EMS physician reimbursement pathways.

Emergency medicine and EMS have grown immensely in the past 50 years; however, EMS medicine only recently became a subspecialty of emergency medicine in 2010 (2006 by the AOA).[1] EMS fellowships were established to give emergency physicians the knowledge and experience to provide, oversee, and improve prehospital care. These programs have evolved to include 80 fellowships accredited by the Accreditation Council for Graduate Medical Education (ACGME). Many physicians interested in EMS complete a fellowship to gain experience and engage in their field of interest. Historically, EMS fellowships have varied widely in terms of the experiences for individual fellows. However, with the arrival of subspecialty certification and ACGME accreditation, there is now a standard core curriculum for EMS fellowships. As of today, the subspecialty of EMS is over 800 strong and is the largest subspecialty under the American Board of Emergency Medicine umbrella.

Funding for EMS physician reimbursement pathways has largely depended on local, state, federal, and private positions. Many states and larger EMS systems have dedicated full-time medical directors. Tactical teams and local law enforcement, large event organizations, sporting arenas, and international medical groups may employ the services of an EMS medical director or physician.

Currently, CPT code 99288, Under Other Emergency Services, is described as giving medical direction for a patient's care via a two-way radio with EMS personnel in the field, or during transport to or from the emergency department. Medical direction includes trauma patients or patients who require advanced life support. While limited use of other

CPT codes is possible for EMS directors, additional reimbursement mechanisms should be identified.

The CMS Innovation Center announced in 2019 the Emergency Triage, Treat, and Transport (ET3) voluntary, five-year payment model intended to increase flexibility for ambulance care teams addressing emergency health care needs of Medicare patients after a 911 call. Under the model, Medicare paid Medicare-enrolled ambulance suppliers and hospital-owned ambulance providers to transport patients to Alternative Destination Partners, such as a primary care doctor's office or an urgent care clinic, providing additional options to the hospital ED or other destinations traditionally covered by Medicare. The ET3 Model ended two years early on December 31, 2023, due to low participation.

CMS created new codes in the 2024 Medicare Physician Fee Schedule Final Rule to identify and value the work involved in helping Medicare patients with serious, high-risk illnesses navigate their care (pages 121-123). This includes helping patients understand and implement their specific plan of care and contacting the necessary providers for follow-up care.

- G0023: Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:
  - Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition
    - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed)
    - Facilitating patient-driven goal setting and establishing an action plan
    - Providing tailored support as needed to accomplish the practitioner's treatment plan
  - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
  - Practitioner, home- and community-based care communication
    - Coordinating receipt of needed services from health care practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable)
    - Communicating with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
    - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
    - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
  - Health education - helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making
  - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
  - Health care access/health system navigation
    - Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them
    - Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable
    - Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals
    - Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals

        - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
- G0024: Principal illness navigation services, additional 30 minutes per calendar month (List separately in addition to G0023)
- G0140: Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:
    - Person-centered interview, performed to better understand the individual context of the serious, high-risk condition
        - Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that aren't billed separately)
        - Facilitating patient-driven goal setting and establishing an action plan
        - Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan
    - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
    - Practitioner, home, and community-based care communication
        - Assisting the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors
        - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
    - Health education
        - Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making
        - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
        - Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals
        - Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals
        - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
- G0146: Principal illness navigation - peer support, additional 30 minutes per calendar month (List separately in addition to G0140)

HCPCS codes G0023, G0024, G0140, and G0146 identify services furnished after an initiating E/M visit to provide navigation of a high-risk illness or condition, such as cancer, COPD, congestive heart failure, dementia, HIV/AIDS, etc. These services may be provided by auxiliary personnel, such as patient navigators, under the general supervision of a physician. However, CMS specifies that certain types of E/M visits, including, ED visits, do not serve as initiating visits, "because the practitioner providing the E/M visit wouldn't typically provide continuing care to the patient, including providing necessary PIN services in subsequent months."

ACEP's policy statement "The Role of the Physician Medical Director in Emergency Medical Services Leadership" states: "EMS systems have ethical responsibilities to provide EMS physician medical directors with the tangible resources and remuneration commensurate with the responsibilities and authorities fulfilled by EMS physician medical directors."

ACEP's policy statement "Salary and Benefits Considerations for Emergency Medical Services Professionals" states: "Given the important responsibilities and roles fulfilled by EMS professionals, these healthcare providers should be fairly compensated with salary and benefits commensurate with such responsibilities and roles…"

Background Reference
[1]A Brief History of Emergency Medical Services in the United States, EMRA 2023.

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 30(23) Advocating for Increased Funding for EMS not adopted. The resolution called for ACEP to advocate for: 1) increased funding for EMS services to address inadequacies in reimbursement rates; 2) increased funding for EMS services; 3) a premium rate for EMS reimbursement in rural areas; 4) EMS reimbursement rates for services and mileage to increase in line with Medicare rates based on changes to the consumer price index (CPI); 5) reimbursement of EMS based on the value of the care provided; and 6) reimbursement models that allow for "treatment-in-place" health care delivery

Amended Resolution 36(22) Emergency Medical Services Are Essential Services adopted. Directed ACEP to advocate for EMS to be considered and funded as an essential service and work with the American Medical Association, the American Hospital Association, the National Association of EMS Physicians, and other stakeholder organizations to actively promote the inclusion of Emergency Medical Services among federally and locally funded essential services, including efforts to educate the public.

Resolution 35(20): Supporting the Development of a Seamless Healthcare Delivery System to Include Prehospital Care adopted. Directed ACEP to take a leadership role to ensure inclusion of prehospital care as a seamless component of health care delivery, rather than a transport mechanism; advocate for bidirectional data integration between hospital and EMS; advocate for appropriate payment of EMS services to include clinical services separate from transport; advocate for payment structure for EMS medical direction and oversight; advocate for support to NHTSA Office of EMS; and collaborate with other stakeholders to promote legislation that will allow for the integration of reimbursed prehospital care into a seamless patient-centered system of health care delivery.

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Directed the College to champion the principle that emergency care is an essential public service and make it a key concept in advocacy efforts on behalf of America's emergency medical services safety net.

Prior Board Action

June 2023, approved the revised policy statement "The Role of the Physician Medical Director in Emergency Medical Services Leadership;" originally approved October 2017, replacing the following rescinded/sunsetted policy statements: Leadership in Emergency Medical Services (1995-2017); Medical Direction for Staffing of Ambulances (1999-2017); Medical Direction of Emergency Medical Services (1984-2017); Physician Medical Direction of Emergency Medical Services Dispatch Programs (1998-2017); Professional Liability Insurance for EMS Medical Control Activities (1985-2017).

Amended Resolution 36(22) Emergency Medical Services Are Essential Services adopted.

Resolution 35(20) Supporting the Development of a Seamless Healthcare Delivery System to Include Prehospital Care adopted.

April 2019, approved the policy statement "Salary and Benefits Considerations for Emergency Medical Services Professionals."

February 2018, approved the policy statement "Emergency Medical Services Interfaces with Health Care Systems."

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Background Information Prepared by: Adam Krushinskie
Senior Director, State Legislative and Reimbursement

Jessica Adams
Reimbursement Director

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

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

RESOLUTION: 35(24)

SUBMITTED BY: Massachusetts College of Emergency Physicians
New York Chapter

SUBJECT: Sharing of Protected Health Information

PURPOSE: Provide guidance to members on legally and operationally sound practices for sharing of protected health information and encourage hospital systems to improve the education of relevant employees regarding the legality and appropriateness of sharing protected health information with emergency physicians actively engaged in patient care.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, Emergency departments operate 24/7 but medical records offices typically do not; and
2
3 WHEREAS, Emergency physicians frequently care for patients who have also received care at other
4 emergency departments, hospitals, urgent care centers, and medical offices; and
5
6 WHEREAS, Formal mechanisms for securely sending/receiving written medical records are often
7 incompatible with the exigent needs of emergency physicians seeking protected health information (PHI) for real-time
8 medical decision making; and
9
10 WHEREAS, The HIPAA establishes PHI stewardship responsibilities which may be incompletely understood
11 by emergency department and hospital clinicians and staff; therefore be it
12
13 RESOLVED, That ACEP provide guidance to members on legally and operationally sound practices for
14 sharing of protected health information; and be it further
15
16 RESOLVED, That ACEP encourage hospital systems to improve the education of relevant employees
17 regarding the legality and appropriateness of accessing and/or sharing protected health information with emergency
18 physicians actively engaged in patient care.

Background

This resolution calls for the College to provide guidance to members on legally and operationally sound practices for sharing of protected health information and to encourage hospital systems to improve the education of relevant employees regarding the legality and appropriateness of sharing protected health information with emergency physicians actively engaged in patient care.

The resolution notes the challenges of sharing patients' protected health information (PHI), including that existing formal mechanisms for securely sending or receiving written medical records are incompatible with the exigent needs of emergency physicians seeking PHI for real-time medical decision making, in addition to a lack of clarity or incomplete understanding of legally established PHI stewardship responsibilities under the Health Insurance Portability and Accountability Act (HIPAA).

The issues related to the dramatic expansion and increased utilization of electronic health records (EHRs) and ensuing complexities of safeguarding PHI have been and remain a top priority for the College. While intended to streamline patient records and improve patient care and outcomes, the burdens associated with EHRs have significantly increased the amount of time health care providers spend on administrative tasks, which contributes to growing frustration and

job dissatisfaction for emergency physicians. And in addition to federal laws and regulations governing PHI and patient privacy, health care providers and facilities may also be subject to additional requirements imposed by various state laws, and health care facilities or systems may establish stricter policies themselves.

Broadly, one of the primary challenges in the effort to standardize any processes or develop best practices in the health information technology (HIT) ecosystem is that there are several commercial vendors of EHR solutions, all of which provide products that are configurable and customizable for the particular use cases and needs of each individual customer and can range from individual small practices to large national health systems, and even parts of the federal government (e.g., the U.S. Department of Defense or Department of Veterans Affairs). Protocols and guidelines may vary by department even within a single hospital, adding to the already substantial complexity. As noted in a 2012 Institute of Medicine report, "Health IT and Patient Safety: Building Safer Systems for Better Care," HIT "…is not a single product; it encompasses a technical system of computers and software that operates in the context of a larger sociotechnical system – a collection of hardware and software working in concert within an organization that includes people, processes, and technology."

Existing ACEP policy addresses the concepts of high-quality emergency department medical records ("Patient Medical Records in the Emergency Department") and the responsibility of physicians to protect the confidentiality of their patients' personal health information ("Confidentiality of Patient Information"). As an adjunct to the latter policy statement, ACEP developed a two-part Policy Resource Education Papers (PREPs): "From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine – Part I: Conceptual, Moral, and Legal Foundations" and "From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine – Part II: Challenges in the Emergency Department." Part I reviews the concepts of privacy and confidentiality and also details the moral and legal foundations and limits of these values in health care. Part II addresses emergency medicine-specific privacy and confidentiality issues, including a summary listing of practical ways to protect privacy and confidentiality in the emergency department.

The College also provides several additional resources and summaries of ongoing advocacy related to the ever-growing complexities of HIT and EHRs, including a Health Information Technology landing page and an ACEP4U overview of federal advocacy on Electronic Health Records. Also among these resources is a lesson *from Criticial Decision in Emergency Medicine* (CDEM), Online Relationship: Electronic Health Records for Patient Safety. In this article, the authors address the question of "What steps can be taken to protect patient privacy when using EHRs?" The authors note:

> "Although there are limits to what emergency physicians can change regarding federal and state privacy laws, they can protect themselves from violations when using the EHR. Additional safeguards can be implemented by working with department, hospital, and IT leadership. Examples include limiting information on electronic display boards in public view, providing privacy screens for outward-facing computer monitors, allowing patients to safely opt out of tracking board screens, and creating policies regarding printed documents.
>
> Many EHR systems still rely on paper printouts for outside providers, for use in another location, or for the patient's own records. The user who printed the information should be identified on the paperwork. Staff should protect all materials printed from the EHR by avoiding transporting PHI outside the workplace and shredding documents no longer needed. As more mobile technology is implemented to complement the traditional desktop EHR, the need to print will hopefully diminish."

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 36(21) Mitigating the Unintended Consequences of the CURES Act adopted. Directed ACEP to work with stakeholders to highlight patient safety issues affecting emergency department patients related to the CURES Act implementation and develop a policy statement advocating for release of records only after the treating physician and team have had sufficient opportunity to review results and discuss with the patient.

Amended Resolution 21(15) Healthcare Information Exchanges adopted. Directed ACEP to create a minimum standard of information to be contained in Healthcare Information Exchanges (HIE), promote standardized requirements in development, identify recommended standards for ED summaries, and work with stakeholders to identify and promote standards that allow for notification in the ED EHR of applicable HIE data.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. The resolution 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.

Resolution 22(07) Information Systems for Emergency Care – ACEP Policy adopted. Directed ACEP to update and establish policies regarding the need and utility of information systems for emergency care and produce a paper on the issue.

Prior Board Action

February 2023, approved the revised policy statement "Confidentiality of Patient Information;" revised and approved January 2017 with current title; reaffirmed October 2008, October 2002, and October 1998; originally approved January 1994.

June 2022, approved the revised policy statement "Patient Medical Records in the Emergency Department" revised and approved January 2016, April 2009, and February 2002 with the current title; originally approved January 1997 titled "Patient Records in the Emergency Department."

Resolution 36(21) Mitigating the Unintended Consequences of the CURES Act adopted.

April 2021, approved the revised policy statement, "Health Information Technology for Emergency Care;" replacing rescinded policies "Emergency Care Electronic Data Collection and Exchange," "Health Information Technology Standards," and "Patient Information Systems;" revised June 2015, August 2008 with current title replacing "Internet Access;" rescinded August 2008, February 2003; originally approved October 1998 titled "Internet Access."

Amended Resolution 21(15) Healthcare Information Exchanges adopted.

October 2014, reviewed the information paper, Health Information Exchange in Emergency Medicine.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted.

Amended Resolution 29(13) Support of Health Information Exchanges adopted.

Resolution 22(07) Information Systems for Emergency Care – ACEP Policy adopted

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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

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

RESOLUTION: 36(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Texas College of Emergency Physicians
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: EMTALA Reform to Improve Patient Access to Necessary Care

PURPOSE: Develop a legislative proposal to reform EMTALA to eliminate the ability to deny patients requiring transfer access to capable hospitals while preserving patient access to initial evaluation, stabilization, and treatment within the capability of the facility they present to regardless of ability to pay.

FISCAL IMPACT: Budgeted committee and staff resources. Alternatively, utilizing a consulting firm with specific legislative drafting expertise and services would incur unbudgeted costs ranging from $10,000 – $50,000 depending on the scope of services needed.

1 WHEREAS, The Consolidated Omnibus Resolution Act (COBRA), now known as EMTALA, was passed in
2 1986 primarily in response to the refusal of large comprehensive medical centers to accept transfer patients from small,
3 primarily rural hospitals who did not have the capability to care for those patients; and
4
5 WHEREAS, A secondary concern of Congress was to prevent people without insurance being refused
6 emergency evaluation and stabilizing treatment; and
7
8 WHEREAS, Achieving this secondary concern of initial evaluation and stabilization within the capability of
9 the facility the patient presenting to has been successful from a policy standpoint; and
10
11 WHEREAS, In 1986 medical center “capacity” was defined simply “as the number of physically unoccupied
12 beds and OR tables”; and
13
14 WHEREAS, “Capacity” has subsequently been redefined as the number of “staffed beds” which is determined
15 by non-evidence based, sometimes state mandated, nursing ratios; and
16
17 WHEREAS, Every day in the United States transfers of patients who exceed the capabilities of smaller
18 facilities are refused by capable medical centers under the justification that they cannot be accepted because they
19 exceed their capacity based on nursing ratios rather than physical bed space; and
20
21 WHEREAS, Even in the worst circumstances hospitals by and large have refused to declare or place
22 contingency or emergency standards of care in effect to override nursing ratios in order to facilitate accepting additional
23 transfers into unoccupied beds from facilities that cannot provide capable care; and
24
25 WHEREAS, This results in dangerous delays in care, death, hours of frustration for transferring personnel, and
26 often transfers of hundreds and even thousands of miles from the nearest capable medical centers for patients; and
27
28 WHEREAS, These unfortunate and unintended consequences of EMTALA demonstrate that EMTALA is no
29 longer assuring the primary intent of the Congress in 1986 to protect patients who needed a higher level of care;
30 therefore be it

31 RESOLVED, That ACEP develop a legislative proposal to reform EMTALA in such a way that eliminates the
32 ability to deny patients who require transfer access to capable hospitals while preserving patient access to initial
33 evaluation, stabilization, and treatment within the capability of the facility they present to regardless of ability to pay.

Background

The resolution calls for ACEP to develop a legislative proposal to reform Emergency Medical Treatment and Active Labor Act (EMTALA) to eliminate the ability to deny patients requiring transfer access to capable hospitals while preserving patient access to initial evaluation, stabilization, and treatment within the capability of the facility they present to regardless of ability to pay.

As the overall shape of the U.S. health care system has evolved over the decades since the enactment of EMTALA, some suggest that the law has not similarly evolved and does not reflect the current reality of care delivery in emergency departments and hospitals throughout the country. In particular, some suggest these conditions have led to perverse incentives that discourage hospitals and facilities from accepting transfers of patients from transferring facilities in direct conflict with the intended purpose of EMTALA's fundamental patient protections. ACEP's policy statement "Appropriate Interfacility Patient Transfer" outlines principles regarding patient transfer for those patients who require transfer from the ED to another facility. Among these principles is that "[a]greement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer."

Adding to the complexity of this problem is that despite being only four pages when signed into law and focused on protecting patient access to emergency medical care, EMTALA now functions in a more expansive manner as a result of several subsequent amendments, regulatory interpretation and enforcement, and legal determinations that have shaped the law since its enactment. EMTALA is the federal law requiring Medicare-participating hospitals with emergency departments to screen and treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status, national origin, race, creed, or color. EMTALA was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer. The law was enacted in 1986 in response to reports about "patient dumping," a practice where hospitals and emergency rooms would refuse to treat poor or uninsured patients or transfer or discharge emergency patients based upon the anticipation of high costs of diagnosis and treatment. EMTALA requires Medicare-participating hospitals, as a condition of participation (COP) under Medicare, to provide services to any individual presenting at an emergency department, regardless of insurance status or ability to pay, or face potential enforcement actions and penalties for violations.

Hospitals have three main obligations under EMTALA:

1. The law requires hospitals to provide a ***medical screening examination*** to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition (EMC).
2. If an individual is determined to have an emergency medical condition, the individual must receive ***stabilizing treatment*** within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized.
3. If the individual is not stabilized, ***they may only be transferred*** if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks (the Centers for Medicare & Medicaid Services, or CMS, states in the guidance that patients who request to be transferred can only be transferred after a physician certifies that the medical benefits of the transfer outweigh the risks.)

A hospital must report to CMS or the state survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA.

EMTALA violations may result in the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issuing civil monetary penalties on a hospital ($129,233 for hospitals with more than 100 beds, $64,618 for hospitals with fewer than 100 beds/per violation) or physician ($129,233 per violation) pursuant to 42 CFR §1003.500 for refusing to provide either unnecessary stabilizing care for an individual presenting with an emergency medical condition that requires such stabilizing treatment, or an appropriate transfer of that individual if the hospital does not have the capacity to stabilize the emergency condition. The HHS OIG also has the authority to exclude physicians from participation in Medicare and State health care programs, and the Centers for Medicare & Medicaid Services (CMS) may also penalize a hospital by terminating its provider agreement. Additionally, private citizens who are harmed by a physician's or hospital's failure to provide stabilizing treatment may file a civil suit against the hospital to obtain damages available under the personal injury laws of that state in which the hospital is located, in addition to recouping and equitable relief as appropriate.

Under current federal regulations (42 CFR §489.24) the term "capacity" under EMTALA is defined as "the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits." The resolution notes that in 1986, medical center "capacity" was defined as "the number of physically unoccupied beds and OR tables," and that since then, "capacity" has subsequently been redefined as the number of "staffed beds" which is determined by arbitrary "nursing ratios." The resolution goes on to explain that this interpretation has resulted in perverse incentives or consequences, where transfers of patients to higher care facilities are refused because of this interpretation of "capacity," and that hospitals refuse to declare or place contingency or emergency standards of care in effect to override nursing ratio requirements in order to facilitate accepting additional transfers into unoccupied beds from facilities that cannot provide care, leading to dangerous delays in care, even death, hours of frustration for transferring personnel, and often transfers of hundreds and even thousands of miles from the nearest capable medical centers for patients.

The issue of patient transfers given the constraints of the federal EMTALA mandate remains an area of concern and persistent challenge for overwhelmed EDs. In some cases, an ED or hospital with insufficient resources or ability to care for a patient with complex needs is unable to transfer that patient to a receiving hospital because that facility is also overwhelmed with boarding patients, full units, or insufficient staff. This has resulted in patients succumbing to traumatic wounds or serious illnesses and conditions due to the inability to transfer those patients in a timely fashion. As the resolution also notes, this has been exacerbated as hospitals and facilities have not implemented emergency or crisis standards of care protocols to override nursing ratios or other resource scarcity issues.

A June 2024 article published in *ACEPNow* by James Augustine, MD, FACEP, sheds additional light on this issue. Dr. Augustine notes:

> "The additional lengthy ED stays for transfer patients are equally resource-intense for emergency physicians and especially emergency nurses. Some hospital systems have developed transfer centers or flow centers, which attempt to coordinate patient movement to the best site of care within the system. But for independent, and particularly smaller and rural hospitals, the process of finding an accepting hospital for patients needing transfer is a huge burden that involves placing one phone call or digital request at a time. Once a patient is accepted somewhere, the facility must then begin the process of finding a transport resource, coordinating the right time of transfer with the receiving facility, and completing the required documentation.
>
> This points to a need for centers that may specialize in regional patient movement, to include all hospitals and systems. In regions like San Antonio, Texas, this innovation has taken place already and serves needs across a large geographic region and many patient types (https://www.strac.org/). The state of Georgia has developed and funded a coordinating center for patient movement and EMS communications on hospital capabilities (https://georgiarcc.org/). These coordinating centers have been advantageous when patient surges occurred, such as those experienced during the most stressful days of the COVID-19 pandemic."

There are ongoing efforts outside of amending EMTALA requirements aimed at reducing barriers to patient transfers. Some stakeholders like Apprise Health Insights and others have implemented automated, real-time statewide and

regional bed tracking and capacity management systems to facilitate quicker transfer of patients to appropriate facilities that have the ability and capacity to provide care. ACEP is also in the process of working with legislators to draft federal legislation to help expand the proliferation of these systems throughout the country. Additionally, ACEP has partnered with the American College of Surgeons (ACS) and the ACS Committee on Trauma (COT) to help develop a National Trauma Emergency Preparedness System (NTEPS) blueprint, which envisions a system that provides awareness of resources and surge capacity throughout the health care system, as well as the ability to load balance the system to match patients with appropriate resources and specialty expertise. This coordinated effort should be built upon a framework of an interconnected network of Regional Medical Operations Coordination Centers (RMOCCs) to improve regional care delivery by facilitating the most appropriate level of care based on individual patient acuity, while also
maintaining patient safety and keeping patients in local facilities that are capable of providing high quality care.

RMOCCs are envisioned as having the following essential functions:

- Operationalize the regional plan for patient distribution and health system load balancing for any mass casualty or large public health event;
- Facilitate clinical expertise and consultation for all health-related hazards and coordinate the expertise into the regional plan through current hazard vulnerability assessments;
- Integrate all levels of healthcare leadership (public health, administrative, physician and nursing) from the regional health systems and hospitals into the framework of the emergency operations center and operational plans;
- Provide real-time situational awareness of health care capability and capacity to all regional healthcare systems and other salient healthcare entities. This function includes data collection, analysis, and dissemination (i.e., hospital and EMS capacity data);
- Support dynamic movement of patients when required and load balance the medical facilities to mitigate the need for crisis standards implementation and resource rationing;
- Provide a single point of contact at both the RMOCC and at each hospital/health system for referral requests and life-saving resource sharing;
- Align and coordinate regional resources (e.g., supplies, equipment, medications, etc.) and personnel with the goal of maintaining regional systems for time sensitive care such as cardiac, stroke and trauma that may or may not be directly impacted by the surge event; and
- Provide a communication link to other RMOCCs to lead or participate in a broader coordinated multi-regional, state, or national effort. This includes both a multi-state response and nationwide network integration.

Some of these concepts are included in the Draft Guidelines Regional Health Care Emergency Preparedness and Response Systems issued by the Administration for Strategic Preparedness and Response (ASPR), but ACEP and our partners in this effort continue to encourage ASPR to make RMOCCs the centerpiece of the regionalized approach. ACEP also continues to advocate to Congress to implement this approach as part of our nation’s larger emergency preparedness infrastructure.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources. Alternatively, utilizing a consulting firm with specific legislative drafting

expertise and services would incur unbudgeted costs ranging from $10,000 – $50,000 depending on the scope of services needed.

Prior Council Action

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted. Directed ACEP to work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA and support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs referred to the Board of Directors. Requests ACEP to: 1) work with state and federal agencies to advocate for state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems and to report their activities publicly; 2) advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not available at the referring hospital; 3) advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined as patient catchment areas rather than jurisdictional boundaries; and 4) support research to strengthen the evidence base regarding rural hospital transfer processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes and experience and include investigation of common challenges experienced by all small, non-networked hospitals.

Amended Resolution 23(11) EMTALA adopted. Directed ACEP to submit recommendations to CMS regarding uniform interpretation and fair application of EMTALA; work with CMS to institute confidential, peer-reviewed process for complaints; work with CMS and others to require that complaints be investigated consistently according to ACEP-developed standards and investigators required to adhere to principles of due process and fairness during investigations; and provide a report to the 2012 Council on this issue.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed ACEP to solicit member input to formulate and submit recommendations for the CMS EMTALA advisory process and other appropriate bodies, including recommendations for clarifying medical staff on call responsibilities, obtaining greater consistency of EMTALA enforcement among all the CMS regional offices, protection of peer review confidentiality, and utilizing consultative peer review for issues involving medical decision making.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA and for the Board to provide a report to members in 2001.

Prior Board Action

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs assigned to the ACEP Federal Government Affairs Committee and State Legislative/Regulatory Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution.

January 2022, approved the revised policy statement, "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with current title; revised and approved February 2009, February 2002, June 1997, September 1992 titled, "Appropriate Inter-hospital Patient Transfer;" originally approved September 1989 as position statement "Principles of Appropriate Patient Transfer."

January 2019, reaffirmed the policy statement "EMTALA and On-Call Responsibility for Emergency Department Patients;" revised and approved June 2013, April 2006 replacing "Hospital, Medical Staff, and Payer Responsibility for Emergency Department Patients" (1999),"Medical Staff Responsibility for Emergency Department Patients" (1997), and "Medical Staff Call Schedule."

Amended Resolution 23(11) EMTALA adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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

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

RESOLUTION: 37(24)

SUBMITTED BY: Emily Ager, MD
Michael Bresler, MD, FACEP
Joshua da Silva, DO, FACEP
Kelly Quinley, MD
Monica Rakesh Saxena, MD, JD
Rachel Solnick, MD
Sophia Spadafore, MD
Katherine Wegman, MD
AAWEP Section
California Chapter

SUBJECT: Reinforcing EMTALA in Pregnancy Related Emergency Medical Care

PURPOSE: Develop a policy statement reinforcing that: EMTALA applies universally to all emergency medical conditions without exception; support that treatment decisions, including those involving abortion, should be made solely between the patient and emergency clinician without legal interference; and emphasize the importance of allowing emergency physicians to provide care based on medical best practices without restrictions on treatment options.

FISCAL IMPACT: Budgeted committee and staff resources for development and distribution of policy statements.

1 WHEREAS, Physician advocacy groups including the American College of Emergency Physicians (ACEP),
2 the American College of Obstetricians and Gynecologists and the American Medical Association have affirmed that
3 emergency physicians must be able to practice high quality, objective, evidence-based medicine without legislative,
4 regulatory or judicial interference in the physician-patient relationship; and
5
6 WHEREAS, The Emergency Medicine Treatment and Labor Act (EMTALA) mandates that any patient who
7 presents to an emergency department with an emergency medical condition receive stabilizing and life-saving care, and
8 where such emergency medical conditions are defined as a conditions where the absence of immediate medical
9 treatment could reasonably be expected to result in placing the individual's health in serious jeopardy or jeopardize
10 bodily organs or functions; and
11
12 WHEREAS, EMTALA was established to ensure all patients, and specifically pregnant persons, have access to
13 care and, moreover, protect the ability of physicians and clinicians to provide evidence-based care for patients and use
14 their clinical judgment and expertise to determine how and when to stabilize and treat patients with life-threatening
15 emergencies; and
16
17 WHEREAS, More than 2.77 million pregnant persons visit U.S. emergency departments annually; and
18
19 WHEREAS, Certain pregnancy-related emergencies and complications require termination of pregnancy to
20 prevent death or the endangerment of the health of the pregnant and lifelong impairment including loss of fertility and
21 kidney failure; and
22
23 WHEREAS, Abortion bans have created maternity care deserts where pregnant patients have limited access to
24 prenatal care, resulting in greater numbers of patients likely to present to emergency departments with undiagnosed life-
25 threatening pregnancy complications; and
26
27 WHEREAS, Abortion bans in some states have also created ambiguity and/or legal threats to emergency
28 clinicians and other physicians for providing pregnancy-terminating care that is medically required, therefore be it
29
30 RESOLVED, ACEP develop a policy statement that delineates:

31 • EMTALA applies to all emergency medical conditions and there should be no exceptions to EMTALA for
32 any specific emergency medical condition or the evidence-based treatment that would be used to stabilize a
33 patient.
34 • ACEP supports that the decision to provide any procedure in the course of patient care to satisfy EMTALA
35 requirements, including, but not limited to, abortion care and/or pregnancy termination, be made between
36 the patient and the emergency clinician, and that laws and regulations should not inhibit or obstruct the
37 patient-physician relationship.
38 • ACEP reinforces the need for emergency physicians to be able to provide care at the standard required by
39 medical best practices and that no procedure or treatment be removed from those treatment options in the
40 care of emergency patients served under federal EMTALA protections.

Background

The resolution directs the College to develop a policy statement that delineates that the Emergency Medical Treatment and Labor Act (EMTALA) applies to all emergency medical conditions and evidence-based treatments used to stabilize a patient, without any exceptions; that ACEP supports the autonomy of the patient-physician relationship without inhibition or obstruction by laws and regulations; and that ACEP reinforces the need for emergency physicians to have all procedures and treatment options available to them to provide care at the standard required by medical best practices in the care of emergency patients served under federal EMTALA protections.

The June 24, 2022, decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization* held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. Because emergency departments commonly see patients presenting with obstetrical emergencies, this decision immediately triggered significant uncertainty on whether, in light of the existing federal EMTALA law, restrictions or prohibitions could now be imposed on their treatment in states with abortion and related reproductive health restrictions.

EMTALA has been in place since 1987 and includes three main obligations:

1. The law requires hospitals to provide a ***medical screening examination*** to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition (EMC).
2. If an individual is determined to have an emergency medical condition, the individual must receive ***stabilizing treatment*** within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized.
3. If the individual is not stabilized, ***they may only be transferred*** if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks (the Centers for Medicare & Medicaid Services, or CMS, states in the guidance that patients who request to be transferred can only be transferred after a physician certifies that the medical benefits of the transfer outweigh the risks.)

A little less than a year before *Dobbs,* in September 2021 HHS released guidance reaffirming physicians' legal obligations under EMTALA, specifically when treating patients who are pregnant or are experiencing pregnancy loss. In this guidance, CMS:

- Stated that "an appropriate medical screening exam can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures." Patients must continue to be monitored until a physician or qualified health professional determines if the individual has an emergency medical condition, and if they do, until they are stabilized or appropriately transferred.
- Included a non-comprehensive list of EMCs involving pregnant people: ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. CMS states that the "course of treatment necessary to resolve such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., dilation and curettage (D&C), removal of one or both fallopian tubes, anti-hypertensive

therapy, etc.)." In other words, none of these procedures that a physician or other qualified medical professional directly involved in the care of the patient deems necessary to treat and stabilize a patient under the EMTALA mandate can be restricted by state laws.

- Declared that hospitals can only transfer women in labor "if the benefits of the transfer to the woman and/or the unborn child outweigh its risks. For example, if the hospital does not have staff or resources to provide obstetrical services, the benefits of a transfer may outweigh the risks." Hospitals cannot cite state laws or practices as the basis for transfer. In other words, regardless of where the hospital is located and what state laws are in effect, patients with emergency medical conditions must be treated and cannot be transferred—unless the limited transfer allowances under EMTALA apply.

ACEP issued a statement the day of the *Dobbs* ruling in response expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, and reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship.

Just weeks later, in July 2022 CMS issued additional EMTALA guidance. In this updated guidance, CMS:

- Reiterates that EMTALA pre-empts any directly contradicting state laws around the medical screening examination, stabilizing treatment, and transfer requirements. It specifically clarifies that if a physician believes that an abortion needs to be performed to stabilize a patient with an emergency medical condition, the physician MUST provide the treatment regardless of any state law that may prohibit abortions.
- States that with respect to what constitutes an EMC, the determination of an EMC "is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment."
- States that EMTALA pre-empts "any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital."

In addition to the guidance, HHS Secretary Xavier Becerra, in a letter to providers, further made clear that this federal law preempts state law restricting access to abortion in emergency situations.

However, there is still some grey area after the additional guidance from CMS. While the guidance noted that EMTALA can be raised as a defense by a physician facing state action, EMTALA does not provide any *proactive* protection to prevent an emergency physician from facing criminal charges brought by the state for providing this federally-mandated care. Some state restrictions only have an exception to allow abortion if it's to prevent the death of the pregnant patient, but as noted EMTALA requires stabilizing treatment to prevent "serious impairment of bodily functions," "serious dysfunction of any bodily organ or part," or to prevent placing the health of the patient "in serious jeopardy." ACEP has noted this is a key area of concern, potentially forcing emergency physicians in such states to choose between following EMTALA to avoid potential civil monetary penalties or following the state law to avoid potential criminal charges.

Therefore, ACEP joined amicus briefs addressing these issues. ACEP and the Idaho Chapter submitted a brief in the U.S. District Court for the District of Idaho on August 15, 2022, in support of the U.S. Department of Justice's challenge to an Idaho law in *United States v. State of Idaho*. Because the Idaho law only allows for abortion if the life of the mother is in danger, the brief argued that if applied to emergency medical care, Idaho Law would force physicians to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA – or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services' guidance on the EMTALA. The State of Texas had filed suit (*State of Texas v. Becerra*) arguing the federal government did not have the authority to provide medical guidance. The amicus brief emphasized the proper interpretation of EMTALA and the possibility that what under Texas law would constitute pregnancy termination may be appropriate in the emergency department when deemed necessary to provide stabilizing treatment of the patient. The brief explained that the Federal guidance merely restates physicians' obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

Since that time, there has been significant activity at the state level, in the courts, and at the federal level.

State level activities have been too numerous to summarize fully in this resolution background, but of note several states have undertaken their own EMTALA-like policy-setting:

- The Massachusetts governor, in June, released an executive order reaffirming that Massachusetts law provides a right to prompt treatment in an emergency – including emergency abortion care – without discrimination on account of economic status or source of payment.
- New York saw a bill introduced (A.5297A) under which a healthcare practitioner must not be prohibited from providing healthcare services related to complications with pregnancy in cases in which a failure to act would violate the accepted standard of care. The bill also prohibits a healthcare entity from taking adverse action against a practitioner for providing services consistent with this bill.
- In Washington, the Governor issued a directive calling on the Department of Health to issue a policy statement reaffirming and clarifying the requirements under state law for hospitals to provide emergency abortion services. Issued on June 17, the policy statement says, "If a pregnant person presents to a hospital's emergency department with an emergency medical condition for which termination of the pregnancy is the standard of care, the hospital is required to provide that abortion care in accordance with and as promptly as dictated by the standard of care or, if authorized under RCW 70.170.060(2), WAC 246-320-281(1), and other applicable state and federal law, transfer the patient to another hospital capable of providing the care."

In the courts:

- A preliminary injunction was issued by the U.S. District Court of Idaho (Southern Division) on August 24, 2022 that found that the exception for the life of the mother under Idaho's abortion ban was narrower than federal law which "protects patients not only from imminent death but also from emergencies that seriously threaten their health," and blocked the state law. The injunction provided a degree of legal certainty for EMTALA-certified hospitals, medical providers, and pregnant patients that care for obstetrical emergencies was still permissible under EMTALA.
  - The state legislature then filed an appeal before the 9th Circuit. After continued legal wrangling in the Circuit Court, the US Supreme Court intervened in January of 2024, allowing Idaho's criminal abortion ban to take effect and agreeing to hear the case in April.
  - ACEP joined together with ACOG and the AMA as lead amici on an amicus brief joined by 23 other medical societies to educate the Supreme Court on the importance of protecting the physician-patient relationship and ensuring that all patients receive health care that is medically and scientifically sound and in compliance with EMTALA. ACEP also joined these groups in a statement calling for the Court not to weaken EMTALA, noting:

    > "…In many of these emergency situations, the only way to treat or stabilize a patient is to end the pregnancy that is complicating or threatening their health…As organizations representing health care professionals, we understand that not every patient who presents to the emergency room while pregnant will need abortion care. But EMTALA should guarantee that patients experiencing pregnancy complications in the emergency setting are able to get evidence-based care, which includes being counseled fairly and honestly and receiving an abortion if that is the intervention that they need for their health emergency. Without comprehensive EMTALA protections, the lives of pregnant patients will most certainly be at risk. EMTALA must continue to protect pregnant people just as it protects those who aren't pregnant."

  - The Supreme Court ultimately ruled on June 27, 2024, dismissing the case as improvidently granted, and restored the 2022 lower court order to, for now, allow emergency abortions to proceed in Idaho under EMTALA. This decision does not provide any clarity or determination on whether EMTALA supersedes state laws such as Idaho's, and it is expected the case will return back to the Supreme Court in the coming year.
- In Texas, a federal district judge in August 2022 agreed with the state in *State of Texas v. Becerra*, saying the guidance amounted to a new interpretation of EMTALA and granted a temporary injunction upholding the implementation of the state's law.
  - The case eventually made its way to the 5th Circuit which affirmed the lower court's decision. Judge Leslie Southwick at the hearing described HHS's guidance as an effort to expand abortion access beyond life-saving care to "broader categories of things, mental health or whatever HHS would say an abortion is required for." HHS has since asked the Supreme Court to take up the case. In the meantime, the Biden administration's

guidance that EMTALA preempts state abortion bans is suspended in Texas only. It is possible that this case and the Idaho case could be consolidated and considered by the Supreme Court as one.

Federally:

- In May of 2024, CMS launched a new portal for both patients and providers to submit anonymous complaints of potential EMTALA violations in hospital EDs for investigation. ACEP has added a link to the complaint portal on its own resource page on reproductive health care. It should be noted the portal specifically exempts providers in the state of TX due to the injunction resulting from the Texas 5th Circuit decision.
- Following the Supreme Court decision in Idaho, HHS sent another letter to hospital and provider associations across the country reminding them that it is a hospital's legal duty to offer necessary stabilizing medical treatment (or transfer, if appropriate) to all patients in Medicare-participating hospitals who are found to have an emergency medical condition. CMS also announced that the investigation of EMTALA complaints would proceed in Idaho while litigation continues in the lower courts.

ACEP's policy statement "Interference in the Physician-Patient Relationship" states: "The American College of Emergency Physicians (ACEP) believes that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship."

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

Budgeted committee, Board, and staff resources.

Prior Council Action

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted. Directed ACEP to work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss referred to the Board of Directors.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals. Directed ACEP to support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine. Directed that ACEP oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Prior Board Action

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted.

June 2023, approved the policy statement "Access to Reproductive Healthcare in the Emergency Department."

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

June 2022, approved the policy statement "Interference in the Physician-Patient Relationship"

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted.

October 2016, approved the revised "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy.

Background Information Prepared by: Laura Wooster, MPH
Associate Executive Director, Advocacy and Practice Affairs

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

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

RESOLUTION: 38(24)

SUBMITTED BY: Michael Bresler, MD, FACEP
Monica Saxena, MD, JD
Kelly Quinley, MD
Sarah Hoper, MD, FACEP
AAWEP Section
California Chapter
Ohio Chapter

SUBJECT: Termination of Pregnancy

PURPOSE: Ensure that termination of pregnancy is legally permissible in instances of a non-living fetus, a pregnancy with a fetus with no hope of survival, or when needed to protect the health or life of a pregnant woman.

FISCAL IMPACT: Budgeted staff resources.

1 WHEREAS, It is not uncommon for women to present to emergency departments carrying a non-living fetus or
2 one with no hope of survival; and
3
4 WHEREAS, It is not uncommon for pregnant women to present to emergency departments with potentially
5 life-threatening obstetrical or other emergency medical conditions; and
6
7 WHEREAS, Denial of appropriate medical care, including termination of pregnancy, may constitute a major
8 threat to women's health or their lives, if they present to an emergency department with a non-living fetus or one with
9 no hope of survival, or if they are experiencing other potentially life-threatening obstetrical or emergency medical
10 conditions; and
11
12 WHEREAS, Many states are enacting restrictions or prohibitions pertaining to pregnancy termination that do
13 not differentiate between a normal fetus, a non-living fetus, a fetus with no hope of survival, or other obstetrical or
14 medical conditions which may threaten the health or the life of pregnant women; and
15
16 WHEREAS, Emergency physicians are ethically bound to provide appropriate medical care or referral for
17 women carrying a non-living fetus or one with no hope of survival, or who are experiencing other potentially life-
18 threatening obstetrical or medical emergencies; and
19
20 WHEREAS, The Emergency Medical Treatment and Labor Act (EMTALA) requires emergency physicians to
21 stabilize patients with emergency medical conditions if possible, or to transfer such patients if necessary for
22 stabilization; and
23
24 WHEREAS, Pregnant women carrying a non-living fetus or a fetus with no hope of survival, or who are
25 experiencing other obstetrical or medical emergencies, may be at risk for serious medical complications, including
26 death, and are thus not medically stable; and
27
28 WHEREAS, In order to protect the health or the life of a pregnant woman, therapeutic abortion or induction of
29 labor may be medically indicated for a number of maternal or obstetrical complications, including but not limited to
30 fetal demise, ectopic pregnancy, intrauterine infection, intrauterine hemorrhage, sepsis, pre-eclampsia, eclampsia, and
31 other emergent conditions; and

32 WHEREAS, There have already been reports of life-threatening complications resulting from denial of
33 pregnancy termination to women presenting to emergency departments with non-living or non-viable fetuses and other
34 obstetrical or medical emergencies; therefore be it
35
36 RESOLVED, That ACEP work with the appropriate governmental entities at the federal level and assist
37 chapters in working with state governmental entities, as well as work with other relevant stakeholders, to ensure that
38 termination of pregnancy of a non-living fetus be legally permissible; and be it further
39
40 RESOLVED, That ACEP work with the appropriate governmental entities at the federal level and assist
41 chapters in working with state governmental entities, as well as work with other relevant stakeholders, to ensure that
42 termination of pregnancy of a fetus with no hope of survival be legally permissible; and be it further
43
44 RESOLVED, That ACEP work with the appropriate governmental entities at the federal level and assist
45 chapters in working with state governmental entities, as well as work with other relevant stakeholders, to ensure that,
46 when medically indicated to protect the health or life of a pregnant woman, termination of pregnancy or induction of
47 labor be legally permissible.

Background

The resolution calls on ACEP to collaborate with federal and state governmental entities and other stakeholders to ensure that the termination of pregnancy is legally permissible in the cases of 1) a non-living fetus; 2) a pregnancy of a fetus with no hope of survival; and 3) when medically necessary to protect the health or life of a pregnant woman.

An estimated quarter of all women will experience the early loss of a pregnancy in their lifetime (Ghosh 2021) and 20% of these losses will require some form of intervention to completely clear the uterus of retained tissue (Manning, 2023). Up to 20% of pregnancies end in early pregnancy loss and early pregnancy loss or bleeding in early pregnancy accounts for a combined 2.7% of all emergency department (ED) visits among reproductive-aged women, or approximately 900,000 ED visits annually. Although some patients go to their primary obstetric providers for evaluation of early pregnancy loss, many seek care in the emergency department. Additionally, patients who come to the ED with early pregnancy loss are younger and more likely to be Black or Hispanic compared with other patients in the ED. Studies have also shown that the patients were also less likely to be the primary insurance policy holder or to have established prenatal care as compared to patients presenting to the outpatient setting; these characteristics were also all associated with decreased odds of active early pregnancy loss management.

As it does for other important emerging issues impacting emergency physicians and the care of emergency medicine patients, ACEP issued a statement in response to the Dobbs ruling expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship (as codified in the policy statement, "Interference in the Physician-Patient Relationship," approved by the Board of Directors in June 2022).

In Idaho, the state legislature enacted several laws aimed at restricting abortion access following the *Dobbs* ruling. Among them, the state legislature added Idaho Code § 18-622, which generally makes performance of an abortion—at any pregnancy stage—a felony punishable by two to five years in prison. The initially enacted Section 622 generally defined abortion as the use of any means to intentionally terminate a "clinically diagnosable pregnancy." Section 622 did not (at the time) exclude from the definition actions to address certain pregnancy complications that may necessitate emergency treatment, such as ectopic pregnancies. As initially enacted, Section 622 also did not provide any exceptions to the abortion ban. The provision, instead, provided two affirmative defenses that physicians could invoke upon prosecution. First, an accused physician could avoid conviction by proving, by a preponderance of evidence, that the abortion, in the physician's good faith medical judgment (1) "was necessary to prevent the death of the pregnant woman" and (2) was performed in a manner that "provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman." Second, an accused physician could assert an affirmative defense based on a reported case of rape or incest.

On August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, submitted a brief in the U.S. District Court for the District of Idaho in support of in support of the U.S. Department of Justice's challenge to an Idaho law in *United States v. State of Idaho*. If applied to emergency medical care, the brief argued that Idaho Law would force physicians to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA – or risk criminal prosecution. It noted,

> "In emergency medicine, what Idaho now defines as criminal abortion has long been understood as a necessary, standard, and evidence-based medical treatment. As medically defined, abortion is a medical intervention provided to individuals who need to end the medical condition of pregnancy. Abortion includes the administration of medication to women already experiencing a miscarriage to complete expulsion of pregnancy tissue, including an embryo or fetus. Abortion includes the removal of an embryo, fetus, and potentially a uterus as the result of infection arising from the preterm premature rupture of membranes. An abortion is the critical treatment option for an ectopic pregnancy, which always involves a nonviable pregnancy. And an abortion is the necessary treatment in the event of uncontrolled bleeding from, for example, placental abruption or an ongoing miscarriage, even when fetal cardiac activity may still be detectable. In these and many similar circumstances, what Idaho Law defines as the criminal felony of abortion is—and has long been understood as—a standard, essential component of emergency medical care."

The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services' guidance on the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). The brief explained that the Federal guidance merely restates physicians' obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

When the Idaho case eventually came to the United States Supreme Court in April 2024 as *Moyle vs. United States*, ACEP joined together with ACOG and the AMA as lead amici on a new amicus brief, joined by 23 other medical societies to educate the Supreme Court on the importance of protecting the physician-patient relationship and ensuring that all patients receive health care that is medically and scientifically sound and in compliance with EMTALA. ACEP also joined these groups in a statement, noting:

> "…In many of these emergency situations, the only way to treat or stabilize a patient is to end the pregnancy that is complicating or threatening their health…As organizations representing health care professionals, we understand that not every patient who presents to the emergency room while pregnant will need abortion care. But EMTALA should guarantee that patients experiencing pregnancy complications in the emergency setting are able to get evidence-based care, which includes being counseled fairly and honestly and receiving an abortion if that is the intervention that they need for their health emergency. Without comprehensive EMTALA protections, the lives of pregnant patients will most certainly be at risk. EMTALA must continue to protect pregnant people just as it protects those who aren't pregnant."

ACEP has supported chapters in their own advocacy on these issues to state governmental entities. Some recent examples include:

- Supported the Maine ACEP chapter regarding changes to Maine CDC reports requiring physicians to include miscarriage information (pregnancies that end <20 weeks).
- Supported the Idaho ACEP chapter with emergency abortion care after the state banned all forms of abortion in 2023 (in addition to ACEP's participation in the related amicus briefs).
- Supported California legislation that defends Arizona physicians and patients seeking abortion-related care in California.
- Supported North Carolina legislation to decriminalize reproductive health issues.
- Supported Connecticut legislation prohibiting adverse action against health care providers for providing abortion related services and care after an abortion.

ACEP's Policy Statement, Access to Reproductive Health Care in the Emergency Department, includes the following provisions relevant to this resolution:

- ACEP supports the position that the early termination of pregnancy (publicly referred to as "abortion") is a medical procedure, and as such, involves shared decision-making between patients and their physician regarding 1) discussion of reproductive health care, 2) performance of indicated clinical assessments, 3) evaluation of the viability of pregnancy and safety of the pregnant person, 4) availability of appropriate resources to perform indicated procedure(s), and 5) is to be made only by healthcare professionals with their patients.
- ACEP specifically opposes the penalization of and or retaliation against patients, patient advocates, physicians, healthcare workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services and medications for contraception, abortion, and pregnancy complications, and will further advocate for legal protection of said individuals.
- ACEP opposes the statutory provision of criminal penalties for any medically appropriate care provided in the emergency department. ACEP also opposes mandatory reporting with the intent (explicit or implicit) to prosecute patients or their healthcare providers, which includes, but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss.
- ACEP supports clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between state and federal laws which include EMTALA and HIPAA.

Elements of this new policy statement were used in ACEP's response to the U.S. Department of Health & Human Services' proposed "HIPAA Privacy Rule to Support Reproductive Health Privacy".

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted. Directed ACEP to work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss referred to the Board of Directors.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and

possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals. Directed ACEP to support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Prior Board Action

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted.

June 2023, approved the policy statement "Access to Reproductive Healthcare in the Emergency Department."

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

June 2022, approved the policy statement "Interference in the Physician-Patient Relationship"

October 2016, approved the revised "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy.

Background Information Prepared by: Laura Wooster, MPH
Associate Executive Director, Advocacy and Practice Affairs

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

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

RESOLUTION: 39(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Urgent Care Transparency on Available Resources and Credentials

PURPOSE: 1) Advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing resources that are or are not available; 2) advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

FISCAL IMPACT: Budgeted staff resources for federal and state advocacy initiatives.

1 WHEREAS, Urgent care centers provide an important resource to patients that do not require the higher level
2 of resources of emergency departments, thereby providing relief to already overcrowded emergency departments; and
3
4 WHEREAS, Urgent care centers vary in terms of resources available and resources such as x-rays and lab
5 testing are not necessarily constant during hours of operation; and
6
7 WHEREAS, Urgent care centers vary widely in the level of educational and/or clinical experience of those
8 providing care to patients; and
9
10 WHEREAS, Patients often present to urgent care centers with complaints/medical needs that cannot be
11 provided for in the urgent care setting; therefore be it
12
13 RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent
14 care centers, listing what resources are or are not available at a given time; and be it further
15
16 RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent
17 care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with
18 or without physician on site).

Background

This resolution directs ACEP to advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing what resources are or are not available at a given time and to advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

The number of urgent care centers has continued to grow in the United States. Urgent care centers offer patients flexible hours and walk-in availability and their medical focus has grown. Many urgent care centers offer broader services and now offer in-house x-rays, lab testing, and specialized services such as pediatric care.

ACEP's "Urgent Care Centers" policy statement defines an urgent care center as a "walk-in clinic focused on the delivery of medical care for minor illnesses and injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department." The policy also states:

> "Any facility that does not meet the definition of an ED or freestanding ED as defined by ACEP and that advertises itself as providing unscheduled care should:

- Not use the word “emergency” or “ER” in its name in any way.
- Not use the word “emergency” or “ER” in any advertisements, claims of service, or to describe the type or level of care provided or as an alternative to an ED. Doing so may be considered a deceptive trade practice, as defined by federal or applicable state law.
- Be required to comply with appropriate state or federal licensing requirements that specify staffing and equipment criteria to provide clear information to patients accessing medical care.”

ACEP has addressed the issue of credentials of care providers on site by supporting the “Health Care Professional Transparency Act,” which requires all health care professionals are required to wear a name tag during all patient encounters clearly identifying the type of license they hold. Health care professionals will also have to display their education, training, and licensure in their office.

The AMA conducted a survey that shows there is significant public confusion about the qualifications of different health care professionals. Advertisements and websites for urgent care clinics are not always free of deceptive or misleading information and do not always identify the professional license. The “Truth in Advertising” campaign and model legislation seeks to ensure that any advertisements or professional websites facilities have do not promote services beyond what they are legally permitted to provide. ACEP has supported the passage of this legislation in 20 states as of July 2024.

Throughout the spring of 2023, ABEM piloted a campaign promoting the value of board certification in three markets (urban, suburban, and rural) that included billboards and other environmental ads, a digital campaign, and pre- and post-campaign surveys. Enduring materials for the campaign are available to diplomates and the public on the ABEM website, which includes video content provided by ACEP.

ACEP President Aisha Terry, MD, FACEP, recently appointed an Urgent Care Task Force with the following objectives:

1. Determine the current landscape of urgent care centers in terms of quantity, locations, volumes, and capabilities, as well as associated physician and non-physician provision of care.
2. Make the distinction between urgent care centers, retail clinics, minute clinics, and otherwise, particularly relative to collaborative potential in the emergency care space.
3. Assess the prevalence of clinical partnerships between emergency departments and urgent care centers across the country.
4. Explore credentialing opportunities for physicians practicing in urgent care centers, to include possible ABEM sub-specialization as well as by other means of credentialing.
5. Understand business and financial models of urgent care practice and reimbursement, to include the typical billing and charging process when a patient is transferred between an emergency department and an urgent care center.
6. Apart from traditional emergency medicine residency training skills that are taught, determine what additional skills might equip and prepare emergency physicians for practicing urgent care medicine.
7. Identify key supports and resources that emergency physicians who primarily work in urgent care centers need.
8. Make recommendations for how to enhance the body of scholarly work related to urgent care practice, and how ACEP might be instrumental in such efforts.
9. Survey the ACEP membership regarding their participation in urgent care delivery – currently and potential for future, level of involvement (clinical care, management of site, management of system), interest in ABEM focus practice designation/board certification.
10. Make recommendations to ACEP on filling current gaps and our future role in this space.
11. Monitor ABEM’s interest in urgent care as an area of focus practice designation.

The task force will hold its first meeting during ACEP24 in Las Vegas.

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and

levels, including federal, state, and professional.
- Expand and strengthen the role, approach, and impact of state-level advocacy.

Fiscal Impact

Budgeted staff resources for federal and state advocacy initiatives.

Prior Council Action

Amended Resolution 39(22) Signage at Emergency Departments with Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or eligible emergency physician where care is delivered.

January 2022, approved the revised policy statement "Urgent Care Centers;" originally approved October 2016.

Amended Resolution 33(15) Defining and Transparency in Urgent Care Centers. Directed ACEP to 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 ACEP work with state and federal stakeholders to advocate for appropriate regulatory standards for urgent care centers.

Prior Board Action

Amended Resolution 39(22) Signage at Emergency Departments with Onsite Emergency Physicians adopted.

Amended Resolution 33(15) Defining and Transparency in Urgent Care Centers adopted.

Background Information Prepared by: Adam Krushinskie
Senior Director, State Legislative and Reimbursement

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

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

RESOLUTION: 40(24)

SUBMITTED BY: New York Chapter

SUBJECT: Telehealth Emergency Physician Standards

PURPOSE: Affirm that physicians providing telehealth emergency medicine or urgent care services be board certified or board eligible in emergency medicine.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, ACEP affirms that the best emergency medical care is provided and led by board certified
2 emergency physicians; and
3
4 WHEREAS, Patients expect emergency care to be given or directly supervised by an emergency physician;
5 and
6
7 WHEREAS, Emergency medical care may include all levels and locations of emergency departments
8 including but not limited to rural and virtual settings; and
9
10 WHEREAS, Recognizing variations in resources and access, patients should be able to expect the same
11 quality of emergency physician led care regardless of the location or setting of the emergency department to which
12 they present; therefore be it
13
14 RESOLVED, ACEP affirms that physicians providing telehealth emergency medicine or telehealth urgent
15 care services be board certified or board eligible in emergency medicine.

Background

The resolution calls for the College to affirm that physicians providing telehealth emergency medicine or urgent care services be board certified or board eligible in emergency medicine.

ACEP policy statements promote the gold standard for emergency department care as that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.

ACEP's policy statement "Emergency Medicine Telehealth" states:

> "…With the aim of ensuring that all patients seeking telehealth services receive high quality care, the American College of Emergency Physicians (ACEP) endorses the utilization of PAs and/or NPs who are supervised by an American Board of Emergency Medicine/American Osteopathic Board of Emergency Medicine (ABEM/AOBEM) board-certified or board-eligible emergency physician according to ACEP guidelines."

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" was most recently updated in June 2023 and states:

> "Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety. Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

The College has considered this broader issue of the gold standard of emergency care being led by board certified or board eligible emergency physicians on several occasions, including previous Council resolutions regarding onsite staffing in both urban and rural emergency departments, and particularly in terms of promoting the gold standard of onsite emergency physician presence to supervise nurse practitioners and physicians. ACEP has promoted and continues to promote the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians. ACEP has also advocated for this standard to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, and the U.S. Congress. For example, in ACEP's response to the Medicare and Medicaid Programs; Conditions of Participation (CoPs for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates proposed rule and in ACEP's comments on the calendar year (CY) 2022 Hospital Outpatient Prospective Payment (OPPS) proposed rule, stated that all services delivered in REHs to be supervised by emergency physicians either in-person or virtually via telehealth

ACEP's "Practice Guidance for Emergency Telehealth and Acute Unscheduled Care Telehealth" states:

> "Emergency physicians are uniquely qualified to leverage acute care medical decision making via telehealth, unscheduled or scheduled, to provide medical care across the spectrum of conditions and severity."
>
> and
>
> "Any PA or NP providing emergency telehealth care should be supervised by an emergency physician as determined appropriate by the EP responsible for and providing the supervision and/or collaboration."

A Telehealth Task Force was appointed in 2021 to define a vision for the impact of telehealth on emergency medicine and identify ACEP resources necessary to position emergency physicians to be the leaders in acute unscheduled

telehealth. Substitute Resolution 36(20) Telehealth Free Choice, which was referred to the Board, called on ACEP to address a wide variety of issues in Emergency Telehealth including who should provide emergency care. The resolution was assigned to the Telehealth Task Force to review and provide recommendations. The task force was not instructed to focus solely on the referred resolveds and developed numerous objectives divided into five key subject areas:

- Care Models
- Quality
- Legislative, Regulatory, Policies
- Reimbursement
- Education

The recommendations include that ACEP take the position that emergency medicine and board-certified emergency physicians are appropriate and well suited to practice acute unscheduled telehealth, while recognizing that other specialties practice within certain care models (Direct-to-Consumer, remote home monitoring, etc.); and that ACEP advocate that the practice of emergency telehealth is an extension (via an additional modality) of emergency medicine and clinical practice within the scope of a Board-Certified Emergency Physician.

ACEP President Aisha Terry, MD, FACEP, recently appointed an Urgent Care Task Force with the following objectives:

1. Determine the current landscape of urgent care centers in terms of quantity, locations, volumes, and capabilities, as well as associated physician and non-physician provision of care.
2. Make the distinction between urgent care centers, retail clinics, minute clinics, and otherwise, particularly relative to collaborative potential in the emergency care space.
3. Assess the prevalence of clinical partnerships between emergency departments and urgent care centers across the country.
4. Explore credentialing opportunities for physicians practicing in urgent care centers, to include possible ABEM sub-specialization as well as by other means of credentialing.
5. Understand business and financial models of urgent care practice and reimbursement, to include the typical billing and charging process when a patient is transferred between an emergency department and an urgent care center.
6. Apart from traditional emergency medicine residency training skills that are taught, determine what additional skills might equip and prepare emergency physicians for practicing urgent care medicine.
7. Identify key supports and resources that emergency physicians who primarily work in urgent care centers need.
8. Make recommendations for how to enhance the body of scholarly work related to urgent care practice, and how ACEP might be instrumental in such efforts.
9. Survey the ACEP membership regarding their participation in urgent care delivery – currently and potential for future, level of involvement (clinical care, management of site, management of system), interest in ABEM focus practice designation/board certification.
10. Make recommendations to ACEP on filling current gaps and our future role in this space.
11. Monitor ABEM's interest in urgent care as an area of focus practice designation.

The task force will hold its first meeting during ACEP24 in Las Vegas.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources for ongoing federal and state advocacy initiatives.

Prior Council Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments, and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician certified by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, or certified by the American Board of Pediatrics in pediatric emergency medicine.

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Substitute Resolution 36(20) Telehealth referred to the Board of Directors. Called for ACEP to support legislation to allow patients to be at any location, allow emergency medicine physicians or other clinicians that are supervised by emergency medicine physicians, to be at any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that reflects the service provided; support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer's network, or outside of insurer's network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; that ACEP, in collaboration with other medical organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and, oppose restrictions to tele-health care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the

independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing two policy statements. "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

September 2022, approved the revised policy statement "Emergency Medicine Telehealth;" revised and approved February 2020 with the current title; originally approved January 2016 titled "Emergency Medicine Telehealth." June 2022, reviewed the reimbursement recommendations from the Telehealth Task Force report, and approved the recommendations except for number 4, number 8, and number 12.

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

January 2022, reviewed the recommendations from the Telehealth Task Force Report and referred the reimbursement recommendation to the Coding & Nomenclature Advisory Committee and the Reimbursement Committee to provide further analysis and submit their recommendations to the Board on appropriate advocacy action regarding telehealth reimbursement.

October 2021, filed the Telehealth Task Force Report and assigned subgroups of the Board to review each of the recommendations contained in the report and provide their analysis to the Board.

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

January 2021, approved the policy statement "Telehealth Inclusion."

October 2020, approved the "Practice Guidance for Emergency Telehealth and Acute Unscheduled Care Telehealth."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine. NCCPA advised they would contact the workgroup representatives regarding next steps, however, there was no further contact from NCCPA about the program.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.
June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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

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

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

RESOLUTION: 41(24)

SUBMITTED BY: Wellness Section
Arizona College of Emergency Physicians
Colorado Chapter
District of Columbia Chapter
South Carolina Chapter

SUBJECT: Workplace Violence Data Collection

PURPOSE: Advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives. Costs for local reporting would be absorbed by the institution. Creation of a national centralized reporting portal would be very costly, likely in excess of $100,000, and require considerable staff resources to create, analyze, and maintain.

1 WHEREAS, Episodes of workplace violence are known to be significant contributors to a decline in overall
2 healthcare worker wellbeing; and
3
4 WHEREAS, ACEP previously adopted Resolution 55(17) Workplace Violence:
5
6 *RESOLVED, That ACEP move past policy creation and simple awareness campaigns with*
7 *state and national regulatory agencies to develop actionable guidelines and measures (e.g., percent of*
8 *events with legal outcome, paid post-trauma leave, use of de-escalation techniques, counseling*
9 *provided), to ensure safety in the Emergency Department for patients and staff; and be it further*
10 *RESOLVED, That ACEP work with local, state, and federal bodies to provide for appropriate*
11 *protections and enforcement of violations of Emergency Department patient and staff protections from*
12 *violence in the workplace to provide safe and efficacious emergency care; and be it further*
13 *RESOLVED, That ACEP create model legislative and regulatory language that can be shared*
14 *with state chapters and hospitals addressing workplace violence.;* and
15
16 WHEREAS, ACEP previously adopted Amended Resolution 35(22) Workplace Violence Towards Health Care
17 Workers:
18 *RESOLVED, That ACEP advocate for legislation at the state and federal level that includes*
19 *clear language outlining consequences for those who assault a healthcare worker at the workplace.;*
20 and
21
22 WHEREAS, The landscape of emergency medical care has significantly changed in the post COVID era with
23 an exodus of experienced healthcare professionals offering emergency medical care in the context of declining hospital
24 bed availability and impaired outpatient care platforms; and
25
26 WHEREAS, Challenges with rising prevalence of substance abuse and disparities of health care equity result in
27 greater risks of episodic violence within the workplace; and
28
29 WHEREAS, Health care facility leadership encounters barriers to individually institute commonly accepted
30 violence prevention strategies, such as entry screening, metal detectors, armed guards, and/or warning signage in an
31 increasingly competitive healthcare landscape driven by financial incentives to enhance patient recruitment; and

32 WHEREAS, Health care worker victims of workplace violence are encountering barriers to reporting incidents
33 of violence resulting in uncertainty in the true scope of the problem of workplace violence without a unified means of
34 data collection; and
35
36 WHEREAS, Resource allocation to address the issues of workplace violence to care for the caregiver and
37 create effective abatement strategies is contingent upon understanding the scope of the problem; therefore be it
38
39 RESOLVED, That ACEP both advocate for and support the ability of victims and witnesses to report
40 workplace violence events without repercussion and recriminations; and be it further
41
42 RESOLVED, That ACEP create a mechanism for tracking workplace violence reports such that the scope of
43 the problem can be identified.

Background

This resolution calls for the College advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem.

ACEP has taken an active role in trying to address the problem of violence in the emergency department. A 2018 ACEP survey of more than 3,500 emergency physicians showed that nearly half had been physically assaulted at work, with the majority of those assaults occurring within the previous year. 49% of respondents also said that hospitals can do more by adding security guards, cameras, metal detectors and increasing visitor screening. In a follow-up ACEP survey in 2022, 85% of emergency physicians indicated that they believe the rate of violence experienced in emergency departments has increased over the past five years., ACEP conducted a poll of members in January 2024 and found that 91% of emergency physicians reported that they or a colleague were victims of violence in the past year. As part of that effort, ACEP gathered more than 800 troubling stories directly from emergency physicians. These findings highlight the prevalence regarding workplace violence in emergency settings.

ACEP has advocated for local reporting of violence in the ED. While a national database of violent acts would provide important information on the incidence and prevalence of ED based or hospital violence, creation of such a portal would be costly and time consuming. It would require a data analyst to clean the data and compile the reports. It would also require input of data from a sufficient number of hospitals to be meaningful, which would require a standardized reporting structure as well as universal terminology. ACEP has learned from the implementation of the Clinical Emergency Data Registry, and even with the CDC, hospitals are reluctant to provide such data outside of state or federal requirements.

Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts and has featured as one of the key advocacy priorities during the recent ACEP Leadership & Advocacy Conference (LAC) meetings in Washington, DC. ACEP helped inform and supports the "Workplace Violence Prevention Act for Health Care and Social Service Workers" (H.R. 2663/S.1176), introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI). This bill compels on the Occupational Safety and Health Administration (OSHA) to issue federal standards to require health care and social service employers to create and implement workplace violence prevention plans. Among the provisions of this bill are:

- The OSHA standard mandates that employers shall investigate each incident of workplace violence as soon as practicable, document the findings, and take corrective measures.
- The OSHA standard requires that employers must record workplace violence incidents in a Violent Incident Log ("Log"). An annual summary of the Log shall be posted in the workplace in the same manner as the posting of the OSHA Annual Summary of Injuries and Illnesses, and similarly shall be transmitted to OSHA. Employers shall maintain records related to the Plan, and employees are provided the right to examine and make copies of the Plan, the Log and related Plan documents, with appropriate protections for patient and worker privacy. Patient names and personal identifying information will be excluded from the Violent

Incident Log.
- The OSHA standard prohibits retaliation against a covered employee for reporting a workplace violence incident, threat, or concern to an employer, law enforcement, local emergency services, or a government agency. A violation of this prohibition shall be enforceable as a violation of an OSHA standard.

Moreover, ACEP has been working with OSHA for several years as they have attempted to develop and issue these standards, which have been in development since 2015. The agency plans to release a proposed rule for a workplace violence prevention in health care and social service facilities in December 2024. The proposed rule will most likely apply to work performed in hospitals, medical centers, residential treatment centers, nursing homes, mental health centers, and private homes where home health aides or social workers visit clients. The agency is expected to publish a final rule in 2025.

ACEP also helped inform and supports the bipartisan "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768), bipartisan, bicameral legislation introduced by Reps. Larry Bucshon (R-IN) and Madeleine Dean (D-PA), and Sens. Joe Manchin (D-WV) and Marco Rubio (R-FL). The SAVE Act establishes federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP's letter of support can be found here, and Christopher Kang, MD, FACEP, who was ACEP president at that time, was quoted in the press release when the legislation was introduced.

ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA) on January 30, 2024. ACEP, along with the with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA), hosted another congressional briefing on workplace violence on March 22, 2024. And on July 31, 2024, ACEP and AHA hosted another congressional briefing focused on the Senate, with Senator Joe Manchin (D-WV) attending to deliver remarks to the audience as well. ACEP has also established and leads a coalition of other medical specialties to further amplify these advocacy efforts on Capitol Hill.

ACEP also provided input on The Joint Commission's "Workplace Violence Prevention" project in 2021 and, as a result of that work, TJC announced new requirements for accredited hospitals to ensure safer work environments. The new and revised requirements that went into effect January 1, 2022 include directives for hospitals to have a workplace violence prevention program; conduct annual worksite analysis related to its workplace violence prevention program; establish a process to continually monitor, report, and investigate safety incidents including those related to workplace violence; and to provide training, education and resources to leadership, staff, and licensed practitioners to address prevention, recognition, response and reporting of workplace violence. The Workplace Violence Standards Fact Sheet provides an overview of the new standards.

ACEP began a partnership with ENA in 2019 to launch the "No Silence on ED Violence" campaign to draw more public attention to the problem of violence in the emergency department, to drive policymaker action to address the issue, and to provide resources and support to emergency physicians and emergency nurses. The campaign website, www.stopEDviolence.org, includes fact sheets and advocacy materials highlighting the severity of the issue, as well as resources for members seeking ways to reduce the incidence of violence in the ED. ACEP continues working closely with ENA on this issue. Additionally, ACEP has communicated with the American Nurses Association (ANA) and the National District Attorneys Association (NDAA) to gain a better understanding of the various issues that contribute to the current workplace violence landscape where violence against emergency physicians and other health care workers is either not reported or not prosecuted, and the College continues working to develop a better understanding of the patchwork of state laws related to health care workplace violence. In May 2022, No Silence on ED Violence Press Conference leaders and members of ENA and ACEP, together with Senator Tammy Baldwin (D-WI), held a press conference on Capitol Hill calling on Congress to pass legislation aimed at reducing violence against health care workers." ACEP and ENA hosted a similar press conference on Capitol Hill after LAC2023, and continue closely partnering on related efforts.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of Violence in the Emergency Department" calls workplace violence "a preventable and significant public health problem" and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED

environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a page with a wealth of resources entitled "Violence in the Emergency Department: Resources for a Safer Workplace." The site includes links to information papers on the "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED and "Emergency Department Violence: An Overview and Compilation of Resources."

ACEP's State Legislative/Regulatory Committee (SLRC) has a work group assigned to deal with workplace violence issues and has developed both a white paper and toolkit for chapters and individual groups and hospitals. Part of their work involves discussions with the law enforcement community to ensure that convictions for workplace violence are not dismissed by district attorney offices. Additionally, the SLRC has advocated for mandatory reporting of workplace violence, similar to legislation in North Carolina, which requires hospitals to track and report such incidents.

ACEP Strategic Plan Reference

Career Fulfillment – ACEP supports you in addressing your career frustrations and seeking avenues for greater career fulfillment, and commits to addressing tough issues head on.

Advocacy – ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives. Costs for local reporting would be absorbed by the institution. Creation of a national centralized reporting portal would be very costly, likely in excess of $100,000, and require considerable staff resources to create, analyze, and maintain.

Prior Council Action

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. This resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against healthcare providers , advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on violence prevention issue and encourage the National Institute of Mental Health and Centers for Disease Control and Prevention, among others, to make financial support available for research.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

Approved as legislative and regulatory priorities in March 2024, February 2023, January 2022, and January 2022 to continue advocating for reintroduction or passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved with the title "Protection from Violence in the Emergency Department" April 2016; revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

Resolution 55(17) Workplace Violence adopted.

May 2016, reviewed the information paper "Emergency Department Violence: An Overview and Compilation of Resources."

November 2015, reviewed the information paper, "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

August 2014, reviewed the information paper "Hospital-Based Violence Intervention Programs."

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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

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

RESOLUTION: 42(24)

SUBMITTED BY: New York Chapter

SUBJECT: Workplace Violence

PURPOSE: Advocate for all EDs to preserve and protect the accurate reporting of each workplace violence incident while preserving employee confidentiality without repercussion for employment purposes; officially work with OSHA, the Department of Justice, and other relevant stakeholders to push for national legislation standardizing prevention and response measures for violence against health care workers in EDs.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives.

1 WHEREAS, Emergency Departments (EDs) are high-risk settings for workplace violence (WPV) often
2 creating occupational hazard conditions for ED physicians; and
3
4 WHEREAS, Despite the incidence of WPV episodes there is often under reporting of such incidents[1]; and
5
6 WHEREAS, Violence towards ED physicians carry unintended consequences including mental health issues,
7 job dissatisfaction, and decreased quality of patient care; and
8
9 WHEREAS, Despite multiple proposed anti-WPV strategies in the literature, there are few empirical metrics
10 of effectiveness associated with these ideas[2]; and
11
12 WHEREAS, Physicians and other ED health care workers often choose to not report WPV incidents due to
13 fear of the consequences and lack of management support[3]; therefore be it
14
15 RESOLVED, That ACEP advocate for all emergency departments to preserve and protect the accurate
16 reporting of each workplace violence incident while preserving employee confidentiality without repercussion for
17 employment purposes; and be it further
18
19 RESOLVED, That ACEP officially work with the Occupational Safety and Health Administration, the
20 Department of Justice, and other relevant stakeholders to advocate for national legislation that standardizes the
21 prevention and the response to harmful acts of violence on health care workers in emergency departments.

References
1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6357631/
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8783572/
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8783572/

Background

This resolution calls for the College to advocate for all emergency departments to preserve and protect the accurate reporting of each workplace violence incident while preserving employee confidentiality without repercussion for employment purposes. Additionally, it requests collaborate with the Occupational Safety and Health Administration (OSHA), the Department of Justice, and other relevant stakeholders to push for national legislation standardizing prevention and response measures for violence against health care workers in emergency departments.

ACEP has taken an active role in trying to address the problem of violence in the emergency department. A 2018 ACEP survey of more than 3,500 emergency physicians showed that nearly half had been physically assaulted at

work, with the majority of those assaults occurring within the previous year. 49% of respondents also said that hospitals can do more by adding security guards, cameras, metal detectors and increasing visitor screening. In a follow-up ACEP survey in 2022, 85% of emergency physicians indicated that they believe the rate of violence experienced in emergency departments has increased over the past five years. ACEP conducted a poll of members in January 2024 and found that 91% of emergency physicians reported that they or a colleague were victims of violence in the past year. As part of that effort, ACEP gathered more than 800 troubling stories directly from emergency physicians. These findings highlight the prevalence regarding workplace violence in emergency settings.

Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts and has featured as one of the key advocacy priorities during the recent ACEP Leadership & Advocacy Conference (LAC) meetings in Washington, DC. ACEP helped inform and supports the "Workplace Violence Prevention Act for Health Care and Social Service Workers" (H.R. 2663/S.1176), introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI). This bill compels on the Occupational Safety and Health Administration (OSHA) to issue federal standards to require health care and social service employers to create and implement workplace violence prevention plans. Among the provisions of this bill are:

- The OSHA standard mandates that employers shall investigate each incident of workplace violence as soon as practicable, document the findings, and take corrective measures.

- The OSHA standard requires that employers must record workplace violence incidents in a Violent Incident Log ("Log"). An annual summary of the Log shall be posted in the workplace in the same manner as the posting of the OSHA Annual Summary of Injuries and Illnesses, and similarly shall be transmitted to OSHA. Employers shall maintain records related to the Plan, and employees are provided the right to examine and make copies of the Plan, the Log and related Plan documents, with appropriate protections for patient and worker privacy. Patient names and personal identifying information will be excluded from the Violent Incident Log.

- The OSHA standard prohibits retaliation against a covered employee for reporting a workplace violence incident, threat, or concern to an employer, law enforcement, local emergency services, or a government agency. A violation of this prohibition shall be enforceable as a violation of an OSHA standard.

Moreover, ACEP has been working with OSHA for several years as they have attempted to develop and issue these standards, which have been in development since 2015. The agency plans to release a proposed rule for a workplace violence prevention in health care and social service facilities in December 2024. The proposed rule will most likely apply to work performed in hospitals, medical centers, residential treatment centers, nursing homes, mental health centers, and private homes where home health aides or social workers visit clients. The agency is expected to publish a final rule in 2025.

ACEP also helped inform and supports the bipartisan "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768), bipartisan, bicameral legislation introduced by Reps. Larry Bucshon (R-IN) and Madeleine Dean (D-PA), and Sens. Joe Manchin (D-WV) and Marco Rubio (R-FL). The SAVE Act establishes federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP's letter of support can be found here, and ACEP President Christopher Kang, MD, FACEP, was quoted in the press release when the legislation was introduced.

ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA) on January 30, 2024. ACEP, along with the with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA), hosted another congressional briefing on workplace violence on March 22, 2024. And on July 31, 2024, ACEP and AHA hosted another congressional briefing focused on the Senate, with Senator Joe Manchin (D-WV) attending to deliver remarks to the audience as well. ACEP has also established and leads a coalition of other medical specialties to further amplify these advocacy efforts on Capitol Hill.

ACEP also provided input on The Joint Commission's "Workplace Violence Prevention" project in 2021 and, as a result of that work, TJC announced new requirements for accredited hospitals to ensure safer work environments. The

new and revised requirements that went into effect January 1, 2022 include directives for hospitals to have a workplace violence prevention program; conduct annual worksite analysis related to its workplace violence prevention program; establish a process to continually monitor, report, and investigate safety incidents including those related to workplace violence; and to provide training, education and resources to leadership, staff, and licensed practitioners to address prevention, recognition, response and reporting of workplace violence. The Workplace Violence Standards Fact Sheet provides an overview of the new standards.

ACEP began a partnership with ENA in 2019 to launch the "No Silence on ED Violence" campaign to draw more public attention to the problem of violence in the emergency department, to drive policymaker action to address the issue, and to provide resources and support to emergency physicians and emergency nurses. The campaign website, www.stopEDviolence.org, includes fact sheets and advocacy materials highlighting the severity of the issue, as well as resources for members seeking ways to reduce the incidence of violence in the ED. ACEP continues working closely with ENA on this issue. Additionally, ACEP has communicated with the American Nurses Association (ANA) and the National District Attorneys Association (NDAA) to gain a better understanding of the various issues that contribute to the current workplace violence landscape where violence against emergency physicians and other health care workers is either not reported or not prosecuted, and the College continues working to develop a better understanding of the patchwork of state laws related to health care workplace violence. In May 2022, No Silence on ED Violence Press Conference leaders and members of ENA and ACEP, together with Senator Tammy Baldwin (D-WI), held a press conference on Capitol Hill calling on Congress to pass legislation aimed at reducing violence against health care workers." ACEP and ENA hosted a similar press conference on Capitol Hill after LAC2023, and continue closely partnering on related efforts.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of Violence in the Emergency Department" calls workplace violence "a preventable and significant public health problem" and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a page with a wealth of resources entitled "Violence in the Emergency Department: Resources for a Safer Workplace." The site includes links to information papers on the "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED and "Emergency Department Violence: An Overview and Compilation of Resources."

ACEP's State Legislative/Regulatory Committee (SLRC) has a work group assigned to deal with workplace violence issues and has developed both a white paper and toolkit for chapters and individual groups and hospitals. Part of their work involves discussions with the law enforcement community to ensure that convictions for workplace violence are not dismissed by district attorney offices. Additionally, the SLRC has advocated for mandatory reporting of workplace violence, similar to legislation in North Carolina, which requires hospitals to track and report such incidents.

ACEP Strategic Plan Reference

Career Fulfillment – ACEP supports you in addressing your career frustrations and seeking avenues for greater career fulfillment, and commits to addressing tough issues head on.

Advocacy – ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives.

Prior Council Action

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a

healthcare worker at the workplace.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. This resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against healthcare providers , advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on violence prevention issue and encourage the National Institute of Mental Health and Centers for Disease Control and Prevention, among others, to make financial support available for research.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

March 2024, February 2023, January 2022, and January 2022, continuing to advocate for reintroduction or passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved with the title "Protection from Violence in the Emergency Department" April 2016; revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

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Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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

2024 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice
Resolutions 43-62

Kurtis Mayz, JD, MD, MBA, FACEP – Chair
Sara Ann Brown, MD, FACEP – (IN)
Angela P. Cornelius, MD, FACEP (TX)
Dan Freess, MD, FACEP (CT)
Michael C. Smith, MD, MBA, FACEP (LA)
Carol Wright Becker, MD, FACEP (WV)

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

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RESOLUTION: 43(24)

SUBMITTED BY: Young Physicians Section
California Chapter
Careers in Emergency Medicine Section

SUBJECT: Addressing Challenges Related to the New ABEM Oral Board Exam Format

PURPOSE: Continue engagement with ABEM to delay implementation of the new oral board format; relocate the primary testing site to a more central US location; implement an income-based fee structure; oral board candidates will not bear undue financial burdens related to the newly proposed ABEM Oral Boards Update for 2026; provide a 5-year period after implementation during which the cost of retaking the new oral boards will be waived for those who do not pass; develop and implement a comprehensive, candidate facing, evaluation process for the new oral board examination; and to establish accommodations and alternative arrangements for candidates with health, safety, or legal concerns, who may face risks or challenges in traveling to the examination site.

FISCAL IMPACT: Budgeted staff resources.

1 WHEREAS, The American Board of Emergency Medicine (ABEM) announced a new oral board examination
2 format to begin in 2026[1]; and
3
4 WHEREAS, The new oral board examination format requires candidates to travel to a single testing site in
5 Raleigh, NC posing significant logistical and financial challenges for candidates, particularly those from the West
6 Coast, Alaska, and Hawaii[2]; and
7
8 WHEREAS, Requiring candidates to travel to a single testing site in Raleigh, NC may pose significant health
9 risks for pregnant candidates, particularly those experiencing complications that make travel inadvisable or dangerous;
10 and
11
12 WHEREAS, North Carolina's 12-week abortion ban may make it extremely challenging for pregnant
13 candidates experiencing complications to receive necessary medical care while traveling to Raleigh for the oral board
14 examination, potentially putting their health and well-being at risk[3]; and
15
16 WHEREAS, Emergency medicine residency programs and graduating residents may not feel adequately
17 prepared for the new oral board examination format by the proposed implementation date; and
18
19 WHEREAS, Some emergency medicine physician groups may not offer full salaried physician compensation to
20 doctors until they have achieved board certification[4], placing a significant financial burden on candidates who must
21 delay taking the oral board examination; and
22
23 WHEREAS, The cost of the new oral board examination may pose a financial burden for candidates,
24 particularly those with lower incomes or those who are required to make multiple attempts; and
25
26 WHEREAS, The American Medical Association has resolved to encourage national specialty boards holding
27 in-person centralized mandatory exams for board certification to provide alternate options when exams are conducted in
28 states with laws that ban or restrict abortion, gender-affirming care, or reproductive health care services, as such laws
29 may limit access to necessary medical care or pose threats of civil or criminal penalties to examinees and examiners[5];
30 therefore be it
31
32 RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to:

33 1. Explore delaying implementation of the new oral board examination format to allow for adequate
34 preparation by emergency medicine residency programs and graduating residents;
35 2. Relocate the primary testing site to a more central U.S. location or add an additional testing site in
36 the western half of the U.S. to reduce travel costs and minimize time zone impacts for candidates;
37 3. Implement an income-based fee structure for the new oral board examination to improve
38 affordability and accessibility for all candidates, including differentiating between early career
39 attendings and fellows;
40 4. Ensure oral board candidates will not bear undue financial burdens related to the newly proposed
41 ABEM Oral Boards Update for 2026;
42 5. Provide a 5-year period after implementation during which the cost of retaking the new oral boards
43 will be waived for those who do not pass;
44 6. Develop and implement a comprehensive, candidate facing, evaluation process for the new oral
45 board examination format to ensure that it equitably assesses communication, procedural skills,
46 patient management, high-stakes communication, difficult conversations, patient communications
47 beyond diagnosis, procedural skills, clinical decision making/shared decision making, team
48 management, leadership, troubleshooting, task switching, prioritization, and continues to bring
49 value to the public and diplomates;
50 7. Establish accommodations and alternative arrangements for candidates with health, safety, or legal
51 concerns, who may face risks or challenges in traveling to the examination site.

References

1. ABEM. *Certifying Exam.* https://www.abem.org/public/become-certified/certifying-exam. Accessed June 1, 2024.
2. ABEM. *Why Raleigh.* https://www.abem.org/public/docs/default-source/default-document-library/for-website_why-rale igh.pdf?sfvrsn=c4b1d3f4_1. Published January 11, 2024. Accessed June 1, 2024.
3. New York Times. *North Carolina Legislature Passes 12-Week Abortion Ban.* https://www.nytimes.com/2023/05/04/us/abortion-ban-north-carolina.html. Published May 4, 2023. Accessed June 1, 2024.
4. ACEP Policy Statement: "Emergency Physician Compensation Transparency" Approved October 2020
5. AMA Resolution – approved at AMA Annual Meeting House of Delegates, June 2024 *https://www.ama-assn.org/system/files/a24-refcomm-c-annotated.pdf*
   a. *"RESOLVED that our American Medical Association encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners."*

Background

This resolution calls for ACEP to continue engagement with the American Board of Emergency Medicine (ABEM) to revise and delay the implementation of the new oral board format set to begin in 2026. Specific asks to be addressed are: 1) delay implementation of the new oral board format to allow more time for programs to prepare residents; 2) relocate the primary testing site to a more central U.S. location or add additional sites; 3) implement an income-based fee structure; 4) ensure oral board candidates will not bear undue financial burdens; 5) provide a 5-year period after implementation during which the cost of retaking the new oral boards will be waived for those who do not pass; 6) develop and implement a comprehensive, candidate facing, evaluation process for the new oral board examination; and 7) establish accommodations and alternative arrangements for candidates with health, safety, or legal concerns, who may face risks or challenges in traveling to the examination site.

Prior to COVID-19, all emergency medicine residency graduates were required to take a qualifying written exam at a local testing center and then travel to Chicago for the oral certification exam. The oral board exams were moved to a virtual format during COVID. According to ABEM, the oral examination measures elements and competencies that are not measured on a written examination as evidence by a study showing that only moderate correlation between the two exams indicating that the exams are related but different. ABEM launched a Becoming Certified Taskforce in 2021 that was informed by a stakeholder advisory group. Multiple stakeholders from a broad range including emergency physicians from both academic and community practices, residents, residency program directors, department chairs, hospital leaders, patients and public, were invited to a summit in March of 2022. Key findings of the Becoming Certified initiative included:

- Assess additional skills and competencies important to the specialty.
- Create an assessment that is more relevant to practice and with the flexibility to adapt to changes in practice.
- Provide a format that can assess the aspects of emergency medicine practice that are not easily replaced by artificial intelligence.
- Provide candidates with a meaningful assessment experience. The current format of the virtual Oral Certification Exam (OCE) cannot adequately grow in size or structure to meet these needs; however, the specialty believes that an exam beyond medical knowledge is still needed.

The new format of the OCE will include clinical care cases and objective structured clinical examination (OSCE) cases. The clinical cases will be similar to the current OCE and will assess procedural skills, complex communication, professionalism, and other technical skills. Scenarios could involve standardized patient actors or procedural equipment.

Conducting the OCE, including the OSCEs, requires a specialized testing center. ABEM explored numerous options and sites that could meet the requirements. The AIME Center in Raleigh, NC was chosen because it is a state-of-the-art facility with flexible space that can accommodate clinical cases, procedural cases, and simulation. Using a single center will help ensure standardized testing for all candidates regardless of administration. The AIME Center has the infrastructure to support both simulation and a group of actors who work as Standardized Patients (SPs).

EMRA released a statement in January 2024 about the new ABEM certifying exam. EMRA's statement expressed several concerns: undue financial and logistical burden for newly-graduated emergency physicians, unclear patient outcome-based evidence showing a clear and proven benefit to in-person oral exams, and lack of stakeholder input since the Becoming Certified Task Force (BCTF) did not include resident or early-career physician representation.

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

None

Prior Board Action

None

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

Julie Rispoli
CUAP Accreditation Manager

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

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

RESOLUTION: 44(24)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations

PURPOSE: Advocate for CAH funding for EM resident rotations at rural CAHs; collaborate with CORD to enable CAHs and residency programs to use CMS funding for training residents to promote rural experience; task the Rural Emergency Medicine Section to maintain a rural rotation list as a resource for CORD; and request the ACGME to require emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

FISCAL IMPACT: Budgeted committee, section, and staff resources for continuing current initiatives.

1 WHEREAS, Rural patients have worse health outcomes than their urban peers and face significant barriers to
2 care including long distances to specialty care, primary care deserts, and hospital closures; and
3
4 WHEREAS, Rural emergency departments face significant future emergency physician staffing shortages; and
5
6 WHEREAS, The vast majority of US residencies (92%) are in urban areas and with no Accreditation Council
7 for Graduate Medical Education (ACGME) requirement for rural emergency medicine education; and
8
9 WHEREAS, Only 52% of emergency medicine residency programs offer a rural clinical rotation (ACEP 2020
10 Rural Task Force Report); and
11
12 WHEREAS, ACEP has previously issued the "Rural Emergency Medical Care" policy statement suggesting
13 rural electives as one possible avenue for improving rural access to board certified/board eligible emergency care; and
14
15 WHEREAS, Centers for Medicare & Medicaid Services (CMS) can potentially reimburse critical access
16 hospitals (CAHs) 101% of the cost of resident salaries but full reimbursement only applies to the percentage of patients
17 that are covered by Medicare, leaving any other care provided by residents to be funded by the hospital
18 (https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf); and
19
20 WHEREAS, CMS does not provide any additional funding for resident housing or travel to rural regions. This
21 is inadequate financial support for any critical access hospital or emergency medicine resident seeking to support rural
22 training; therefore be it
23
24 RESOLVED, That ACEP continue to advocate for additional critical access hospital funding to cover the full
25 salary, housing, and travel costs of emergency medicine resident rotations at rural Critical Access Hospitals; and be it
26 further
27
28 RESOLVED, That ACEP collaborate with the Council of Residency Directors in Emergency Medicine to
29 create clear pathways that enable rural Critical Access Hospitals and residency programs to use the existing partial
30 Centers for Medicare & Medicaid Services funding for training residents to promote rural clinical experiences including
31 using critical access hospitals as non-provider sites, building rural residency tracks, and expanding rural elective
32 opportunities; and be it further
33
34 RESOLVED, That ACEP support the Rural Emergency Medicine Section in maintaining a central "Rural
35 Rotation List" to be managed by the ACEP Rural Emergency Medicine Section and shared with the Council of
36 Residency Directors in Emergency Medicine; and be it further

37 RESOLVED, That ACEP request that the Accreditation Council for Graduate Medical Education require all
38 emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

Background

This resolution calls for ACEP to advocate for CAH funding for emergency medicine resident rotations at rural critical access hospitals (CAHs); collaborate with CORD to enable CAHs and residency programs to use CMS funding for training residents to promote rural experience; task the Rural Emergency Medicine Section to maintain a Rural Rotation list as a resource for CORD; and request the ACGME to require all emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

According to the AHA nearly 35% of hospitals in the US are considered rural. The "National Study of the Emergency Physician Workforce, 2020," reported that the nation's rural emergency physician shortage is expected to worsen in the coming years, the authors note. Of the 48,835 clinically active emergency physicians in the United States, 92 percent (44,908) practice in urban areas with just 8 percent (3,927) practicing in rural communities, down from 10 percent in 2008.

ACEP's current legislative and regulatory priorities for the Second Session of the 118th Congress include:

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs.
- Support innovative models of care that enable or promote access to emergency care, such as Rural Emergency Hospitals, digital health, Free Standing Emergency Departments, telehealth, etc.
- Identify innovative staffing, payment, and reimbursement models, such as potential global budgeting for emergency physician professional services to maintain viability of ED coverage in rural and underserved areas.

There are several barriers to rural experiences for emergency medicine residents. The complexities of the Medicare Graduate Medical Education funding is tied to resident rotating at the home institution, so when a resident rotates at rural site, it may result in the loss of the funding for the duration of the rotation. Additionally, the ACGME requirements may create challenges around supervision for rural rotations. Additionally, the ACGME requirements may create challenges for faculty and supervision of residents during rural rotations. According to section II.B.2.g) of the ACGME Program Requirements in Emergency Medicine:

> *Faculty members supervising emergency medicine residents in an adult emergency department must either be ABEM/AOBEM board-eligible or have current ABEM and/or AOBEM certification in emergency medicine.*

The 2022 Council and the Board of Directors adopted Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings and assigned the resolution to the Academic Affairs Committee. The resolution directed ACEP to support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work in rural settings; and support working with the Accreditation Council for Graduate Medical Education and Centers for Medicare and Medicaid Services to increase resident exposure and remove regulatory barriers to rural emergency medicine. The committee is in the process of developing an information paper and resources to help promote rural experiences for emergency medicine residents.

ACEP has had three separate task forces in the past ten years to address the issue of attracting emergency physicians to practice in rural areas. They have identified several strategies, including rural rotations for emergency medicine residents and loan forgiveness programs. However, a survey of emergency medicine residency graduates showed that few, if any, of those who answered the survey took jobs in the rural area, even though those jobs paid an average of $100,000 more in compensation and included loan forgiveness programs. Though they were not asked directly why they did not take rural positions, they were asked the major factors for their decision. The most common responses

were spouse, job needs, and to be near family. Despite an increased supply of emergency physicians and higher salaries in rural areas there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board-certified physicians working in rural EDs.

ACEP Strategic Plan Reference

Practice Innovation: Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.

Fiscal Impact

Budgeted committee, section, and staff resources for continuing current initiatives.

Prior Council Action

Amended Resolution 38(23) Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals adopted. Called for ACEP to advocate for sufficient reimbursement for emergency physician services in critical access hospitals and rural emergency hospitals to ensure the availability of board certified emergency physicians who possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient safety, and supporting the sustainability of health care services in rural communities.

Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings adopted. The resolution directed ACEP to support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work in rural settings; and support working with the Accreditation Council for Graduate Medical Education and Centers for Medicare and Medicaid Services to increase resident exposure and remove regulatory barriers to rural emergency medicine.

Resolution 49(22) Enhancing Rural Emergency Medicine Patient Care not adopted. The resolution called for ACEP to support initiatives that encourage the placement of emergency medicine-trained and board certified medical directors in all U.S. EDs, whether in person or virtual; support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-emergency medicine physicians, physician assistants, and nurse practitioners already working in rural EDs.

Resolution 35(21) Preserving Care in Rural Critical Access Hospitals and Rural Emergency Hospitals first two resolveds adopted and last three resolveds referred to the Board of Directors. The resolution directed ACEP to: 1) Support the rural critical access hospital program, including conversion of certain rural hospitals into rural emergency hospitals; 2) support rural health services research to better understand the optimal funding mechanism for rural hospitals; 3) support cost-based reimbursement for rural critical access hospitals and rural emergency hospitals at a minimum of 101% of patient care; 4) support changes in CMS regulation to allow rural off-campus EDs and rural emergency hospitals to collect the facility fee as well as the professional fee; and 5) advocate for insurance plans to aggregate all institutional and professional billing related to an episode of care and send one unified bill to the patient.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas adopted. The resolution directed that ACEP engage appropriate stakeholders, including at the federal and state levels, to find innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to work with stakeholders within the college including the Rural Emergency Medicine Section and chapters to provide a regular mechanism to seek input from rural physicians in legislation that impacts rural communities; seek rural

physician representation on the State Legislative/Regulatory Committee and the Federal Government Affairs Committee to reflect the fact that nearly half of all US EDs are located in rural areas.

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to Board. Directed ACEP to: 1) work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; 2) identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; 3) develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and 4) encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

Prior Board Action

March 2024, February 2023, January 2022, and January 2021 approved legislative and regulatory priorities that included several initiatives related to rural emergency care.

Amended Resolution 38(23) Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals adopted.

Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings adopted.

June 2022, approved the revise policy statement "Rural Emergency Medical Care" with the current title; originally approved June 2017 titled "Definition of Rural Emergency Medicine."

Resolution 35(21) Preserving Care in Rural Critical Access Hospitals and Rural Emergency Hospitals first two resolveds adopted.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas adopted.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" reaffirmed April 2012 and October 2006; originally approved June 2000.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

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

Julie Rispoli
CUAP Accreditation Manager

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

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

RESOLUTION: 45(24)

SUBMITTED BY: Tabitha Baca, MD
Marc Futernick, MD, FACEP
Gayle Galletta, MD, FACEP
Rita Manfredi-Shutler, MD, FACEP
Dana Mathew, DO, FACEP
Scott Mueller, DO, FACEP
Kristen Nordenholz, MD, FACEP
Matthew Siket, MD, FACEP
David Terca, MD, FACEP
Kreager Taber, MS4
Alexandra Thran, MD, FACEP
California Chapter
Vermont Chapter

SUBJECT: Climate Change Research and Education in Emergency Medicine

PURPOSE: 1) Encourage and support research efforts on the health effects of climate change; 2) Promote initiatives collecting data on climate-related health emergencies; and 3) Support medical school and residency program curricula addressing climate change.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, Climate change is recognized as a global health emergency, with adverse effects on public health,
2 including increased risks of heat-related illnesses, vector-borne diseases, and extreme weather events[1,2,3,4]; and
3
4 WHEREAS, Emergency medicine plays a vital role in responding to and mitigating the health consequences of
5 climate change, as emergency departments often serve as the first point of contact for individuals affected by climate-
6 related health emergencies[5]; and
7
8 WHEREAS, Evidence-based interventions are crucial for effective response and preparedness in the face of
9 climate change-induced health challenges[6]; and
10
11 WHEREAS, Research on the health effects of climate change and the role of emergency medicine in
12 addressing these effects is essential for developing efficient strategies for emergency preparedness, response, and
13 mitigation[7,8]; and
14
15 WHEREAS, The American Association of Medical Schools (AAMS) has endorsed producing climate-aware
16 physicians[9]; therefore be it
17
18 RESOLVED, That ACEP wholeheartedly encourage and support comprehensive research efforts on the health
19 effects of climate change and the pivotal role of emergency medicine in mitigating and responding to these effects; and
20 be it further
21
22 RESOLVED, That ACEP call for and promote initiatives to facilitate data collection on climate-related health
23 emergencies, such as heat-related illnesses, vector-borne diseases, and extreme weather events, to inform evidence-
24 based interventions, strengthen disaster preparedness, and enhance the capacity to respond effectively to climate
25 change-induced health challenges; and be it further
26
27 RESOLVED, That ACEP support the introduction of curricula that address climate change in medical schools
28 and residency programs.

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3. Patz JA, Frumkin H, Holloway T, Vimont DJ, Haines A. Climate change: challenges and opportunities for global health. JAMA. 2014;312(15):1565-1580. doi:10.1001/jama.2014.13186
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Background

This resolution calls for the college to encourage and support research efforts on the health effects of climate change; promote initiatives collecting data on climate-related health emergencies; and support medical school and residency program curricula addressing climate change.

In 2019, multiple public health, environmental health, patient advocacy, healthcare, nursing and medical organizations declared climate change a health emergency and call for immediate action to protect the public's health from the current and future impacts of climate change, and with climate change negatively impacting the health in the U.S. and around the globe, the American Medical Association (AMA) adopted policy in 2022 declaring climate change a public health crisis that threatens the health and well-being of all people. Additionally, the World Health Organization has called climate change the single greatest threat facing humanity.

The health impacts of climate change manifest both directly and indirectly. It alters the patterns of infectious disease transmission, leading to more frequent and severe outbreaks and pandemics; increases the incidence of heat-related illnesses; exacerbates chronic diseases; deteriorates mental health; and affects maternal and neonatal health. These effects often result in heightened demand for emergency medical services, which can lead to prolonged patient wait times, staffing shortages, worker fatigue, and compromised patient outcomes, depending on system-wide capacity and preparedness. To effectively address the current and future health challenges posed by climate change, it is imperative for the healthcare sector to be thoroughly prepared, with robust local leadership and adaptability. Emergency medicine is particularly well-positioned to assume a leading role in this regard, given its function as an acute care provider, a critical support for vulnerable populations, and a leader in disaster medicine. Its involvement is essential for addressing the needs of patients who are most adversely affected by these changing conditions.

A survey of 2,817 medical schools in 112 countries by the International Federation of Medical Students Association found that only 15% of medical schools taught climate change, and a second pilot study of US EM program directors showed that while most program directors believe that climate change and sustainability are important to EM, agreement with the importance of the inclusion of climate change in EM curricula was lower. In 2019, the AMA issued a policy on Climate Change Education Across the Medical Education Continuum, which states that the AMA *supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change*.

ACEP joined the Medical Society Consortium on Climate and Health, a consortium consisting of 25 state network groups and 56 major medical societies representing over 1 million physicians and health professionals, in 2022. The Medical Society Consortium on Climate and Health tasks itself with educating the public and local, state, and federal policymakers in government and industry about the harmful human health effects of global climate change.

ACEP's policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine"

states:

> "ACEP supports collaborating with public health agencies and other stakeholders to:
> - Raise awareness of the short- and long-term implications of climate change in population health and its effect in the practice of emergency medicine.
> - Engage in research examining the effects of climate change on human health, health care systems, and public health infrastructure.
> - Advocate for policies and practices to mitigate and address the effects of climate change on human health, health care systems, and public health infrastructure.
> - Expand and improve upon regional surveillance systems of emerging diseases related to extreme weather events linked to climate change.
> - Advocate for initiatives to reduce the carbon footprint of emergency departments and their affiliated institutions through energy conservation and health care waste reduction and/or recycling.
> - Educate patients on appropriate precautions in extreme weather, avoidance of exacerbation triggers, early identification of exacerbations, and temporizing measures when needed."

The Public Health Committee, in partnership with the Ethics Committee, is currently reviewing and revising this policy statement and will be developing a Policy Resource & Education Paper (PREP) as an adjunct to the policy statement.

ACEP Strategic Plan Reference

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 21(20) Medical Society Consortium on Climate & Health adopted. The resolution directed ACEP to become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

June 2018, approved the policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine."

Resolution 21(20) Medical Society Consortium on Climate & Health adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

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

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

RESOLUTION: 46(24)

SUBMITTED BY: Michael J. Bresler, MD, FACEP
Gus M. Garmel, MD, FACEP
Nicole Exeni McAmis, MD
California Chapter
Colorado Chapter
Georgia College of Emergency Physicians
Massachusetts College of Emergency Physicians
West Virginia College of Emergency Physicians

SUBJECT: Human Trafficking Training for All Emergency Medicine Residents

PURPOSE: Work with ABEM to incorporate education on human trafficking for EM residents; develop a standardized training presentation for all institutions to use; and incorporate education on human trafficking in *Scientific Assembly* offerings.

FISCAL IMPACT: Unbudgeted and unknown costs to develop a standardized training program by ACEP and ongoing review of the curriculum once developed. It would require diverting current budgeted staff resources from other initiatives to support this effort.

1 WHEREAS, Emergency physicians are one of the few groups of professionals likely to interact with victims of
2 human trafficking; and
3
4 WHEREAS, Up to 88% of victims of human trafficking come into contact with the healthcare system while
5 being trafficked[1,2,3,4]; and
6
7 WHEREAS, Approximately 64% of victims of human trafficking present to an emergency department[3]; and
8
9 WHEREAS, 57.8% of health care providers across the U.S. have not been trained in identifying human
10 trafficking, while 93.4% felt they would benefit from training[5]; and
11
12 WHEREAS, Emergency medicine providers are becoming increasingly aware of human trafficking victims in
13 health care settings due to modifications in practice to help facilitate disclosure; therefore be it
14
15 RESOLVED, That ACEP work with the American Board of Emergency Medicine to incorporate education on
16 human trafficking into *The Model of the Clinical Practice for Emergency Medicine* to ensure inclusion in all emergency
17 medicine residency training; and be it further
18
19 RESOLVED, That ACEP develop a standardized training presentation for human trafficking that can be used at
20 all institutions; and be it further
21
22 RESOLVED, That ACEP include education on human trafficking as part of the annual ACEP Scientific
23 Assembly.

References

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[4]Chisolm-Straker, M, Baldwin, S, Gaigbe-Togbe, B, Ndukwe, N, Johnson, PN, Richardson, LD. Healthcare and human trafficking: we are seeing the unseen. J Health Care Poor Underserved. 2016;27:1220-1233.
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Background

This resolution calls for ACEP to work with the American Board of Emergency Medicine (ABEM) to incorporate education on human trafficking for emergency medicine residents, develop standardized training presentations for institutions to use, and incorporate education on human trafficking in *Scientific Assembly* offerings.

The "2022 Model of the Clinical Practice of Emergency Medicine" does include Human Trafficking in Table 4, Section 14.6.5. This element was added in 2016 and should already be included in emergency medicine residency curricula.

At ACEP24 there are two lectures that address human trafficking and there have been two lectures per year at *Scientific Assembly* in the last 3 years:

> ACEP24: 2 lectures: Hidden Horrors: Unveiling Human Trafficking and Intimate Partner Violence in EM; Pediatric Sexual Assault: What Do You Need to Know?
>
> ACEP23: 2 lectures: Human Trafficking: It is Happening in Your ED; Abuse or Not Abuse: Interactive Visual Clues in Child Abuse
>
> ACEP22: 2 lectures: Sexual Assault, IPV & Human Trafficking: At Risk Patients in Your ED; Subtle Signs of Abuse: It's Not All About Bruises
>
> ACEP21: 2 lectures: Subtle Signs of Abuse: It's Not All About Bruises; Sexual Assault, IPV & Human Trafficking: At Risk Patients in Your ED

The "Human Trafficking" policy statement is quite comprehensive and recommends that physicians be familiar with potential signs, symptoms and indicators of human trafficking. It is recommended that hospitals and emergency departments (EDs) have protocols in place to manage this population. ACEP further recommends that "Emergency medical services (EMS), medical schools, and emergency medicine residency curricula should include education and training in recognition, assessment, documentation, and interventions for patients surviving human trafficking."

Amended Resolution 25(14) Human Trafficking directed ACEP and its chapters to 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 that "ACEP and its chapters work together to ensure indemnification for providers reporting suspected cases of human trafficking to the appropriate authorities." The Public Health & Injury Prevention Committee (PHIPC) developed an information paper, "Human Trafficking – A Guide to Identification and Approach for the Emergency Physician" that was reviewed by the Board in October 2015 in response to the resolution. The information paper was published in *Annals of Emergency Medicine* in October 2016 and it is available on the ACEP website. The PHIPC was also assigned an objective to explore development of a policy statement on human trafficking. The policy statement "Human Trafficking" was approved by the Board in April 2016.

Congress passed The Trafficking Victims Protection Act of 2000, which was designed to bring the full power and attention of the federal government to the fight against human trafficking. There have been at least nine federal acts addressing human trafficking since 2000.

The National Human Trafficking Hotline has a resource library with training materials and technical assistance

resources. The Joint Commission has resources on identifying potential victims of Human Trafficking. The American Hospital Association has many resources including webinars and suggested staff training.

Creation of a standardized training program by ACEP would require considerable unbudgeted staff time from Clinical Affairs, Legal, and Education Departments in addition to technical support for videos and other resources. It would also require the creation of a member-based workgroup to compile the materials with review of the materials on an ongoing basis after completion. Once compiled, residency programs would be able to utilize this resource as they are able to utilize existing resources on human trafficking. Residency programs have the freedom to determine what resources and training they provide.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Unbudgeted and unknown costs to develop a standardized training program by ACEP and ongoing review of the curriculum once developed. It would require diverting current budgeted staff resources from other initiatives to support this effort.

Prior Council Action

Amended Resolution 25(14) Human Trafficking adopted. Called for the College to support state and federal initiatives to reduce and eliminate human trafficking, coordinate efforts to educate pre -hospital and hospital emergency care providers about this issue and available resources.

Prior Board Action

July 2022, approved the revised policy statement, "2022 Model of the Clinical Practice of Emergency Medicine." Joint policy with American Academy of Emergency Medicine (AAEM), American Board of Emergency Medicine (ABEM), Council of Emergency Medicine Residency Directors (CORD), Emergency Medicine Residents' Association (EMRA), Residency Review Committee for Emergency Medicine (RRC-EM), and Society for Academic Emergency Medicine (SAEM)

February 2020, approved the revised policy statement "Human Trafficking;" originally approved April 2016.

October 2015, reviewed the information paper, "Human Trafficking – A Guide to Identification and Approach for the Emergency Physician."

Amended Resolution 25(14) Human Trafficking adopted.

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

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

RESOLUTION: 47(24)

SUBMITTED BY: Michael Bresler, MD, FACEP
Gus Garmel, MD, FACEP
Nicole Exeni McAmis, MD
California Chapter
Colorado Chapter
Massachusetts College of Emergency Physicians
New York Chapter
Oregon Chapter
West Virgina College of Emergency Physicians
Wisconsin Chapter

SUBJECT: Human Trafficking is a Public Health Crisis

PURPOSE: ACEP declare human trafficking as a public health crisis in the United States.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives related to human trafficking and communications to members and the public. Budgeted committee and staff resources to updated ACEP's "Human Trafficking" policy statement. Potential unknown and unbudgeted costs depending on the scope of a communications campaign and whether staff and financial resources are diverted from other projects.

1 WHEREAS, Emergency physicians have the privilege of working on the front lines of health care; and
2
3 WHEREAS, Emergency physicians have the responsibility to care for victims of human trafficking in our
4 communities; and
5
6 WHEREAS, Human trafficking is defined as "Recruitment, harboring, transportation, provision, or obtaining of
7 a person for labor or services, through the use of force, fraud, or coercion for the purpose of involuntary servitude, debt
8 bondage, or commercial sex acts;" and
9
10 WHEREAS, Human trafficking affects over 1 million people within the United States with 70% being women
11 and girls and one in four victims being children under the age of 18[1,2,3]; and
12
13 WHEREAS, Up to 88% of victims have come into contact with the healthcare system while being trafficked
14 with up to 64% being in the Emergency Department[4,5,6,7]; and
15
16 WHEREAS, Emergency department providers are often the only professionals that interact with trafficking
17 victims who are still in captivity; therefore be it
18
19 RESOLVED, That ACEP declare human trafficking is a public health crisis in the United States.

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[1]UN Office on Drugs and Crime (UNODC), *Global Report on Trafficking in Persons*, 2021. Available at: https://www.unodc.org/documents/data-and-analysis/tip/2021/GLOTiP_2020_15jan_web.pdf. Accessed October 2021.
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[6]Lederer, LJ, Wetzel, CA. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Ann Health Law. 2014;23:61-91.
[7]Chisolm-Straker, M, Baldwin, S, Gaigbe-Togbe, B, Ndukwe, N, Johnson, PN, Richardson, LD. Healthcare and human trafficking: we are seeing the unseen. J Health Care Poor Underserved. 2016;27:1220-1233.

Background

This resolution calls for ACEP to declare human trafficking a public health crisis in the United States.

ACEP has included support for legislation to prevent human trafficking and helping victims as part of its legislative priorities every year since 2019.

Human trafficking is a human rights violation affecting individuals of all ages and has significant implications for the physical, sexual, and psychological health of those affected. Trafficking victims are treated for acute injuries and illnesses in emergency departments more often than in any other health care facility and thus emergency physicians are in the best position to assess, intervene, and refer for assistance. It is estimated that approximately 24.9 million people worldwide are victims of human trafficking at any given moment, with more than 1 million affected in the United States alone. Among these victims, approximately 70% are women and girls, and one in four is a child under 18. Research suggests that over 60% of trafficking victims seek care at an emergency department at some point during their captivity. A study found that 68.3% of 173 trafficking victims surveyed had visited a health care provider, typically an emergency or urgent care facility, while being trafficked. Additionally, in 2023, according to the Nasdaq 2024 Global Financial Crime Report, $346.7 billion in illicit funds were linked to human trafficking.

ACEP's policy statement on "Human Trafficking" could be updated to declare human trafficking a public health crisis. A similar approach was taken to declare firearm violence a public health crisis by amending ACEP's "Firearm Safety and Injury Prevention" policy statement in response to Resolution 35(23) Declaring Firearm Violence a Public Health Crisis that was adopted by the 2023 Council and the Board of Directors. Additionally, ACEP could seek to work with the U.S. Surgeon General's office to declare human trafficking a public health crisis. The U.S. Surgeon General issued an advisory on June 25, 2024, declaring firearms violence a public health crisis. ACEP provided a brief quote from ACEP's President Aisha Terry, MD, FACEP, to be included in the press release on this issue: "By raising awareness of this public health crisis, the Surgeon General's Advisory on Firearm Violence Prevention speaks to the gun violence that emergency physicians observe all too often, as well as the repercussions on the communities they serve."

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives related to human trafficking and communications to members and the public. Budgeted committee and staff resources to updated ACEP's "Human Trafficking" policy statement. Potential unknown and unbudgeted costs depending on the scope of a communications campaign and whether staff and financial resources are diverted from other projects.

Prior Council Action

Amended Resolution 25(14) Human Trafficking adopted. Directed ACEP to: 1) work with chapters 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 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 2) work with chapters to ensure indemnification for providers reporting suspected cases of human trafficking to the appropriate authorities.

Prior Board Action

March 2024, February 2023, January 2022, January 2021, February 2020, and January 2019 approved a legislative priority to support legislation to prevent human trafficking and help victims.

February 2020, approved the revised policy statement "Human Trafficking;" originally approved April 2016.

June 2017, approved a grant to the Trauma & Injury Prevention Section for their project "ACEP Human Trafficking Curriculum: Defining Core Competencies and Developing Educational Online Resources for Emergency Medicine."

October 2015, reviewed the information paper, "Human Trafficking – A Guide to Identification and Approach for the Emergency Physician."

January 2015, approved a grant to the Minnesota Chapter for their project "Human Trafficking & Exploitation – Front Line Intervention."

Amended Resolution 25(14) Human Trafficking adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

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

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

RESOLUTION: 48(24)

SUBMITTED BY: Laurel Barr, MD, FACEP
Elyse Lavine, MD, FACEP
Samuel Sondheim, MD
AAWEP Section
Quality Improvement & Patient Safety Section
Young Physicians Section

SUBJECT: Alarm Fatigue

PURPOSE: Support research for evidence-based solutions to alarm fatigue in the ED and identify a multidisciplinary workgroup to develop evidence-based best practices to minimize clinically inactionable or false alarms.

FISCAL IMPACT: Unbudgeted and unknown costs to support research on alarm fatigue. Costs will vary depending on how the resolution is implemented, such as ACEP pursuing grant funding for external research.

1 WHEREAS, Management of the cardiac or undifferentiated patient in the ED often includes cardiac
2 monitoring; and
3
4 WHEREAS, 72-99% of clinical alarms are false[1] and one study demonstrated including up to 34% of alarms
5 for accelerated ventricular rhythm of which 95% were false or inactionable[1]; and
6
7 WHEREAS, High rates of clinically inactionable alarms result in desensitization to alarms, alarm fatigue, and
8 missed alarms[3] and The Joint Commission reported 80 deaths between 2009-2013 attributed to alarm fatigue[4]; and
9
10 WHEREAS, Despite alarm fatigue being the focus of a 2014 Joint Commission National Patient Safety Goal[1],
11 few strategies for reduction in the number of clinically significant alarms have been rigorously studied in the ED; and
12
13 WHEREAS, Methods for reducing alarms often differ between the ED and inpatient setting and best practices
14 on which alarms can be silenced, and which can be silenced after the initial alert is addressed (latching), would be
15 helpful to reduce clinically inactionable alarms; and
16
17 WHEREAS, With lack of evidence-based approaches to reduce monitoring, developing a system to limit false
18 alarms while preserving actionable alarms would require access to data from alarm vendors, and it is often difficult to
19 obtain data from vendors on numbers of clinically significant alarms; and
20
21 WHEREAS, The effective development and implementation of artificial intelligence could represent a unique
22 opportunity to help reduce the number of audible alarms to caregivers to combat alarm fatigue, therefore be it
23
24 RESOLVED, That ACEP support further research into evidence-based solutions to alarm fatigue in the
25 emergency department setting, with topics including indications for cardiac monitor use in the emergency department
26 for both cardiac and undifferentiated ED patients, appropriate silencing of clinical alarms including when latching
27 (silencing the alarm after the initial alert) is appropriate, indications to discontinue cardiac monitoring; and be it further
28
29 RESOLVED, That ACEP identify a workgroup to facilitate collaboration between clinicians, computer
30 scientists, industry vendors, and regulatory agencies to develop evidence-based best-practices to reduce clinically
31 inactionable alarms and alarm fatigue that can result in patient harm and avoidable deaths to build a culture of safety
32 around the use of cardiac monitors.

Resolution References
[1]Sendelbach S, Funk M. Alarm fatigue: a patient safety concern. AACN Adv Crit Care. 2013 Oct-Dec;24(4):378-86; quiz 387-8. doi: 10.1097/NCI.0b013e3182a903f9. PMID: 24153215.
[2]Drew BJ, Harris P, Zègre-Hemsey JK, et al. Insights into the problem of alarm fatigue with physiologic monitor devices: a comprehensive observational study of consecutive intensive care unit patients. PLoS One. 2014;9(10):e110274. doi: 10.1371/journal.pone.0110274.
[3]Hravnak M, Pellathy T, Chen L, Dubrawski A, Wertz A, Clermont G, Pinsky MR. A call to alarms: Current state and future directions in the battle against alarm fatigue. J Electrocardiol. 2018 Nov-Dec;51(6S):S44-S48. doi: 10.1016/j.jelectrocard.2018.07.024. Epub 2018 Jul 29. PMID: 30077422; PMCID: PMC6263784.
[4]Joint Commission. Medical device alarm safety in hospitals. Sentinel Event Alert. 2013 Apr 8;(50):1-3. PMID: 23767076.

Background

This resolution calls for ACEP to support research for evidence-based solutions to alarm fatigue in the ED and identify a multidisciplinary workgroup to develop evidence-based best practices to minimize clinically inactionable or false alarms.

Clinical alarm systems can alert caregivers to any problem ranging from a patient exiting their bed without assistance to dangerous arrhythmias. A valid clinical alarm correctly alerts the clinical staff to a change in the patient's physiology. Actionable alarms are those that do require intervention or attention. Invalid alarms are alarms that are neither actionable nor valid and have recently been measured to account for 85% to 99.4% of all alarms.[1] The frequency of false alarms leads to alarm fatigue. Alarm fatigue leads to increased response time, contributes to burnout, and contributes to missed actionable alarms. Beginning in 2013 and continuing through 2024, the Joint Commission's National Patient Safety Goals highlight the problems surrounding alarm fatigue by including "Reduce patient harm associated with clinical alarm systems" in their annual goals.[2] According to the Joint Commission, hospitals should be prioritizing alarm system safety and implementing changes in alarm parameters, staff training, and individualized monitor parameters.[2]

Alarm fatigue has been studied extensively, particularly from the nursing and intensive care perspective.[1] The American Association of Critical Care Nurses (AACN), for example, has researched and promoted the use of a CEASE bundle (Communication, Electrodes, Appropriateness, Setup, Education) to improve alarm management,[3] however, there is limited published research regarding implementation or long-term efficacy of this bundle. A systematic review of intelligent management interventions to reduce false alarms confirms that various strategies can improve nurse response time, but also calls for additional research to identify ways artificial intelligence can be used to improve clinical alarm systems.[4] The Association for the Advancement of Medical Instrumentation (AAMI) has also worked extensively with hospital executives, researchers, and The Joint Commission to develop strategies to improve alarm systems and reduce alarm fatigue.[5]

Despite the focus and research done by critical care and nursing organizations, there are no studies assessing the impact of these initiatives in the emergency department. There is little literature regarding false alarms, alarm fatigue, or patient outcomes in the emergency department when changes are made to alarm systems. Interventions studied have included reduction in telemetry/cardiac monitoring[6,7] and customizing alarm parameters for each patient.[8] Studies monitoring the impact of alarms and alarm fatigue in emergency medicine are also limited.[9,10]

ACEP does not have policy statements regarding alarm fatigue or reducing invalid alarms in cardiac monitoring, however, ACEP's policy statement "Protection of Physicians and other Health care Professionals from Criminal Liability for Medical Care Provided" includes the following information:

- Institution based physicians and other health care professionals should be able to rely on the integrity of institutional endorsed patient safeguards, automation, and alarm or warning systems.
- This system utilizing patient care technology should acknowledge the well validated adverse impact of "alarm fatigue" occurring in acute care settings, and develop a vendor partnered system to deliver only valid and appropriate warning alerts.

Background References
[1]Albanowski K, Burdick KJ, Bonafide CP, Kleinpell R, Schlesinger JJ. Ten Years Later, Alarm Fatigue Is Still a Safety Concern. *AACN Adv Crit Care*. 2023;34(3):189-197. doi:10.4037/aacnacc2023662
[2]Joint Commission. National Patient Safety Goals Effective January 2024 for the Hospital Program. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2024/npsg_chapter_hap_jan2024.pdf on August 6, 2024.
[3]Bosma S, Christopher R. Implementing a Unit-Based Alarm Management Bundle for Critical Care Nurses. *Crit Care Nurse*. 2023;43(2):36-45. doi:10.4037/ccn2023418
[4]Li B, Yue L, Nie H, et al. The effect of intelligent management interventions in intensive care units to reduce false alarms: An integrative review. *Int J Nurs Sci*. 2023;11(1):133-142. Published 2023 Dec 14. doi:10.1016/j.ijnss.2023.12.008
[5]Association for the Advancement of Medical Instrumentation (AAMI). Alarm Anthology. Retrieved from https://www.aami.org/anthology-alarm-management-solutions/alarm-anthology-a-robust-collection-of-knowledge on August 6, 2024.
[6]Krouss M, Israilov S, Alaiev D, et al. Tell-a provider about tele: Reducing overuse of telemetry across 10 hospitals in a safety net system. *J Hosp Med*. 2023;18(2):147-153. doi:10.1002/jhm.13030
[7]Horwood CR, Moffatt-Bruce SD, Rayo MF. Continuous Cardiac Monitoring Policy Implementation: Three-year Sustained Decrease of Hospital Resource Utilization. *Adv Health Care Manag*. 2019;18:10.1108/S1474-823120190000018007. doi:10.1108/S1474-823120190000018007
[8]Fujita LY, Choi SY. Customizing Physiologic Alarms in the Emergency Department: A Regression Discontinuity, Quality Improvement Study. *J Emerg Nurs*. 2020;46(2):188-198.e2. doi:10.1016/j.jen.2019.10.017
[9]Jämsä JO, Uutela KH, Tapper AM, Lehtonen L. Clinical alarms and alarm fatigue in a University Hospital Emergency Department-A retrospective data analysis. *Acta Anaesthesiol Scand*. 2021;65(7):979-985. doi:10.1111/aas.13824
[10]Fleischman W, Ciliberto B, Rozanski N, Parwani V, Bernstein SL. Emergency department monitor alarms rarely change clinical management: An observational study. *Am J Emerg Med*. 2020;38(6):1072-1076. doi:10.1016/j.ajem.2019.158370

ACEP Strategic Plan Reference

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

- Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.
- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

Unbudgeted and unknown costs to support research on alarm fatigue. Costs will vary depending on how the resolution is implemented, such as ACEP pursuing grant funding for external research.

Prior Council Action

None

Prior Board Action

June 2022, approved the policy statement "Protection of Physicians and other Health care Professionals from Criminal Liability for Medical Care Provided."

Background Information Prepared by: Kaeli Vandertulip, MBA, MS, AHIP
Clinical Practice Manager

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

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RESOLUTION: 49(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Texas College of Emergency Physicians
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: Centralized Repository of Credentialing Data

PURPOSE: 1) Create a policy statement advocating for the establishment of a centralized repository of verified primary source documents, work history, case logs, certificates of insurance, and other materials; and 2) Work with the AMA, AOA, FSMB, TJC, AHA, state agencies, and other interested parties to establish a recognized centralized repository of verified credentialing documents that can be used by all hospitals in the process of credentialing and privileging physicians at their facility that requires a minimum amount of additional submissions by physicians applying for privileges.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy statement. Working with the AMA and other organizations to create a centralized repository is not a current initiative of the College and is unbudgeted. It would require diverting staff time and resources from other initiatives to support this effort.

1 WHERAS, Emergency physicians are the safety net for society and our communities; and
2
3 WHERAS, Emergency physicians have always had a tradition of working at multiple facilities, often in
4 different states or regions within states; and
5
6 WHERAS, Movement of emergency physicians between states and practice locations has been shown to
7 increase willingness to provide additional hospital coverage and prolong the careers of emergency physicians; and
8
9 WHEREAS, The current process for granting hospital privileges to provide this coverage requires a
10 credentialing process; and
11
12 WHEREAS, Credentialing processes are focused on providing identical “primary source verification” of
13 relevant documents to verify the physicians identity and qualifications; and
14
15 WHEREAS, In past years doing this at each individual hospital was necessary based on 20th century concerns
16 to prevent individuals from falsifying their credentials; and
17
18 WHEREAS, The advent of instant digital communications and electronic verifications have essentially made
19 the established means of individual hospital verification antiquated; and
20
21 WHEREAS, Performing the exact same process repeatedly at each hospital is redundant, time consuming, and
22 expensive; and
23
24 WHERAS, Based on 21st century protections, state licensure compacts have been established to decrease this
25 type of burden on applicants; therefore be it
26
27 RESOLVED, That ACEP create a policy advocating for the establishment of a centralized repository of
28 verified primary source documents, work history, case logs, certificates of insurance, and other materials; and be it
29 further

30 RESOLVED, That ACEP work with the American Medical Association, the American Osteopathic
31 Association, the Federation of State Medical Boards, The Joint Commission, American Hospital Association, state
32 agencies, and other interested parties to establish a recognized centralized repository of verified credentialing
33 documents that can be used by all hospitals in the process of credentialing and privileging physicians at their facility
34 that requires a minimum amount of additional submissions by physicians applying for privileges.

Background

This resolution calls for ACEP to create a policy statement advocating for the establishment of a centralized repository of verified primary source documents, work history, case logs, certificates of insurance, and other materials and work with the AMA, AOA, FSMB, TJC, AHA, state agencies, and other interested parties to establish a recognized centralized repository of verified credentialing documents that can be used by all hospitals in the process of credentialing and privileging physicians at their facility that requires a minimum amount of additional submissions by physicians applying for privileges.

ACEP's policy statement, "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" and the corresponding Policy Resource and Education Paper (PREP) "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine" contain "guidelines to assist individuals and institutions in creating application procedures for hospital medical staff appointments in the department of emergency medicine (credentialing), plus delineation of clinical privileges in emergency medicine (privileging). The policy, and the PREP, includes a list of considerations for emergency medicine credentialing as well as a sample request for emergency medicine privileges. While physician credentialing is a medical staff and hospital process, these documents emphasize the role of the ED medical director and ED in the process of determining emergency physician credentialing and delineation of clinical privileges.

The Federation of State Medical Boards has established the Federation Credentials Verification Service (FCVS) as a way for physicians to store core credentials. FCVS has created a centralized, uniform process for obtaining primary source verified, medical education information, post graduate training, and examinations to create a permanent credentials profile that can be used throughout the medical professional's career. Core credentials verified by FCVS can be used for state licensure, hospital privileges, employment and professional memberships. FCVS is accredited by the National Committee for Quality Assurance (NCQA) and meets the requirements of The Joint Commission's ten principles for a primary source verification. Currently, FCVS focuses on educational information, but does not include work history, case logs, certificates of insurance, and other materials.

The National Association of Medical Staff Services (NAMSS) has a standardized form, the "Verification of Graduate Medical Education Training Form" (VGMET). NAMSS partnered with the American Hospital Association (AHA), the Accreditation Council for Graduate Medical Education (ACGME), and the Organization of Program Director Associations (OPDA) to develop the VGMET Form to streamline the process physicians and hospitals use to verify graduate medical education training and alleviate duplications associated with this credentialing step. The VGMET Form captures all primary-sourced components of a physician's medical-education history so hospitals can confirm this information from program directors and GME programs. The concept is that a GME program would create a completed and signed form for each graduate that is then included in the trainee's file that can be used to facilitate verification when requested in the future.

Several years ago ACEP offered a service where members could upload their personal information and documents into a cloud based system. However, ACEP was not able to do direct reporting because we could not verify the materials that were uploaded. There were other competing commercial products that were able to act as repositories and ACEP's service was discontinued.

ACEP Strategic Plan Reference

Career Fulfillment: Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

Budgeted committee and staff resources to develop a policy statement. Working with the AMA and other organizations to create a centralized repository is not a current initiative of the College and is unbudgeted. It would require diverting staff time and resources from other initiatives to support this effort.

Prior Council Action

Resolution 20(18) Verification of Training adopted. Directed ACEP to work with various stakeholders to support the development of standardized forms and applications to create a streamlined process for hospital credentialing.

Amended Resolution 15(03) Granting Clinical Privileges adopted. The resolution directed ACEP to revise the policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" to reflect that the emergency physician medical director or chief of emergency medicine, acting in a manner consistent with the hospital credentialing process, should be responsible for assessing and making recommendations to the hospital's credentialing body related to the qualifications of the ED's physicians with respect to the clinical privileges granted to that physician.

Resolution 53(95) Managed Care – Application and Certification adopted. This resolution states ACEP believes there should be a standardized application to be used by all managed care companies, with a single completed application centrally stored and distributed to managed care companies as required, with annual updated only if pertinent changes occur and that ACEP should work with other physician organizations to promulgate this policy.

Prior Board Action

January 2024, reaffirmed the policy statement "Emergency Medicine Training, Competency and Professional Practice Principles;" reaffirmed June 2018 and April 2012; revised and approved January 2006; originally approved November 2001.

Resolution 20(18) Verification of Training adopted.

August 2017, reviewed the revised PREP "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" originally published June 2006.

April 2017, approved the revised policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" revised and approved October 2014, June 2006, June 2004; reaffirmed October 1999; revised and approved September 1995, June 1991; originally approved April 1985 titled "Guidelines for Delineation of Clinical Privileges in Emergency Medicine."

Amended Resolution 15(03) Granting Clinical Privileges adopted.

Resolution 53(95) Managed Care – Application and Certification adopted.

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

Julie Rispoli
CUAP Accreditation Manager

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

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RESOLUTION: 50(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: Communication to Established Patients Being Referred to the Emergency Department

PURPOSE: 1) Gather information to quantify the extent of the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression; 2) develop feedback and a behavioral modification campaign to physicians through both general and specialty societies; and 3) action to advocate for appropriate payor incentives and disincentives to require physicians caring for patients with end stage or terminal diseases to educate them on prognosis and to make timely decisions about advance directives, hospice, and other palliative care.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Estimated costs of $250,000 for a consultant to conduct a study and an additional $50,000 to develop an educational and behavioral modification campaign and disseminate it to other medical societies depending on the social media requirements. This project would require diverting staff resources from other initiatives to support this effort.

1 WHEREAS, The Code of Ethics of the American Medical Association, the American Osteopathic Association,
2 and the American College of Emergency Physicians implicitly require that physicians fully communicate diagnostic,
3 treatment and prognostic information to their patients for the conditions that they are treating them for; and
4
5 WHEREAS, It is increasingly common for patients with complex medical conditions, such as end stage cancer,
6 to be sent to the Emergency Department (ED) with expected complications and disease progression for which their
7 doctors have not educated, discussed, or prepared them for, placing this burden on the emergency physician; and
8
9 WHEREAS, Patients with chronic or terminal diseases should be educated on their prognosis and disease
10 progression by their specialist in the appropriate outpatient setting; and
11
12 WHEREAS, Education by an emergency physician on prognosis and disease progression is inappropriate and
13 consumes large amounts of time and resources in the emergency department that could be devoted to other patients;
14 therefore be it
15
16 RESOLVED, That ACEP gather information to quantify the extent of the problem of patients with terminal or
17 end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression
18 of which they and their families were not educated by the physicians responsible for doing so; and be it further
19
20 RESOLVED, That information quantifying the extent of the problem of patients with terminal or end stage
21 diseases being referred to the ED for education and disposition of expected prognosis and disease progression be used
22 to develop feedback and a behavioral modification campaign to physicians through both general and specialty societies;
23 and be it further
24
25 RESOLVED, That ACEP take action to advocate that appropriate payer incentives and disincentives be
26 developed to require physicians caring for patients with end stage or terminal diseases to educate them on prognosis and
27 to make timely decisions about advance directives, hospice, and other palliative care.

Background

This resolution calls on ACEP to address the problem of patients who have terminal or end stage disease being referred to the ED by primary care physicians and specialists to be informed of the diagnosis, prognosis, and planning by studying the extent of the problem, work with other medical societies to develop a campaign to change the behavior of these referring physicians, and work with payers to develop incentives and disincentives to require physicians caring for patients with end stage or terminal diseases to educate them on prognosis and to make timely decisions about advance directives, hospice, and other palliative care.

The prevalence of chronic and behavioral health conditions is rising as the U.S. population ages and people often have multiple, complex underlying conditions. Half of adult Americans have at least one chronic condition and more than two-thirds of Medicare patients have two or more. People with complex, chronic, and behavioral health conditions contribute to higher health care costs and account for more than 90%t of the nation's $3.3 trillion in health care spending.

Hospitals, health systems and other health care workers are increasingly facing financial pressures, including decreased fee-for-service reimbursements and increased operating costs at a time when payers are driving them to take on more risk. Costs associated with chronic conditions are of particular concern for health care professionals participating in two-sided risk payment arrangements with commercial and public payers. High value networks, such as accountable care organizations (ACOs), and clinically integrated networks (CINs), for instance, must be able to provide high-quality care while efficiently managing the health care expenditures of these populations.

Patients with serious illness often have a lack of understanding of their disease process and prognosis. Patients are even sent to the ED after a life-altering critical test result without being informed of the diagnosis. Emergency physicians are often put in the situation of "breaking" the bad news to a patient they have just met. One study found that while 87% of patients with terminal cancer have documentation of a discussion with clinicians about their goals by the end of their lives, these discussions begin, on average, one month before death, and the majority take place in acute care settings with clinicians who are not the treating oncologist.[1] Literature suggests that having clear goals of care will improve quality of life, reduce hospital length of stay, ED visits, improve patient and family satisfaction, result in less utilization of intensive care, and provide significant cost savings.[2,3,4,5,6] Patients with chronic or terminal diseases should be educated on their prognosis and disease progression by their primary care physician or specialist in the appropriate outpatient setting. Education by an emergency physician on prognosis and disease progression consumes large amounts of time and resources in the emergency department that could be devoted to other patients. Conversations held by a patient's primary care team would allow better linkages to resources and ongoing care.

Per the AMA Code of Ethics, a patient has a right:

- *To courtesy, respect, dignity, and timely, responsive attention to his or her needs.*
- *To receive information from their physicians and to have the opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.*
- *To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.*

Additionally, the AMA Code of Ethics states: *The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.*

ACEP has multiple policy statements regarding the role of emergency medicine physicians such as the "Definition of Emergency Medicine" and "Emergency Physician Rights and Responsibilities." Emergency physicians are firmly committed to providing care for everyone who needs it and in emergency medicine anyone who has an emergency must be treated or stabilized, regardless of their insurance status or ability to pay. While emergency physicians are certainly capable and qualified to have these goals of care discussions when necessary; the question what roles the

emergency department should play in these conversations. The Geriatric ED Accreditation program (GEDA) guidelines state that "the provision of appropriate end-of-life care in the geriatric population is essential to a successful Geriatric ED program, and that the ED will provide access to palliative care and end-of-life care for medically complex patients in the Geriatric ED."

Background References

1. Paladino J, Bernacki R, Neville BA, et al. Evaluating an Intervention to Improve Communication Between Oncology Clinicians and Patients With Life-Limiting Cancer: A Cluster Randomized Clinical Trial of the Serious Illness Care Program. *JAMA Oncol.* 2019;5(6):801–809. doi:10.1001/jamaoncol.2019.0292
2. Beemath A, Zalenski R. Palliative emergency medicine: resuscitating comfort care? Ann Emerg Med. 2009;54: 103-105. 161. Ciemins EL, Blum L, Nunley M, et al. The economic and clinical impact of an inpatient palliative care consultation service: a multifaceted approach. J Palliat Med. 2007;10: 1347-1355.
3. Barbera L, Taylor C, Dudgeon D. Why do patients with cancer visit the emergency department near the end of life? CMAJ. 2010;182: 563-568.
4. Grudzen CR, Richardson LD, Hopper SS, et al. Does palliative care have a future in the emergency department? Discussions with attending emergency physicians. J Pain Symptom Manage. 2012;43: 1-9.
5. Penrod J, Deb P, Luhrs C, et al. Cost and utilization outcomes of patients receiving hospital-based palliative care consultation. J Palliat Med. 2006;9: 855-860.
6. Penrod J, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: effects on hospital cost. J Palliat Med. 2010;13: 973-979.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Estimated costs of $250,000 for a consultant to conduct a study and an additional $50,000 to develop an educational and behavioral modification campaign and disseminate it to other medical societies depending on the social media requirements. This project would require diverting staff resources from other initiatives to support this effort

Prior Council Action

Amended Resolution 31(11) End of Life Care adopted. Directed ACEP to study how emergency medicine can positively affect end of life care, specifically addressing the provision of compassionate and dignified end of life care, and the necessary stewardship of resources; work with other appropriate entities to address patient focused, compassionate end of life care; and update the membership regarding actions being taken by ACEP on the important topic of end of life care.

Prior Board Action

October 2023, approved the revised policy "Code of Ethics for Emergency Physicians"; revised and approved January 2017; revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved June 1997 with the current title; originally approved January 1991 titled "Ethics Manual."

March 2023, approved the revised policy "Guidelines for Emergency Physicians on the Interpretation of Portable Medical Orders"; originally approved April 2017 titled, "Guidelines for Emergency Physicians on the Interpretation of Physician Orders for Life-Sustaining Therapy (POLST)."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008 and July 2001; originally approved September 2000.

January 2021, approved the revised policy statement "Definition of Emergency Medicine;" revised and approved June 2015, April 2008, and April 2001; reaffirmed October 1998; revised April 1994 with the current title replacing "Definition of Emergency Medicine and the Emergency Physician."

April 2020, approved the revised policy statement "Ethical Issues at the End of Life;" reaffirmed April 2014; revised and approved June 2008 with the current title; originally approved September 2005 titled "Ethical Issues in Emergency Department Care at the End of Life."

Background Information Prepared by: Sam Shahid,
Director, Emergency Medicine Clinical Practice and Innovation

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

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

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RESOLUTION: 51(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: Consultant Communication and Feedback to Referring Emergency Physicians

PURPOSE: 1) Gather information to quantify the extent of poor communication and/or untimely feedback from consultants and/or hospitalists concerning ED patients and its impact on our mutual patients; and 2) Work with stakeholders and specialty societies to develop a campaign to improve communication and feedback to emergency physicians from consultants and/or hospitalists concerning ED patients.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Estimated costs of $250,000 for a consultant to conduct a study and an additional $50,000 to develop an educational and behavioral modification campaign and disseminate it to other medical societies depending on the social media requirements. This project would require diverting budgeted staff resources from other initiatives to support this effort.

1 WHEREAS, The Code of Ethics of the American Medical Association, the American Osteopathic Association,
2 and the American College of Emergency Physicians implicitly require that physicians treat each other with courtesy and
3 communicate information between each other for the benefit of the patient; and
4
5 WHEREAS, It seems increasingly common for specialists to not communicate their findings, decisions,
6 recommendations, and plans to the emergency physician; and
7
8 WHEREAS, Poor communication of recommendations or plans to the emergency physician can cause
9 dangerous delays in care that can be detrimental to both the involved patient and to the care of other patients in the
10 emergency department; therefore be it
11
12 RESOLVED, That ACEP gather information to quantify the extent of poor communication and/or untimely
13 feedback from consultants and/or hospitalists concerning emergency department patients and its impact on our mutual
14 patients; and be it further
15
16 RESOLVED, That ACEP, in coordination with other stakeholders and specialty societies, develop a campaign
17 to improve communication and feedback to emergency physicians from consultants and/or hospitalists concerning
18 emergency department patients.

Background

This resolution calls for ACEP to gather information to quantify the extent of poor communication and/or untimely feedback from consultants and/or hospitalists concerning emergency department (ED) patients and its impact on our mutual patients and to work with stakeholders and specialty societies to develop a campaign to improve communication and feedback to emergency physicians from consultants and/or hospitalists concerning ED patients.

The Joint Commission identified miscommunication as a leading cause of the adverse events reported by over 22 000 health care organizations between 2010 and 2022.[1] Several frameworks exist for best practices for communicating consults.[2,3] There is also a body of literature on communication regarding results of imaging procedures.

In response to Amended Resolution 32(15) Critical Communications for ED Radiology Findings, the Emergency Medicine Practice Committee developed "Guiding Principles for Critical Communication for Emergency Department Radiology Findings." ACEP leaders met with leaders of the American College of Radiology (ACR) in June 2016 and 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, "Interpretation of Imaging Diagnostic Studies." A draft revision was completed and reviewed by ACR. A significant concern raised by ACR was the inclusion of language addressing reimbursement for emergency physicians. ACR recommended that the language addressing reimbursement be eliminated from the policy. The Emergency Medicine Practice Committee believed the language concerning reimbursement should be retained in the policy, although it was softened to indicate any clinician providing contemporaneous interpretations is entitled to reimbursement. The ACEP Board of Directors reviewed the revised policy statement "Interpretation of Diagnostic Imaging Tests" in June 2018.

The American College of Radiology (ACR) has a practice parameter for Communication of Diagnostic Imaging Findings. The parameter states "Effective communication is a critical component of diagnostic imaging. Quality patient care can only be achieved when study results are conveyed in a timely fashion to those responsible for treatment decisions." The ACR also has a practice parameter for Radiologist Coverage of Imaging Performed in Hospital Emergency Departments. This parameter states "The timely interpretation of ED imaging examinations by qualified radiologists facilitates decisions regarding patient diagnosis, treatment, and the potential need for hospital admission. Radiologists should be available, either onsite or remotely via teleradiology, to provide timely interpretation of imaging examinations performed on ED patients. These interpretations are then promptly made available to the ED health care providers so they may be integrated into patient care decisions. Communication of the interpretation should be in accordance with the ACR Practice Parameter for Communication of Diagnostic Imaging Findings." ACEP does not have an analogous guidance for general consultation in the emergency department although there are several models available from other sources.

The College has not addressed feedback from consultations done in the ED beyond radiology. Feedback regarding the immediate care and recommended disposition of the patient is generally good, however, feedback on the ultimate outcome of the case is usually lacking. The one exception is when there is an adverse outcome. This lack of feedback is not true in other consultations between specialties and/or primary care. This lack of feedback, especially in admitted and transferred cases, provides an obstruction to learning and emphasizes the feedback of negative results.

ACEP has a grant with the Council of Medical Specialty Societies (S Schneider PI) to examine the feasibility of creating a feedback loop for emergency physicians. The Technical Expert Panel for this grant is beginning to grapple with basic questions such as which cases warrant feedback, the form and structure of that feedback, and whether the feedback is provided on an individual basis or group performance. The remainder of the grant is to examine the feasibility of creating a functional, efficient feedback process using our Emergency Medicine Data Institute as a prototype data repository.

ACEP's policy statement "Code of Ethics for Emergency Physicians" states:

> II.C.1. Relationships with other physicians
>
> "Emergency physicians must interact with other physicians to achieve their primary goal of benefitting patients. Channels of communication among physicians must remain open to optimize patient outcomes. Communication may, however, be delayed when a sick patient requires immediate and definitive intervention before discussion with other physicians can take place. When practical, emergency physicians should cooperate with the patient's primary care physician to provide continuity of care that satisfies the needs of the patient and minimizes burdens to other health care professionals. Emergency physicians should support the development and implementation of systems that facilitate communication with primary care physicians, consultants, caregivers, and others involved in patient care."

> "On-call physicians, like emergency physicians, are morally obligated to provide timely and appropriate emergency medical care. Emergency physicians should strive to treat consultants fairly and to make care as efficient as possible. In choosing consultants, emergency physicians may be guided by primary care physicians, patients and institutional protocols. If multiple physicians work in the ED, each patient should have clearly identified physician who is responsible for his or her care. Transfer of this responsibility should be communicated clearly to the patient, family, caregivers, and staff and should be clearly documented in the patient's medical record. When a patient is discharged from the ED, there must be a clearly communicated transfer of responsibility to the admitting inpatient physician or follow-up outpatient physician."

Background References

1. The Joint Commission on the Accreditation of Healthcare Organizations. Sentinel event data summary. n.d. Available: https://www.jointcommission.org/resources/sentinel-event/sentinel-event-data-summary/
2. Cohn SL. Communication With Consultants. PSNet [internet]. Rockville (MD): Agency for Healthcare Research and Quality, US Department of Health and Human Services. 2016.
3. Kessler CS, Kalapurayil PS, Yudkowsky R, Schwartz A. Validity evidence for a new checklist evaluating consultations, the 5Cs model. Acad Med. 2012 Oct;87(10):1408-12. doi: 10.1097/ACM.0b013e3182677944. PMID: 22914527.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Estimated costs of $250,000 for a consultant to conduct a study and an additional $50,000 to develop an educational and behavioral modification campaign and disseminate it to other medical societies depending on the social media requirements. This project would require diverting budgeted staff resources from other initiatives to support this effort.

Prior Council Action

Amended Resolution 32(15) Critical Communications for ED Radiology Findings adopted. Directed ACEP to 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.

Prior Board Action

October 2023, approved the revised policy "Code of Ethics for Emergency Physicians"; revised and approved January 2017; revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved June 1997 with the current title; originally approved January 1991 titled "Ethics Manual."

June 2018, approved the revised policy statement "Interpretation of Diagnostic Imaging Tests" revised and approved February 2013, and June 2006 with current title; reaffirmed October 2000; originally approved March 1990 titled "Interpretation of Diagnostic Studies."

April 2016, reviewed "Guiding Principles for Critical Communication for Emergency Department Radiology Findings."

Resolution 32(15) Critical Communications for ED Radiology Findings adopted.

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

Julie Rispoli
CUAP Accreditation Manager

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

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

RESOLUTION: 52(24)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Delegation of Critical Care to Non-Physician Practitioners

PURPOSE: Revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement to include that: emergency physicians should retain primary responsibility for performing critical care activities within EDs to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care scenarios effectively; credentialing processes must prioritize patient safety and quality of care, ensuring that physicians and non-physician practitioners are granted privileges to manage patients commensurate with their training; the scope of practice for nurse practitioners and physician assistants in EDs should be clearly defined, focusing on roles where their training and expertise can complement but not substitute for the specialized skills of emergency physicians in critical care.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, Emergency physicians are trained extensively in the management of critical care situations,
2 possessing specialized knowledge and skills crucial for delivering high-quality care in emergency settings; and
3
4 WHEREAS, Critical care requires a deep understanding of complex medical conditions, rapid decision-making,
5 and the ability to manage life- threatening situations promptly and effectively; and
6
7 WHEREAS, Emergency medicine residency programs need the following minimum procedures: Adult medical
8 and nontraumatic surgical resuscitation – 45; Adult trauma resuscitation – 35; Cardioversion/ Defibrillation/ Pacing – 6;
9 Central venous access – 20; Chest tube insertion – 10; Procedural sedation – 15; Cricothyrotomy – 3; Dislocation
10 reduction – 10; Endotracheal Intubation – 35; Lumbar puncture – 10; Pediatric medical and nontraumatic surgical
11 resuscitation – 15; Pediatric trauma resuscitation – 10; Pericardiocentesis – 3; Vaginal delivery – 10; emergency
12 department bedside ultrasound – 150[1]; and
13
14 WHEREAS, Standardized care protocols and guidelines established for critical care are essential for ensuring
15 consistent and reliable treatment outcomes, which may not be uniformly applied or understood across different
16 healthcare disciplines; and
17
18 WHEREAS, Nurse practitioners (NPs) and physician assistants (PAs) have had an increasing role in emergency
19 departments; and
20
21 WHEREAS, The training pathways and scope of practice for NPs and PAs differ significantly from those of
22 emergency medicine physicians, with potentially variable levels of experience and exposure to critical care scenarios.
23 In addition, there is no accepted national standard for non-physician provider emergency department training[2]; and
24
25 WHEREAS, Hospital medical staff committees recommend hospital privileges for physicians and non-
26 physician providers; and
27
28 WHEREAS, Medical staff committees require patient procedure logs, letters of recommendation, evidence of
29 training, and so on, during the intense credentialing and privileging process for physicians, however, medical staff
30 committees may require different training for non-physician providers who work in the emergency department and
31 grant privileges to non-physician practitioners who are not competent or trained to perform emergency department
32 duties; and

33 WHEREAS, This negligent credentialing where practitioners are granted privileges beyond their training or
34 competence levels poses significant risks to patient safety and quality of care in critical care settings and has legal
35 implications in almost 30 states[3,4] and, furthermore, emergency physicians and other physicians train and allow non-
36 physician practitioners to perform critical care management and procedures[5]; therefore be it
37
38 RESOLVED, That ACEP revise the "Guidelines Regarding the Role of Physician Assistants and Nurse
39 Practitioners in the Emergency Department"[6] policy statement to include that:
40
41 1. Emergency physicians should retain primary responsibility for performing critical care activities within
42 emergency departments to ensure that practitioners possess the requisite knowledge, skills, and experience
43 to manage critical care scenarios effectively; and
44 2. Credentialing processes must prioritize patient safety and quality of care, ensuring that physicians and non-
45 physician practitioners are granted privileges to manage patients commensurate with their training; and
46 3. The scope of practice for nurse practitioners and physician assistants in emergency departments should be
47 clearly defined, focusing on roles where their training and expertise can complement but not substitute for
48 the specialized skills of emergency physicians in critical care.

Resolution References

1. ACGME International. Case Log Information for Emergency Medicine Programs. 2018
2. Roberta Proffitt Lavin, Tener Goodwin Veenema, Lesley Sasnett, Sarah Schneider-Firestone, Clifton P. Thornton, Denise Saenz, Sandy Cobb, Muhammad Shahid, Michelle Peacock, Mary Pat Couig. Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments. Journal of Nursing Regulation. Volume 12, Issue 4, 2022. Pages 50-62
3. *Larson v. Wasemiller*, 738 N.W.2d 300 (Minn. 2007)
4. https://medicalmalpracticelawyers.com/6-1m-oklahoma-medical-malpractice-verdict-for-death- of-19-year-old-in-er/
5. Colin Campo. "Family waits for closure, wants answers about death after hospital restraint, intubation." The Courier April 4, 2023
6. ACEP. "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." Revised 2023.

Background

This resolution asks for ACEP to revise the policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement to address the supervision of PAs and NPs performing critical care activities within EDs to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care patients safely and effectively.

Emergency departments (EDs), which serve patients 24 hours a day, 7 days a week, play a vital role in the U.S. health care system. With over 130 million visits each year – 14% of which result in hospitalization – millions of Americans receive care in EDs.[1] In fact, EDs contribute nearly one-half of all hospital-associated medical care in the country; more than 4 in 10 hospitalized patients enter through the ED. Often the first stop for urgent or lifesaving care, EDs have also become the "safety net of the safety net," given the role they play in providing care to the uninsured and underinsured.[2]

The ED environment is distinguished by its imperative to swiftly and efficiently manage a wide array of medical conditions, frequently under significant time constraints and with limited initial information. This setting demands a high level of adaptability and expertise from healthcare professionals, who must deploy advanced diagnostic and therapeutic skills to navigate the considerable variability in patient presentations. The complexity of cases often necessitates rapid decision-making and the ability to integrate diverse clinical knowledge to provide effective, timely care. This dynamic and high-pressure environment underscores the critical need for healthcare professionals to exhibit exceptional clinical acumen and flexibility in their approach to patient management.

While NPs, PAs, and physicians (MDs and DOs) all work in EDs, each possess distinct academic degrees and licenses, complete a different number of clinical hours of training, and have different requirements for entry into practice. Physicians complete between 10,000 – 16,000 hours of clinical education and training, four years in medical school, and another three to seven years of residency training. By comparison, NPs complete between 500–720 hours

of clinical training during two or three years of graduate-level education.

ACEP has continued to highlight the significance of physician-led health care teams in the emergency care setting. ACEP advocates for a model in which emergency physicians lead and coordinate multidisciplinary teams to ensure comprehensive and high-quality patient care. By underscoring the central role of emergency physicians in directing clinical decisions, managing complex cases, and overseeing patient care, ACEP highlights the essential nature of their leadership in optimizing outcomes. This approach not only enhances the efficiency and effectiveness of emergency care but also ensures that patients receive timely and coordinated treatment across various aspects of their care. ACEP's efforts in promoting physician-led teams reflect a commitment to advancing standards in emergency medicine and improving overall patient safety and care quality.

A recent study showed that unsupervised NPs led to unnecessary tests and procedures, and hospital admissions. Overall, the study shows that NPs increase the cost of care in the emergency department by 7%, about $66 per patient, increased length of stay in the emergency department by 11% and raised 30-day preventable hospitalizations by 20%. While many other studies attempt to draw comparisons based on NPs or other nonphysicians who are actually practicing in collaborative arrangements with physicians, this study leverages data from a time—2017 to 2020, right before the pandemic—in which NPs within the Veterans Health Administration were truly practicing without physician supervision.

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states "the medical director of the ED and the director of emergency nursing should assess staffing needs on a regular basis." It further states: "staffing patterns should accommodate the potential for unexpected arrival of additional critically ill or injured patients. A plan should exist for the provision of additional nursing, physician assistant, advanced practice registered nurse, and physician support in times of disaster, natural or man-made." The policy also states that each nurse working in the ED should "provide evidence of adequate previous ED or critical care experience or have completed an emergency care education program. The CEN credential is an excellent benchmark."

ACEP launched a new national scope of practice campaign in correlation with National Doctors Day on March 30, 2022, Who Takes Care of You in an Emergency?, to educate people about emergency physicians' role and the vast difference in experience, education, and training compared to other members of the care team. In addition to the results of a national opinion poll on scope of practice issues, ACEP released a Chapter/Spokesperson toolkit with talking points, media materials (including a template op-ed), sample social media, and infographics. A series of videos were also created to better explain the vital role of emergency physicians.

Background References

1. Cairns, Christopher and Kang, Kai (2022). National Hospital Ambulatory Medical Care Survey: 2020 Emergency Department Summary Tables.
2. Institute of Medicine (US). Evidence-Based Medicine and the Changing Nature of Healthcare: 2007 IOM Annual Meeting Summary. Washington (DC): National Academies Press (US); 2008. PMID: 21391346
3. Chan, D. and Chen, Y. (2022) The Productivity of Professions: Evidence from the Emergency Department. National Bureau of Economic Research, Working Paper 3060

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

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

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work

with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and continue to promote the gold standard for physicians working in an ED is a board-certified/board-eligible emergency physician certified by the ABEM, AOBEM, or certified by the ABP in pediatric emergency medicine.

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing two policy statements. "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

June 2012, reviewed the information paper, "Physician Assistants and Nurse Practitioners in Emergency Medicine." The information paper was posted on the ACEP website.

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine. NCCPA advised they would contact the workgroup representatives regarding next steps, however, there was no further contact from NCCPA about the program.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted.

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

Julie Rispoli
CUAP Accreditation Manager

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

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

RESOLUTION: 53(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Emergency Nursing and Emergency Department Accreditation

PURPOSE: Collaborate with relevant organizations to modify the requirements for emergency nursing in the ED accreditation criteria.

FISCAL IMPACT: Budgeted staff resources for administration of the ED Accreditation Program and staffing support to the ED Accreditation Program Board of Governors. Delay in implementation of the ED accreditation program would result in lost revenue.

1 WHEREAS, The April 2021 ACEP-approved policy statement "Emergency Department Planning and
2 Resource Guidelines" states that "Appropriately educated and qualified emergency physicians, NPs, PAs, registered
3 nurses and ancillary staff should staff the ED during all hours of operation"[1]; and
4
5 WHEREAS, The April 2021 ACEP-approved policy statement "Emergency Department Planning and
6 Resource Guidelines" states that "Each nurse working in the ED should: Provide evidence of adequate previous ED or
7 critical care experience or have completed an emergency care education program. The CEN credential is an excellent
8 benchmark. Demonstrate evidence of the knowledge and skills necessary to deliver nursing care in accordance with the
9 Standards of Emergency Nursing Practice"[1]; and
10
11 WHEREAS, The April 2022 ACEP-approved policy statement "Emergency Department
12 Nurse Staffing" states that "The American College of Emergency Physicians (ACEP) supports emergency department
13 (ED) nurse staffing systems that provide adequate numbers of registered nurses who are trained and experienced in the
14 practice of emergency nursing"[2]; and
15
16 WHEREAS, The January 2024 ACEP-approved policy statement "Advocating for Certified Emergency Nurses
17 (CENs) in Departments of Emergency Medicine" states that "The American College of Emergency Physicians supports
18 the efforts of the Emergency Nurses Association (ENA) and the Board of Certification for Emergency Nursing (BCEN)
19 regarding defining standards of emergency nursing care and the provision of resources, support, and incentives for
20 emergency nurses to be able to readily attain Certified Emergency Nurses (CEN) certification"[3]; and
21
22 WHEREAS, In April 2024, ACEP released its Emergency Department Accreditation Criteria, modeled after the
23 successes of ACEP's Geriatric ED Accreditation (GEDA) Program, which argued that a "...tiered system aims to allow
24 any ED to obtain at least a level 3 accreditation easily, while Level 1 and 2 sites involve more significant investments
25 and demonstrate a true commitment to excellent geriatric care. Thus, access to accreditation is appealing to a range of
26 sites, from small, rural hospitals to tertiary care academic centers. Accreditation can add value to all of them.[4]"; and
27
28 WHEREAS, The ACEP Emergency Department Accreditation Criteria notes that this accreditation process
29 "will allow the public to find and utilize those facilities with the best staffing to handle any emergency" and also
30 "ensures that staff work in an environment that best supports their practice[4]"; and
31
32 WHEREAS, Despite the above support for emergency nursing, there are no requirements related to emergency
33 nursing in the ACEP ED accreditation pathway; therefore, be it
34
35 RESOLVED, That ACEP collaborate with relevant organizations to amend and include requirements for
36 emergency nursing within the tiered levels of the ACEP ED accreditation pathway.

Resolution References

1. https://www.acep.org/siteassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf
2. https://www.acep.org/patient-care/policy-statements/emergency-department-nurse-staffing/
3. https://www.acep.org/siteassets/new-pdfs/policy-statements/advocating-for-certified-emergency-nurses-cens-in-departments-of-emergency-medicine.pdf
4. https://www.acep.org/siteassets/sites/edap/media/documents/ed-accreditation-criteria.pdf

Background

The resolution asks for the College to collaborate with relevant organizations to modify the requirements for emergency nursing in the ED accreditation criteria.

ACEP's ED Accreditation Program will help improve patient care and promote fair, productive, and safe working environments for emergency physicians and other members of the emergency care team through the implementation of evidence-based policies and practices across all practice settings and all staffing models. The overall goal of ED accreditation is to elevate the practice of emergency medicine and the role of emergency physicians in leading the ED health care team. The accreditation criteria was developed based on ACEP's policies and the current accreditation criteria have been in development for several years. The criteria have been proposed by emergency physicians, written, and re-written by emergency physicians, and represent the values and desires of emergency physicians for their workplace. Most importantly, this program highlights staffing with board-certified emergency physicians and the importance of physician-led teams and recognizes the critical role of other clinicians and the need for resources to ensure that every patient receives the best possible care.

There were discussions with the Emergency Nurses Association (ENA) early in the development of the ED accreditation program about participating in the process. ENA declined to participate after exchanges about ACEP's goals for the program and the commitment to physician-led teams.

The initial ED accreditation criteria and levels were approved by the ACEP Board of Directors in March 2024 and a pilot application process was initiated. The ED Accreditation Board of Governors oversees the standards for each tier of ED Accreditation. The program has begun accepting pilot applications, with early pilot sites able to provide feedback of suggested improvements for future consideration.

ENA sent a letter to its members and issued a statement shortly after the public release of the criteria urging ACEP to delay the roll out of the program. ACEP was not contacted by ENA about their concerns prior to these actions. According to Becker's Healthcare, "the Emergency Nurses Association said the accreditation program does not recognize the vital role emergency nurses, nurse practitioners and advanced practice nurses play in successfully operating an ED." An additional concern raised by the ENA is that "the program does not allow nurse practitioners to work to their full scope of practice."

ACEP leaders and the ED Accreditation Board of Governors have held several meetings with ENA leadership since the concerns were expressed. ACEP strives to continue the dialogue with ENA about how to incorporate nursing criteria. ENA has stated that part of their public policy agenda is to support efforts to allow Advanced Practice Registered Nurses (APRNS) to practice autonomously and independently prescribe medication. Additionally, ENA will support public policies that remove restrictions on the role and scope of practice of Registered Nurses (RNs) and Advanced Practice Registered Nurses (APRNs) in appropriate health care settings. ENA will support efforts to allow these professionals to practice to the full extent of their education and training. The current ED accreditation criteria adheres to Council resolutions and ACEP policy statements that have been adopted addressing the need for supervision of nurse practitioners and physician assistants.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted staff resources for administration of the ED Accreditation Program and staffing support to the ED Accreditation Program Board of Governors. Delay in implementation of the ED accreditation program would result in lost revenue.

Prior Council Action

Amended Resolution 42(23) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and continue to promote that the gold standard for those physicians working in an ED is a board-certified/board-eligible emergency physician certified by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, or certified by the American Board of Pediatrics in pediatric emergency medicine.

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Prior Board Action-

April 2024 approved the revised ED Accreditation Program Criteria, with the "Blue Ribbon Recognition" approved only in "concept."

January 2024 approved the revised ED Accreditation Program Criteria; originally approved October 2023.

Amended Resolution 42(23) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

October 2023 approved the ED Accreditation Program Criteria.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse

Practitioners in the Emergency Department;" revised and approved March 2022 and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing two policy statements. "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

February 2023 approved establishing an ED Accreditation Program based on the business plan. Also approved the preliminary criteria and tiers for the accreditation program.

January 2023, agreed to proceed with adoption and execution of an accreditation program for Emergency Departments (ED's).

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

Background Information Prepared by: Nicole Tidwell
Senior Accreditation Program Manager

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

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

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

RESOLUTION: 54(24)

SUBMITTED BY: New York Chapter

SUBJECT: Mandated Public Health Screening

PURPOSE: Work with relevant stakeholders to prioritize the acute care and evaluation of emergent patients and not require routine unrelated screenings in the emergency department and develop a policy statement noting that mandating the ED to offer public health disease screening and behavioral health screening outside of the reason for the acute visit in the ED may have unintended consequences on workflow and care of ED patients.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, HIV, tobacco, and hepatitis screening and testing is being required in some states emergency
2 departments (ED) for all patients; and
3
4 WHEREAS, EDs are already overcrowded and serving as a safety net for the health care system; and
5
6 WHEREAS, These mandates do not come with additional funding or resources for already struggling EDs;
7 therefore be it
8
9 RESOLVED, That ACEP work with relevant stakeholders, including departments of health, to prioritize the
10 acute care and evaluation of emergent patients and not require routine unrelated screenings in the emergency
11 department; and be it further
12
13 RESOLVED, That ACEP develop a policy statement noting that mandating the emergency department to
14 offer public health disease screening and behavioral health screening outside of the reason for the acute visit in the
15 emergency department may have unintended consequences on workflow and care of emergency department patients.

Background

This resolution requests the College to work with relevant stakeholders to prioritize the acute care and evaluation of emergent patients and not require routine unrelated screenings in the emergency department and develop a policy statement noting that mandating the ED to offer public health disease screening and behavioral health screening outside of the reason for the acute visit in the emergency department may have unintended consequences on workflow and care of ED patients.

With recent policy changes, including the movement toward accountable care organizations as health delivery systems, there has been an increasing priority placed on both screening for social risk factors, (defined as the "adverse social conditions that are associated with poor health") and assessing social needs, or the patient's prioritization of social interventions. Although emergency department (ED) patient populations have a high prevalence of social risk, optimal strategies for identifying these factors within the busy and time-limited setting of the ED have yet to be described. The Joint Commission and other regulatory entities require that patients be assessed during an ED visit for a variety of high-risk situations (e.g., suicidal ideation, physical/sexual abuse, intimate partner violence [IPV]). Regulatory entities do not dictate when during the visit these assessments must occur, only that they must occur. To meet these regulatory assessment requirements, the temptation is to add them to the triage process, precisely because every patient is triaged, although these questions may not add to the assignation of an accurate acuity level. Risk assessment for social determinants of health and associated comorbidities such as mental health status, self-harm behaviors, and various types of abuse is often conducted during triage, yet the evidence is absent regarding whether

querying patients during the triage process is the most effective approach to identify at-risk patients. Required screenings and assessments may overburden the triage encounter, lengthening the process and delaying rapid assessment of patients in the triage queue.

Some believe that emergency medicine is uniquely positioned to address SDH as emergency physicians treat more than 25% of all acute care in the U.S. with more than 50% of that for the uninsured. Additionally, EDs are often referred to as society's "safety net," leading some to define the ED as a de facto environment for incorporating social context into patient care. EDs also see a growing demand for serving lower socioeconomic patients with unmet social needs. Others believe that taking on a SDH perspective could overburden already overwhelmed EDs and that it would interfere with the ED's primary mission of caring for acute medical issues, while others rebuttal that without treating patients adequately (to include SDH) patients will likely continue to return. Additionally, the added costs, lack of available follow-up services, and the potential impact on ED throughput. One study looking at the feasibility of incorporating a SDH screening process within an ED found that while they were able to demonstrate the ability to systematically screen and refer for needs, ensuring buy-in from staff conducting the screening was critical as well as ensuring that there were available resources within the community.

ACEP's policy statement "Screening for Disease and Risk Factors in the Emergency Department" states:

> "…ACEP recommends that EDs strongly consider screening for disease and risk factors based on the following criteria:
> - Screening should only occur if there is sufficient capacity, such that primary ED functions (treating emergency conditions) are not delayed, and key quality metrics are largely unaffected.
> - Screening processes should be developed to work within ED workflow and minimize impact on patients and ED staff.
> - Screening with inadequate or inappropriate follow-up systems available for the targeted disease or risk factor may lead to unintentional harm.
> - Screening should be performed in a manner that is financially sustainable to patients and the health system."

A supporting Policy Resource & Education Paper (PREP) "Principles of Screening for Disease and Health Risk Factors in the Emergency Department," which is an adjunct to the policy statement, was published in *Annals of Emergency Medicine*.

ACEP's policy statement "Social Services and Care Coordination in the Emergency Department" states: "ACEP recognizes the impact of health-related social needs (HRSN).…ACEP further recognizes that comprehensively addressing HRSN within the ED is best accomplished by dedicated staff, such as social workers, case managers, patient navigators, and other individuals with specialized training in social services delivery. Social service professionals are more experienced and better equipped than medical staff to coordinate outpatient follow-up care and social support services."

ACEP's policy statement ""Screening Questions at Triage," which is a joint policy statement with the Emergency Nurses Association, states:

> "Delays can occur when regulatory questions are routinely asked of patients during initial triage. Although screening for active thoughts of harm to self or others, substance use/abuse, and interpersonal violence can provide important information about the care some patients may require, the routine inclusion of general screening questions in the initial triage process creates a preventable delay in caring for patients. Screening information should be obtained after the initial prioritization process is complete and should not interfere with timely access to needed care."
>
> "The American College of Emergency Physicians and the Emergency Nurses Association support initial triage processes that limit the focus and content of questions to information pertinent to the patient's condition to determine the priority in which patients should be seen by an emergency physician, PA, or NP."

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

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

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted. Directed ACEP to seek to improve the recognition of, and attention to, social determinants of health by supporting research of evidence-based SDH screening and interventions in the ED; advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

Amended Resolution 46(14) Triage Screening Questions adopted. Directed ACEP to create a practice resource that identifies best practice triage processes.

Prior Board Action

October 2023, approved the revised policy statement "Social Services and Care Coordination in the Emergency Department;" revised and approved October 2020 titled "Social Work and Case Management in the Emergency Department;" revised and approved April 2019; originally approved October 2007 titled "Patient Support Services."

April 2022, approved the revised policy statement "Screening Questions at Triage;" originally approved October 2016.

April 2021 approved the policy statement "Screening for Disease and Risk Factors in the Emergency Department."

Amended Resolution 46(14) Triage Screening Questions adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
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Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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RESOLUTION: 55(24)

SUBMITTED BY: New York Chapter

SUBJECT: Patient Experience Reporting

PURPOSE: Work with relevant stakeholders to change reporting for ED patient experience scores to be based on mean score rather than percentile score and revise ACEP's "Patient Experience of Care" policy statement to advocate for mean score rather than percentile scores.

FISCAL IMPACT: Budgeted committee and staff resources for development and distribution of policy statements and ongoing advocacy initiatives.

1 WHEREAS, ACEP has recognized that patient experience of care surveys can be reflective of the patient's
2 perception of their health experience; and
3
4 WHEREAS, ACEP has noted survey issues include variable inclusion/ exclusion criteria, lack of
5 standardization, small sample sizes, and exclusion of the most acutely ill patients where emergency physicians
6 appropriate devote a disproportionate amount of time; and
7
8 WHEREAS, Factors leading to poor scores including wait times are often extrinsic to ED operations and
9 outside the control of ED staff; and
10
11 WHEREAS, ACEP has issued a policy statement on appropriate sampling; and
12
13 WHEREAS, Small variations in mean score can lead to drastic fluctuations in percentile ranking; and
14
15 WHEREAS, Mean scores are typically much higher and a better representation of a department's
16 performance than a more variable percentile ranking; therefore be it
17
18 RESOLVED, That ACEP work with relevant stakeholders to change reporting for ED patient experience
19 scores to be based on mean score rather than percentile score; and be it further
20
21 RESOVLED, ACEP revise the "Patient Experience of Care Surveys" policy statement to advocate for mean
22 score to be the reporting metric rather than percentile scores.

Background

This resolution calls for ACEP to work with relevant stakeholders to change reporting for ED patient experience scores to be based on mean score rather than percentile score and to revise the "Patient Experience of Care Surveys" policy to advocate for mean score rather than percentile. The current language of the policy statement includes the following language that aligns with the intent of the resolution to move away from percentiles.

> "Patient experience scores whether attributed to an individual physician, other elements of the department, or the entire ED must be criterion-referenced. The standard to which it is compared must be previously determined and applicable to similar institutions in similar settings. The use of rank ordered percentiles must be abandoned, given irrelevant meaning of such comparative positioning."

The 2023 Council and the Board of Directors adopted Amended Resolution 51(23) Quality Measures and Patient Experience Scores:

> RESOLVED, That ACEP advocate for alignment with current ACEP policy and previous recommendations that patient experience surveys be extended to all appropriate categories of emergency department patients to attempt to improve validity; and be it further
> RESOLVED, That ACEP oppose reimbursement metrics and employment decisions correlated with or dependent on patient experience surveys; and be it further
> RESOLVED, That ACEP work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

The resolution was assigned to the Emergency Medicine Practice Committee to revise the policy statement "Patient Experience of Care Surveys" to reflect the intent of Amended Resolution 51(23). The committee is still working on the revisions to the policy statement. Additionally, the Advocacy and Practice Affairs staff in Washington, DC, have been addressing the issue at the federal and regulatory levels.

In the past, and with input from ACEP members, CMS worked with the RAND Corporation on the Emergency Department Patient Experience of Care (EDPEC) survey, now renamed the Emergency Department Consumer Assessment of Healthcare Providers & Systems (ED CAHPS) survey. The program was introduced by CMS in the mid-2000s as part of the overall shift of healthcare from a fee-for-service to a pay-for-performance model. The program was designed to assess the experiences of adult ED patients who were subsequently discharged home. Importantly, acutely ill or injured patients who are admitted to the hospital are typically excluded. ACEP members were appointed to the Technical Expert Panel that modified the original ED PEC survey, making it more physician friendly. Even in its revised format, it was 24 questions long with an additional 11 demographic questions. CMS decided to not make the ED CAHPS survey mandatory. The current ACEP policy defines standardized inclusion and exclusion criteria for the patient populations and define improved methodologies.

In response to Amended Resolution 55(21) Patient Experience Scores, ACEP included specific recommendations about modifying the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) survey along with the ED CAHPS survey in response to the Calendar Year (CY) 2023 Physician Fee Schedule proposed rule. Specifically, ACEP cautioned CMS that most current vendors that would administer ED CAHPS do not survey a large enough sample size to allow for statistically valid individual physician attribution. We further urged CMS that we believe the patient engagement module ACEP offers for all participants of our qualified clinical data registry (QCDR), the Clinical Emergency Data Registry (CEDR) is superior to ED CAHPS and advocated that we believe strongly that performance improvement cannot be accomplished without the capability to give individual clinicians feedback and resultant skills training to improve physician-patient communication.

Hospitals and survey vendors may sample or receive responses from a small percentage of the patients seen in the emergency department (ED) potentially leading to results with poor validity. Currently, CMS states the minimum number is 30, and recommend 50, however that standard is not applied uniformly by physician groups and hospitals when they act on these scores. Press Ganey reports a response rate of 16.5%.

It should be noted that the use of patient experience scores during the pandemic had greater detrimental effect. It is widely known that boarding and crowding affect patient experience scores, particularly when they include the question "Did you receive timely care?"[1]

A 2013 JAMA study comparing CAHPS data and mortality, found that higher patient satisfaction was associated with lower emergency department utilization, higher inpatient utilization, greater total health care expenditures, and higher expenditures on prescription drugs. The most satisfied patients also had statistically significantly greater mortality risk compared with the least satisfied patients.[2]

Background References

1. Pines JM, Iyer S, Disbot M, Hollander JE, Shofer FS, Datner EM. The effect of emergency department crowding on patient satisfaction for admitted patients. Acad Emerg Med. 2008 Sep;15(9):825-31.

2. Fenton JJ, Jerant AF, Bertakis KD, Franks P. The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality. Arch Intern Med. 2012;172(5):405–411. doi:10.1001/archinternmed.2011.1662

ACEP Strategic Plan Reference

Career Fulfillment: Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

Budgeted committee and staff resources for development and distribution of policy statements and ongoing advocacy initiatives.

Prior Council Action

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted. Directed ACEP to advocate for alignment with current ACEP policy and previous recommendations that patient experience surveys be extended to all appropriate categories of emergency department patients to attempt to improve validity; oppose reimbursement metrics and employment decisions correlated with or dependent on patient experience surveys; and work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

Amended Resolution 55(21) Patient Experience Scores adopted. Directed ACEP to acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy; define standardized inclusion and exclusion criteria for patient experience survey populations; define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias, and appropriate power calculations such that sufficient surveys are collected to yield more statistically valid results; and advocate for patient experience survey validity and work with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Resolution 39(15) Patient Satisfaction Surveys in Emergency Medicine referred to the Board. Called for the College to acknowledge that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, many components of medical care not under physician control, and to oppose the use of patient satisfaction surveys for physician credentialing or for emergency medicine financial incentives or disincentives.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non -evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Resolution 43(13) Patient Satisfaction Scores not adopted. Called for the College to take a clear public stance to reject the continued use of non-valid patient satisfaction scoring tools in emergency medicine and that current patient satisfaction surveys should not be used to determine ED physician compensation and reimbursement. Referred to the Board of Directors.

Resolution 26(12) Patient Satisfaction Scores and Pain Management not adopted. Called for the College to work with appropriate agencies and organizations to exclude complaints from ED patients with chronic non -cancer pain from patient satisfaction surveys; to oppose new core measures that relate to chronic pain management in the ED; to continue to promote timely, effective treatment of acute pain while supporting treating physicians' rights to determine individualized care plans for patients with pain; and to bring the subject of patient satisfaction scores and pain management to the American Medical Association for national action.

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted. Directed ACEP to disseminate information to educate members about patient satisfaction surveys, including how emergency physicians armed with more knowledge can assist hospital leaders with appropriate interpretation of the scores and encourage hospital and emergency physician partnership to create an environment conducive to patient satisfaction.

Substitute Resolution 12(98) Benchmarking adopted. Directed ACEP to study and develop appropriate criteria for methodology and implementation of statistically valid patient satisfaction surveys in the ED.

Resolution 51(95) Criteria for Assessment of EPs adopted. States that ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by an individual emergency physician.

Prior Board Action

March 2024, February 2023, and January 2022, approved legislative and regulatory priorities that include advocating for patient experience validity and working with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted.

February 2023, approved the revised policy statement "Patient Experience of Care Surveys;" revised and approved June 2016 with the current title; originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 55(21) Patient Experience Scores adopted.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

February 2013, approved "Crowding" policy statement. Originally approved January 2006.

June 2011, reviewed the information paper "Emergency Department Patient Satisfaction Surveys."

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted.

Substitute Resolution 12(98) Benchmarking adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
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RESOLUTION: 56(24)

SUBMITTED BY: New York Chapter

SUBJECT: Patient and Visitor Code of Conduct

PURPOSE: Develop and adopt a universal code of conduct for patients and visitors in the emergency department.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, The provisions of EMTALA apply to all individuals who attempt to gain access to a hospital for
2 emergency care; and
3
4 WHEREAS, All patients deserve to be cared for with dignity in a safe environment; and
5
6 WHEREAS, Words or actions that are disrespectful, racist, discriminatory, hostile, or harassing are not
7 welcome in any workplace; and
8
9 WHEREAS, Workplace violence is a continued threat in all of our ED's and the top concern of most
10 emergency physicians; and
11
12 WHEREAS, The safety and wellbeing of emergency physicians is a priority for ACEP; and
13
14 WHEREAS, Some hospitals have already adopted a patient code of conduct; therefore be it
15
16 RESOLVED, That ACEP develop and adopt a universal code of conduct for patients and visitors in the
17 emergency department.

Background

This resolution calls for ACEP to develop and adopt a universal code of conduct for patients and visitors in the emergency department.

Violence in the emergency department is unacceptable. ACEP is working to strengthen protections for physicians, care teams and patients by increasing public awareness, advocating for policy changes, and developing resources to help professionals mitigate and respond to these incidents.

According to a January 2024 poll of ACEP members, 91% of emergency physicians said that they, or a colleague, were a victim of violence in the past year. In a 2022 ACEP survey, 85% of emergency physicians said they believe the rate of violence experienced in emergency departments has increased over the past five years.

The Board of Directors adopted the new policy statement in "Emergency Department Patient Rights and Responsibilities" in January 2024. The policy is a "Bill of Rights" that applies to every ED patient and also includes patient responsibilities:

- act with courtesy and respect to staff, patients, and visitors
- participate in communication and decision making
- comply with reasonable medical care and perform self-care
- respect other patients' privacy and confidentiality

- respect boundaries set for safety by staff
- be respectful and considerate of other patients, staff, and property
- never exhibit threatening, violent, abusive, or discriminatory speech or behavior"

ACEP's "Code of Ethics for Emergency Physicians" states: "Hospitals have a duty to provide adequate numbers of trained security personnel to assure a safe environment. Ensuring safety may mean that patients who present a high risk of violence will lose some autonomy if they need to be restrained physically or chemically."

ACEP's advocacy initiatives continue to support protecting emergency physicians from ED violence. Emergency physicians' support has led to the introduction of the "Workplace Violence Prevention Act for Health Care and Social Service Workers," H.R. 2663/S.1176), a bill introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI) that calls on the Occupational Safety and Health Administration (OSHA) to require health care and social service employers to create and implement workplace violence prevention plans.

ACEP also strongly supports the "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768) introduced by Reps. Larry Bucshon (R-IN) and Madeleine Dean (D-PA), and Sens. Joe Manchin (D-WV) and Marco Rubio (R-FL). The SAVE Act establishes federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP's letter of support can be found here. ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA) on January 30, 2024. Another congressional briefing was held on March 22, 2024, and co-hosted with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA).

ACEP and the Emergency Nurses Association have partnered since 2018 on the No Silence on ED Violence campaign to raise awareness, advocate for policy changes and strengthen protections for frontline workers. Emergency physicians can advocate within their own workplace using ACEP's sample checklist of safety and violence prevention measures that they can ask their workplace about to understand which are in place.

In early 2022, The Joint Commission established and began enforcing new workplace violence prevention requirements to guide hospitals in developing strong workplace violence prevention programs. ACEP contributed to the development of these new requirements by participating in an expert workgroup and supplying comments.

Many health systems have Patient Rights and Responsibilities. Some examples include:

- Texas Health Resources (TX) "Aggressive behavior will not be tolerated. Examples of aggressive behavior includes physical assault, verbal harassment, abusive language and threats."

- St. Elizabeth Healthcare (KY) "Aggressive language or violent behavior will not be tolerated on hospital grounds." "There is a zero tolerance of all forms of aggression. In accordance with Kentucky law, these types of incidents may result in removal from this facility, potential arrest and prosecution. St. Elizabeth Healthcare fully supports associates reporting to law enforcement aggressive or violent behavior they encounter on hospital premises."

- Inova (VA) "… zero tolerance for inappropriate language or behavior that is aggressive, disruptive or threatening. This allows us to ensure a safe and positive healing environment for everyone at our care sites."

- WellSpan (PA) "As a patient, family member or health care representative, we expect that you: recognize and respect the rights of other patients, families and staff. Any threatening, violent or harassing behavior exhibited toward other patients, visitors and/or care location staff for any reason,…"

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

Resolution 34(22) Emergency Department Safety adopted. Directed ACEP to work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state, and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. The resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against health care providers, advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on this issue and encourage the National Institute of Mental Health and Centers for Disease Control and Prevention, among others, to make financial support available for research 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 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

March 2024, approved the legislative and regulatory priorities for the 2nd session of the 118th Congress that includes continuing to advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

January 2024, approved the policy "Emergency Department Patient Rights and Responsibilities."

October 2023, approved the revised policy "Code of Ethics for Emergency Physicians"; revised and approved January 2017; revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved June 1997 with the current title; originally approved January 1991 titled "Ethics Manual."

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

Resolution 34(22) Emergency Department Safety adopted.

June 2022, approved revised policy "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved April 2016 and June 2011 with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

April 2021, approved the policy statement "Safer Working Conditions for Emergency Department Staff."

Resolution 55(17) Workplace Violence adopted.

May 2016, reviewed the information paper "Emergency Department Violence: An Overview and Compilation of Resources."

November 2015, reviewed the information paper, "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

August 2014, reviewed the information paper "Hospital-Based Violence Intervention Programs."

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

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

Julie Rispoli
CUAP Accreditation Manager

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

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

RESOLUTION: 57(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: Rationalizing Communication of Imaging Hazards to Improve Care

PURPOSE: 1) Create a task force, in conjunction with the American College of Radiology and other stakeholders to develop a policy statement or other resource information on the rational communication of imaging hazards to emergency patients; and 2) provide information to hospital imaging departments and Chief Medical Officers to update their imaging and patient communication and consent policies to be consistent with the findings in a policy statement or other resource information developed by ACEP, the American College of Radiology, and other stakeholders.

FISCAL IMPACT: Unbudgeted travel expenses of $20,000 – $30,000 for in-person stakeholder/task force meeting depending on the size of the group. Unbudgeted resources for staff support and additional unknown and unbudgeted costs depending on the scope of work.

1 WHEREAS, Imaging is necessary for the practice of emergency medicine and the care of emergency patients;
2 and
3
4 WHEREAS, There are certain known risks to imaging modalities, including radiation, and contrast reactions;
5 and
6
7 WHEREAS, Much has been learned over the decades about the actual risks associated with specific types of
8 imaging and the types of reactions to contrast dye, which has evolved in terms of its safety; and
9
10 WHEREAS, The National Institute of Health advises that in pregnant patients there is zero radiation risk to
11 fetuses when the imaging beam is not pointed the uterus; and
12
13 WHEREAS, The risk of radiation to patients varies based upon the type of imaging and the age of the patient
14 with CT scans being the highest risk; and
15
16 WHEREAS, The concept of "contrast allergy" is based upon reactions to iodinated contrast that is no longer
17 used in the United States; and
18
19 WHEREAS, Reactions to other forms of imaging contrast are believed by most experts to be idiosyncratic and
20 unpredictable; and
21
22 WHEREAS, Nephrotoxicity from imaging contrast has improved over time with the development of better
23 contrast agents;
24
25 WHEREAS, A number of large studies show nephrotoxicity from imaging is now minimal; and
26
27 WHEREAS, Emergency physicians must frequently make decisions that balance risks and benefits of
28 imaging with potentially immediately life-threatening diagnoses that are otherwise difficult to diagnose; and

29 WHEREAS, Radiology policies and procedures in many hospitals are designed for routine outpatients
30 receiving these studies and not specifically focused on the lifesaving benefits of imaging for emergency patients; and
31
32 WHEREAS, It is not unusual for radiology personnel following hospital policies and protocols to frighten
33 Emergency Department (ED) patients, especially pregnant ones, by overstating the risks of imaging or contrast as we
34 now understand them to patients and families; and
35
36 WHEREAS, This creates distrust and otherwise very difficult situations for emergency physicians, placing a
37 barrier between them and their patients; and
38
39 WHEREAS, This is not conducive to good patient care and the identification of life-threatening emergencies to
40 facilitate proper disposition and treatment; therefore be it
41
42 RESOLVED, That ACEP create a task force, ideally in conjunction with the American College of Radiology
43 and other stakeholders, to develop a policy statement or other resource information on the rational communication of
44 imaging hazards to emergency patients; and be it further
45
46 RESOLVED, That information be transmitted to hospital imaging departments and Chief Medical Officers for
47 the purpose of updating their imaging and patient communication and consent policies to be consistent with the findings
48 in a policy statement or other resource information developed by ACEP, the American College of Radiology, and other
49 stakeholders.

Background

This resolution seeks for the College to create a task force in conjunction with the American College of Radiology and other stakeholders to develop a policy statement or other resource information on the rational communication of imaging hazards to emergency patients. Additionally, the resolution requests that information be transmitted to hospital imaging departments and Chief Medical Officers for the purpose of updating their imaging and patient communication and consent policies to be consistent with the findings in a policy statement or other resource information developed by ACEP, the American College of Radiology, and other stakeholders.

Diagnostic imaging has revolutionized the practice of medicine and is essential in emergency medicine, though it carries risks such as radiation exposure and contrast reactions. Patient safety has improved over time as knowledge of the risks has evolved. For example, the National Institutes of Health states that when imaging beams are not directed at the uterus, there is no radiation risk to fetuses. Risks vary by imaging type with CT scans having the highest risk. Reactions to contrast agents are generally unpredictable but have become less severe with improved agents. Despite these advancements, radiology policies often focus on routine outpatient care rather than the urgent needs of emergency patients, which can lead to overstated risk warnings that can create distrust and complicate patient care in the ED.

The refusal of imaging studies in emergency departments (EDs) is a notable issue but can vary widely depending on several factors, including patient demographics, medical conditions, and institutional practices. Precise statistics on the percentage of patients who refuse imaging studies specifically are not universally available, however:

- Refusal rates for imaging in the ED can range from 1% to 10% of patients, depending on the study and context. Factors influencing refusal include the patient's understanding of the need for imaging, perceived severity of their condition, concerns about radiation exposure, and financial constraints.

- Studies have shown that refusal rates can be higher among certain groups, such as those with lower health literacy, non-English speakers, or individuals with a history of distrust in the healthcare system. Additionally, patients who are anxious or have high levels of pain may be more likely to refuse imaging.

- When patients refuse recommended imaging, it can impact diagnostic accuracy and potentially lead to missed diagnoses or delayed treatment. In some cases, refusal may be due to concerns about radiation or the cost of procedures, highlighting the need for effective communication and education by healthcare providers.

- The refusal rate can also vary by institution and is influenced by the ED's protocols, the approach of the medical staff in explaining the need for imaging, and the availability of alternative diagnostic methods.

Overall, while specific statistics can vary, understanding the reasons behind imaging refusal and addressing patient concerns through clear communication and education can help improve compliance and patient outcomes in the ED setting.

ACEP has participated in and supported various efforts regarding imaging practice targeted at both physicians and patients during the past year. ACEP was a supporting organization for the Image Wisely and Image Gently campaigns, attended and participated in multiple American College of Radiology (ACR) Summits, and National Council on Radiation Protection and Measurements workshops. ACEP continues to partner with ACR on the development of their Appropriateness Criteria and has developed multiple policy statements related to the use of imaging, such as:

- "Emergency Ultrasound Imaging Criteria Compendium"
- "Optimizing Advanced Imaging of the Pediatric Patient in the Emergency Department"
- "Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine"

A complete list of ACEP's imaging policy statements can be found on the ACEP website.

ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Unbudgeted travel expenses of $20,000 – $30,000 for in-person stakeholder/task force meeting depending on the size of the group. Unbudgeted resources for staff support and additional unknown and unbudgeted costs depending on the scope of work

Prior Council Action

Substitute Resolution 27(12) Radiation Exposure in the Emergency Department Patient adopted. Directed ACEP to work with appropriate stakeholders to promulgate techniques to minimize radiation exposure.

Prior Board Action

Substitute Resolution 27(12) Radiation Exposure in the Emergency Department Patient adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

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

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

RESOLUTION: 58(24)

SUBMITTED BY: Rita Manfredi-Shutler, MD, FACEP
Kristen Nordenholz, MD, FACEP
Matthew Siket, MD, FACEP
Alexandra Thran, MD, FACEP
Vermont Chapter

SUBJECT: Reducing Waste in Our Emergency Departments

PURPOSE: 1) Encourage and support comprehensive research efforts to facilitate data collection of the measurements of ED waste and energy consumption; 2) Work with stakeholders to decrease energy consumption and decrease the amount of hospital waste; and 3) Support research to decrease waste in the health care sector.

FISCAL IMPACT: Budgeted committee and staff resources to update ACEP's "Impact of Climate Change on Public Health and Implications for Emergency Medicine" policy statement. Unbudgeted staff resources and unbudgeted and unknown costs to work with stakeholders to decrease energy consumption and hospital waste and support research to decrease waste in the health care sector.

1 WHEREAS, The health care sector especially in developed countries produce significant amounts of multiple
2 types of waste[1]; and
3
4 WHEREAS, The total amount of waste generated by health-care activities, about 85% is general, non-
5 hazardous and 15% is considered hazardous material that may be infectious, toxic or radioactive[1];
6
7 WHEREAS, Evidence-based interventions are crucial for effective response and preparedness in the face of
8 climate change-induced health challenges [2];and
9
10 WHEREAS, CMS has developed the CMS Innovation Center, a voluntary Decarbonization and Resilience
11 Initiative which is designed to address threats posed by climate change to the nation's health and health care system by
12 collecting, monitoring, assessing, and addressing hospital carbon emissions and their effects on health outcomes,
13 costs, and quality[3]; therefore be it
14
15 RESOLVED, That ACEP wholeheartedly encourage and support comprehensive research efforts to facilitate
16 data collection of the measurements of emergency department waste and energy consumption; and be it further
17
18 RESOLVED, That ACEP work with stakeholders, such as hospital administrations, to decrease energy
19 consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro
20 plastics, and non-recycled glass, as well as biohazard/medical waste; and be it further
21
22 RESOLVED, That ACEP work to support research to decrease waste in the health care sector.

References

1. World Health Organization. (n.d.). *Health-Care Waste*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/health-care-waste
2. Knowlton K, Rotkin-Ellman M, King G, et al. The 2006 California heat wave: impacts on hospitalizations and emergency department visits. Environ Health Perspect. doi:10.1016/S0140-6736(06)68933-2
3. Centers for Disease Control and Prevention. (2024a, June 11). *NAMCS/NHAMCS - Ambulatory Health Care Data Homepage*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/ahcd/index.htm

Background

This resolutions directs ACEP to: 1) encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; 2) work with stakeholders, such as hospital administrations to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics and non-recycled glass, as well as biohazard/medical waste; and 3) support research to decrease waste in the health care sector.

The health care sector has a large supply chain that generates huge amounts of waste, uses enormous amounts of chemicals and pharmaceuticals, and demands significant food production and disposal, all of which contribute to pollution. According to *The Lancet*, climate change is the biggest public health threat of the 21st century and hospitals in the United States generate a total of 14,000 tons of waste per day, 20% to 25% of which is plastic products or packaging. The health care sector's supply chain is the second largest expense in health care after labor and is a significant contributor to waste and pollution. The health care sector is also the single largest consumer of chemicals in the United States, spending more than twice the amount spent by the next-largest-consuming sector, and is also the largest consumer of pharmaceuticals worldwide.

Emergency departments (EDs) produce various types of waste due to the nature of their operations. The main types of waste generated include:

- Medical Waste: includes items that have been in contact with bodily fluids or are considered hazardous such as sharps, infectious waste, and pathological waste/
- Chemical Waste: includes unused or expired pharmaceuticals, chemicals used in diagnostic tests or treatments, and cleaning agents.
- Hazardous Waste: encompasses any waste that poses a risk to health or the environment, such as some chemical agents or certain types of batteries.
- General Waste: non-hazardous, non-recyclable waste, including packaging materials and food waste.
- Recyclable Waste: items that can be sorted for recycling, such as paper, cardboard, and certain plastics. Efforts to increase recycling in EDs can help reduce overall waste.
- Electronic Waste: discarded or obsolete electronic equipment, including old monitors, computers, and medical devices.

"Climate Smart Healthcare" is a term defined in the 2017 joint report by the World Bank Group and Health Care Without Harm, referring to the combination of low-carbon and resilient health care strategies. Key features of climate-smart health care include waste minimization and sustainable waste management; low-carbon procurement policies for products, supplies, and pharmaceuticals; energy and water efficiency; sustainable transportation policies; and resilience strategies to withstand extreme weather events.

Transitioning to renewable energy, reducing fossil fuel use, and cutting greenhouse gas emissions offer immediate health and environmental benefits. Climate smart healthcare can be both environmentally protective and economically advantageous, potentially saving U.S. hospitals nearly $1 billion over five years through energy efficiency improvements. Additionally, implementing waste reduction and operational efficiency measures could save more than $5.4 billion in five years and $15 billion in ten years for the entire U.S. health care sector. Resilience strategies are crucial for withstanding extreme weather events that can disrupt hospital infrastructure, supply chains, and essential services. Health leaders can ensure operational continuity during crises and preserve financial stability by committing to climate resilience.

ACEP joined the Medical Society Consortium on Climate and Health, a consortium consisting of 25 state network groups and 56 major medical societies representing over 1 million physicians and health professionals, in 2022. The Medical Society Consortium on Climate and Health tasks itself with educating the public and local, state, and federal policymakers in government and industry about the harmful human health effects of global climate change.

ACEP's policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine" states:

"ACEP supports collaborating with public health agencies and other stakeholders to:

- Raise awareness of the short- and long-term implications of climate change in population health and its effect in the practice of emergency medicine.
- Engage in research examining the effects of climate change on human health, health care systems, and public health infrastructure.
- Advocate for policies and practices to mitigate and address the effects of climate change on human health, health care systems, and public health infrastructure.
- Expand and improve upon regional surveillance systems of emerging diseases related to extreme weather events linked to climate change.
- Advocate for initiatives to reduce the carbon footprint of emergency departments and their affiliated institutions through energy conservation and health care waste reduction and/or recycling.
- Educate patients on appropriate precautions in extreme weather, avoidance of exacerbation triggers, early identification of exacerbations, and temporizing measures when needed."

The Public Health Committee, in partnership with the Ethics Committee, is currently reviewing and revising this policy statement and will be developing a Policy Resource & Education Paper (PREP) as an adjunct to the policy statement.

ACEP Strategic Plan Reference

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources to update ACEP's "Impact of Climate Change on Public Health and Implications for Emergency Medicine" policy statement. Unbudgeted staff resources and unbudgeted and unknown costs to work with stakeholders to decrease energy consumption and hospital waste and support research to decrease waste in the health care sector.

Prior Council Action

Resolution 21(20) Medical Society Consortium on Climate & Health adopted. The resolution directed ACEP to become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

June 2018, approved the policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine."

Resolution 21(20) Medical Society Consortium on Climate & Health adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

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

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

RESOLUTION: 59(24)

SUBMITTED BY: Tabitha Baca, MD
Marc Futernick, MD, FACEP
Gayle Galletta, MD, FACEP
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Dana Mathew, DO, FACEP
Scott Mueller, DO, FACEP
Kristen Nordenholz, MD, FACEP
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David Terca, MD, FACEP
Kreager Taber (MS4)
Alexandra Thran, MD, FACEP
California Chapter
Vermont Chapter

SUBJECT: Tap Water is Sufficient Treatment

PURPOSE: 1) Advocate to health care administrators in the U.S. to adopt the use of hospital tap water for wound irrigation; 2) Emphasize the importance of research and education within the emergency medicine community on the safety, efficacy, and potential cost savings of using hospital tap water for wound irrigation; and 3) Urge U.S. policymakers and health care administrators to support initiatives, such as the use of hospital tap water for wound irrigation, that contribute to broader global efforts to enhance environmental sustainability and combat climate change in health care by decreasing the carbon footprint of EDs.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, The impacts of climate change on human health necessitate urgent action to mitigate its effects,
2 including reducing the carbon footprint of health care facilities[1]; and
3
4 WHEREAS, The significant public health and environmental damage caused by health care pollution in the
5 United States, urging the adoption of sustainable practices[2]; and
6
7 WHEREAS, The efficacy of tap water compared to sterile saline in the United States, for wound irrigation,
8 resulting in potential cost savings[3]; and
9
10 WHEREAS, 12.2 to 14.1 million people present to the ED for wound management, and assuming each one
11 uses one bottle for irrigation, that would be 12.2 to 14.1 million bottles of plastic annually saved[4,5]; and
12
13 WHEREAS, Endorsing the use of tap water, in the U.S., instead of sterile saline solutions, emergency
14 physicians can contribute to significant cost savings, reduce the carbon footprint of emergency departments, and
15 advance efforts to mitigate climate change, all while maintaining high standards of patient care; and
16
17 WHEREAS, There are significant financial strains on health care systems and the need for cost-effective
18 solutions; and
19
20 WHEREAS, There are significant environmental implications of medical waste and resource consumption[6];
21 therefore be it
22
23 RESOLVED, That ACEP advocate to transition to hospital tap water in the United States for wound irrigation
24 to decrease the carbon footprint of emergency departments contributing to global efforts to combat climate change; and
25 be further
26
27 RESOLVED, That ACEP emphasize the importance of research and education within the emergency medicine
28 community, and to raise awareness of the financial and environmental benefits of tap water for wound irrigation in the
29 United States highlighting its safety, efficacy, and potential for cost savings; and it further

30 RESOLVED, That ACEP urge policymakers and health care administrators to support initiatives that promote
31 sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency
32 settings, aligning with broader efforts to enhance environmental sustainability in health care.

Resolution References

1. Haines A, Kovats RS, Campbell-Lendrum D, Corvalán C. Climate change and human health: impacts, vulnerability, and mitigation. Lancet. 2006;367(9528):2101-2109. doi:10.1016/S0140-6736(06)68933-2
2. Eckelman, M. J., Huang, K., Lagasse, R., Senay, E., Dubrow, R., & Sherman, J. D. (2020). Health Care Pollution and public health damage in the United States: An update. *Health Affairs*, *39*(12), 2071–2079. https://doi.org/10.1377/hlthaff.2020.01247
3. Moscati, R. M., Mayrose, J., Reardon, R. F., Janicke, D. M., & Jehle, D. V. (2007). A multicenter comparison of tap water versus sterile saline for wound irrigation. *Academic Emergency Medicine*, *14*(5), 404–409. https://doi.org/10.1197/j.aem.2007.01.007
4. Lewis, K. (2023, March 27). *Wound irrigation*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538522/
5. Centers for Disease Control and Prevention. (2024b, June 11). *NAMCS/NHAMCS - Ambulatory Health Care Data Homepage*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/ahcd/index.htm

Background

This resolution calls for ACEP to advocate to health care administrators in the U.S. to adopt the use of hospital tap water for wound irrigation; emphasize the importance of research and education within the emergency medicine community on the safety, efficacy, and potential cost savings of using hospital tap water for wound irrigation; and urge U.S. policymakers and health care administrators to support initiatives, such as the use of hospital tap water for wound irrigation, that contribute to broader global efforts to enhance environmental sustainability and combat climate change in health care by decreasing the carbon footprint of emergency departments.

Climate change refers to long-term shifts in the Earth's temperatures and weather patterns. The causes attributed to the shifts can be natural, due to changes in the sun's activity or large volcanic eruptions, or, more controversially, human industrial carbon emissions from the consumption of fossil fuels.[1] It is estimated that activities related to health care contribute to as much as 5% of industrial carbon emissions globally, with the US health care system contributing up to 1.25% of total global carbon emissions.[2]

Medical supply expenses comprise approximately 10.5% of the average hospital's budget.[3] The cost per milliliter of sodium chloride solution for wound irrigation can range from $0.02 to $0.12 U.S. dollars[4,5] with 1 liter containers being most common. While this price is small, there is a supply, stocking, and disposal cost, and an environmental impact of the plastic containers. The price of tap water in the United States varies greatly from city to city, but on average tap water is less than a penny per gallon or about $1.50 for 1,000 gallons.[6,7]

The World Health Organization (WHO) has advocated for and has encouraged member states to develop and implement strategies that promote sustainable health care practices.[2] ACEP and several other prominent medical organizations, including, but not limited to, the American Medical Association (AMA), the American College of Physicians (ACP), the American Academy of Pediatrics (AAP), the American Lung Association (ALA), and the American Public Health Association (APHA), and the World Association for Disaster and Emergency Medicine (WADEM) have policy statements regarding the impacts of climate change. ACEP's policy statement "Impact of Climate Change on Public Health Implications for Emergency Medicine" makes collaborating with public health agencies and other stakeholders to address key issues relating to climate change official policy of the College. The policy statement calls for the College to "advocate for initiatives to reduce the carbon footprint of emergency departments and their affiliated institutions through energy conservation and health care waste reduction and/or recycling."

ACEP joined the Medical Society Consortium on Climate and Health, a consortium consisting of 25 state network groups and 56 major medical societies representing over 1 million physicians and health professionals, in 2022.[8] The Medical Society Consortium on Climate and Health tasks itself with educating the public and local, state, and federal policymakers in government and industry about the harmful human health effects of global climate change.[3] During their 2019 annual meeting, the Medical Society Consortium on Climate and Health co-created the "U.S. Call to Action on Climate, Health and Equity: A Policy Action Agenda" with their member organizations. Item number 8 of the policy action agenda calls for hospitals and health care systems to "implement climate-smart health care, build

facility resilience, and leverage their economic power to decarbonize the supply chain and promote equitable local economic development."

Several studies have endeavored to compare the use of tap water versus normal saline for wound cleansing. A 2021 Cochrane Review by Fernandez et al included 13 randomized controlled trials that compared wound cleansing with tap water, distilled water, cooled boiled water, or saline with each other or with no cleansing on wound infection, wound healing, reduction in wound size, rate of wound healing, costs, pain, and patient satisfaction.[9] For all wounds, eight trials found the effect of cleansing with tap water compared with normal saline was uncertain: very low-certainty evidence. Regarding cost, two trials examined in the systematic review reported cost analyses, but the cost-effectiveness of tap water compared with the use of normal saline was uncertain: very low-certainty evidence.

A relevant paper published after the Cochrane Review is a literature review by Monika Holman published in the *Journal of Wound Care.*[10] Of the seven studies included in the literature review, six studies demonstrated that use of tap water had no significant influence on wound infection rates when compared to normal saline; one study demonstrated that tap water did not increase wound contamination; and four studies established that tap water was cost-effective compared to normal saline.

Background References

1. The United Nations. What is Climate Change? Accessed August 6, 2024. https://www.un.org/en/climatechange/what-is-climate-change
2. Masud FN, Sasangohar F, Ratnani I, et al. Past, present, and future of sustainable intensive care: narrative review and a large hospital system experience. Crit Care. 2024;28(1):154. Published 2024 May 9. doi:10.1186/s13054-024-04937-9
3. The American Hospital Association. America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities. Published April 2024. Accessed August 19, 2024. https://www.aha.org/costsofcaring#:~:text=Comprising%20approximately%2010.5%%20of%20the%20average%20hospital's,and%20science%20are%20constantly%20evolving%2C%20hospitals%20routinely
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10. Holman M. Using tap water compared with normal saline for cleansing wounds in adults: a literature review of the evidence. *J Wound Care*. 2023;32(8):507-512. doi:10.12968/jowc.2023.32.8.507

ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

- Streamline and innovate our advocacy approach and content to better communicate the relevance, impact and accomplishments of advocacy efforts and empower members to advocate for themselves within their own workplaces, regardless of employment model.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 21(20) Medical Society Consortium on Climate & Health adopted. The resolution directed ACEP to become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine was referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

June 2018, approved the policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine."

Resolution 21(20) Medical Society Consortium on Climate & Health adopted.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

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

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RESOLUTION: 60(24)

SUBMITTED BY: Ashley Foster, MD, FACEP
Sophia Lin, MD
Theresa Walls, MD, MPH
Pediatric Emergency Medicine Section

SUBJECT: Lethal Means Firearm Safety Counseling

PURPOSE: Develop resources to provide evidence-based firearm-related lethal means safety counseling to at risk youth and work with other organizations to develop training for health care providers in firearm-related lethal means safety training.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Unknown costs to develop resources and training and ongoing review of the resources and training once developed This project would require diverting budgeted staff resources from other initiatives to support this effort.

1 WHEREAS, Lethal means safety counseling is an evidence-based suicide prevention practice directed at
2 limiting the availability of lethal methods of self-harm and suicide, notably firearm-related methods, thereby reducing
3 the risk of death due to suicide; and
4
5 WHEREAS, Suicide acts with firearms have the highest case fatality rate of all methods used to attempt suicide
6 with 89.6% of attempts resulting in death; and
7
8 WHEREAS, In June 2024, the U.S. Surgeon General issued a public health advisory declaring firearm violence
9 a public health crisis and calling for firearm risk reduction strategies; and
10
11 WHEREAS, Suicide among children and young adults 10-24 years of age is a leading cause of death in the
12 United States, with nearly half of suicide deaths in this age group occurring by firearms; and
13
14 WHEREAS, Since 2012, the rate of firearm-related suicide has increased by 68% in children 10-14 years of
15 age and by 45% in adolescents and young adults 15-24 years of age; and
16
17 WHEREAS, The emergency department serves as a critical contact point for youth at increased risk of suicide
18 and one-third of youth who die by suicide visit the ED in the six months prior to their death; and
19
20 WHEREAS, Interventions in the ED can be effective at reducing subsequent suicide attempts and connecting
21 youth to mental health care; and
22
23 WHEREAS, Studies have shown that safety planning is effective for youth who are identified in the ED as safe
24 for discharge but have increased risk of suicide; and
25
26 WHEREAS, A crucial component of safety planning is screening for and counseling on access to firearms and
27 resources for ED physicians who wish to provide this critical service to at risk youth are lacking; therefore be it
28
29 RESOLVED, That ACEP develop resources for ACEP members to provide evidence-based firearm-related
30 lethal means safety counseling to at risk youth; and be it further

31 RESOLVED, That ACEP work with other organizations to develop training for health care providers in
32 firearm-related lethal means safety training.

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Background

This resolution calls for ACEP to develop resources to provide evidence-based firearm-related lethal means safety counseling to at risk youth and to work with other organizations to develop training for health care providers in firearm-related lethal means safety training.

Suicide is the second leading cause of death among individuals aged 10–34 in the U.S., with approximately 48,000 suicides in 2018, and suicide is a leading cause of death among children and young adults 10-24 years of age in the United States, with nearly half of suicide deaths in this age group occurring by firearms. Since 2012, the rate of firearm-related suicide has increased by 68% in children 10-14 years of age and by 45% in adolescents and young adults 15-24 years of age, and the increasing suicide rates and associated emotional toll highlight the urgent need for effective public health interventions. Each year, over 500,000 people visit emergency departments (EDs) for self-harm or suicidal thoughts, which are strong predictors of future suicide risk. Studies show that those who visit EDs for self-harm or suicidal ideation have significantly higher suicide mortality rates within the following year. Additionally, more than 12% of suicides involve individuals who had been treated in an ED within three months of their death, emphasizing the critical need for robust prevention strategies in these settings.

Lethal means safety counseling in the emergency department (ED) is a crucial evidence-based suicide prevention intervention aimed at reducing the risk of suicide and self-harm among patients. This recommended practice involves healthcare providers assessing patients' access to means that could be used for self-injury, such as firearms, medications, or other harmful substances, with the goal is to create a supportive environment that helps patients develop coping strategies and access mental health resources, ultimately minimizing the risk of suicide. Effective lethal means safety counseling not only addresses immediate safety concerns but also contributes to long-term mental health support and recovery.

Unfortunately, earlier studies involving emergency physician self-reports found that lethal means assessment was not routine; less than 50% of providers 'almost always' or 'often' ask about suicidal patients' access to firearms, even though more than half thought that this assessment is important. Additionally, it is not uniformly implemented across all facilities, and its frequency can vary based on several factors, including institutional policies, physician training, and the specific protocols of the ED. Training programs and guidelines that emphasize the importance of this counseling can increase its implementation. However, not all EDs may have comprehensive training or resources

available. Overall, while there is growing recognition of the importance of lethal means safety counseling, its frequency of implementation in EDs varies, and efforts are ongoing to standardize and improve its application across different healthcare settings.

ACEP has created a wide variety of resources, in multiple formats targeted at providing care for as well as improving the care of patients presenting with behavioral and mental health emergencies. ACEP is a member of the Coalition on Psychiatric Emergencies and has partnered with multiple organization, such as American Association of Emergency Psychiatry and American Academy of Pediatrics to work towards improving the care of these patients. For example:

- In partnership with the American Foundation of Suicide Prevention, ACEP has developed the ICAR2E point of care tool. This is a bedside/clinical tool to provide guidance to emergency physicians on the risk assessment and reduction, communication, and management of suicidal patients in the ED
- January 2022, the ACEP Board approved the revised joint policy statement "The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies." This is a joint policy statement (and supporting technical report) of the American College of Emergency Physicians, American Academy of Pediatrics (AAP), and Emergency Nurses Association (ENA).
- ACEP is also partnering with the AAP on the revision/update of the Clinical Reports on Evaluation and Management of Children and Adolescents With Acute Mental Health or Behavioral Problems:
  - Evaluation and Management of Children and Adolescents With Acute Mental Health or Behavioral Problems. Part I: Common Clinical Challenges of Patients With Mental Health and/or Behavioral Emergencies
  - Evaluation and Management of Children With Acute Mental Health or Behavioral Problems. Part II: Recognition of Clinically Challenging Mental Health Related Conditions Presenting With Medical or Uncertain Symptoms
- June 2024, the ACEP Board approved the revised policy statement "Firearm Safety and Injury Prevention."
- April 2023, the ACEP Board approved the revised policy statement "Adult Psychiatric Emergencies."
- In 2023-24, the ACEP Pediatric Emergency Medicine (PEM) Committee had the following objective: "Develop a point-of-care tool for screening and assessment of children with suicidality", and this is currently in development. Additionally, in 2024, the PEM Committee also published: and information paper in JACEP Open: Management of youth with suicidal ideation: Challenges and best practices for emergency departments
- For 2024-25, the Pediatric Emergency Committee has been assigned an objective to develop an information paper on safety planning and counseling of youth with increased suicide risk and their families in the emergency department.

ACEP also supports a variety of other firearm safety and injury prevention efforts. The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements, including the current policy statement, "Firearm Safety and Injury Prevention." The policy states that "ACEP supports public health and health care efforts that:

- Provide health care providers with information on the most effective ways to counsel patients and families on proper firearm safety, emphasizing evidence-based methods that are shown to reduce intentional and unintentional injuries;
- Support research into public policies that may reduce the risk of all types of firearm-related injuries, including risk characteristics that might make a person more likely to engage in violent and/or suicidal behavior;

The College also supports federal legislation to establish and support hospital-based violence intervention programs (HVIPs), which are trauma-informed collaborative care initiatives for patients who have suffered a violent injury, including but not limited to non-fatal firearm injuries. HVIPs incorporate efforts to engage patients in care and support networks to reduce recidivism and retaliation for at-risk populations.

Various studies have shown a strong correlation between firearm safety instruction to children and a reduction in dangerous interactions with firearms. A study published July 2023 in JAMA Pediatrics found that children ages 8-12 were three times more likely to avoid touching a discovered firearm when they had been shown a single one-minute firearm safety video a week prior. They were also three times more likely to tell an adult.

The policy statement "Violence-Free Society" also notes that "ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives."

The Public Health & Injury Prevention Committee developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" that provides information on prevention of firearm injuries, including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs, and listings of community-based firearm violence prevention programs by state.

In addition to the College's own specific efforts, ACEP staff and member representatives also continue to work with the American Medical Association (AMA), American College of Surgeons (ACS) and the ACS Committee on Trauma, the American Academy of Pediatrics (AAP), and other stakeholders to address firearm injury prevention and research. These include, but are not limited to:

- In September 2022, ACEP, ACS, AAP, the American College of Physicians (ACP) and the Council of Medical Specialty Societies (CMSS) cohosted the second Medical Summit on Firearm Injury Prevention, featuring representatives from more than 46 organizations. This meeting served as a follow-up to the inaugural summit held in 2019, in which ACEP also participated. The proceedings, including the key takeaways from the summit, were published in the *Journal of the American College of Surgeons* in March 2023. As a continuation of the summit's efforts, the Healthcare Coalition for Firearm Injury Prevention (HCFIP) has been formed as a multidisciplinary coalition of professional organizations representing medicine and public health to collaborate on firearm injury prevention initiatives, with a focus on non-partisan and evidence-based/data driven solutions. The Steering Committee member organizations of HCFIP are AAP, ACEP, ACP, ACS, and CMSS.

- In February 2023, ACEP participated in a firearm injury prevention roundtable organized by the AMA. The meeting was joined by the ACS, AAP, the American College of Physicians (ACP), American Psychiatric Association (APA), and the American Academy of Family Physicians (AAFP). As a result of this initial meeting, the AMA has established a Firearm Injury Prevention Task Force on which an ACEP member serves and ACEP staff supports.

- Helped establish and currently serve as both a steering committee member and regular member of the Gun Violence Prevention Research Roundtable (GVPRR), an effort spearheaded by the AAP. The GVPRR is a nonpartisan and national coalition of leading medical, public health, and research organizations focused on advocating for the value for federal funding for firearm violence prevention research.

ACEP worked successfully with other physician specialties, health care providers, and other stakeholders to restore federal funding for firearm morbidity and mortality prevention research, with $25 million split between the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in December 2019, after a more than 20-year hiatus of federal appropriations for this purpose. ACEP continues to advocate for increased funding for the NIH and CDC to continue and expand this research. For many consecutive years now, ACEP has joined an annual appropriations request letter urging Congress to provide continued funding for firearms injury prevention research. ACEP has also met with the National Collaborative on Gun Violence Research (NCGVR), a research collaborative with the mission to fund and disseminate nonpartisan scientific research to provide necessary data to establish fair and effective policies, in a discussion to share ACEP's policy priorities regarding firearms injury prevention.

The U.S. Surgeon General Vivek Murthy, MD, released an advisory on the public health crisis of firearm violence in the U.S. on June 24, 2024. This new advisory is the first publication from the Office of the Surgeon General dedicated to firearm violence and its consequences for the health and well-being of the American public. The advisory details the impact of gun violence beyond death and injury, describing the layers of cascading harm for youth, families, communities, and other populations. The Advisory outlines an evidence-informed public health approach to addressing the crisis of firearm violence. This approach involves critical research funding, implementation of prevention strategies, and increased mental health access and support. In concert with the Surgeon General's Advisory, leaders at nine of the nation's medical organizations and the YWCA issued statements, including ACEP

President Aisha T. Terry, MD, MPH, FACEP, who said, "By raising awareness of this public health crisis, The Surgeon General's Advisory on Firearm Violence speaks to the gun violence that emergency physicians observe all too often, as well as the repercussions on the communities they serve."

ACEP Strategic Plan Reference

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Unknown costs to develop resources and training and ongoing review of the resources and training once developed This project would require diverting budgeted staff resources from other initiatives to support this effort.

Prior Council Action

The Council has discussed and adopted many resolutions related to firearms, but none that are specific to lethal means safety counseling to at risk youth or developing training for health care providers in firearm-related lethal means safety training.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted. Directed ACEP to declare firearm violence to be a public health crisis in the United States.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted. Directed ACEP to revise the policy statement "Firearm Safety and Injury Prevention" to reflect the current state of research and legislation.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted. Sought to collaborate with other medical specialty organizations on firearms issues.

Amended Resolution 17(93) Firearm Injury Prevention adopted. Consider developing and/or promoting public education materials regarding ownership of firearms and the concurrent risk of injury and death.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Prior Board Action

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted.

June 2024, approved the revised policy statement "Firearm Safety and Injury Prevention;" revised and approved October 2019; revised and approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

April 2023, approved the revised policy statement "Adult Psychiatric Emergencies;" originally approved October 2020.

January 2022, approved the revised joint policy statement "The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies."

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention."

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

Amended Resolution 17(93) Firearm Injury Prevention adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

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

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

RESOLUTION: 61(24)

SUBMITTED BY: Ugo Ezenkwele, MD, FACEP
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Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section

SUBJECT: Safe Storage of Firearms

PURPOSE: 1) Create education to raise awareness that secure gun storage, storing guns locked, unloaded and separate from ammunition, can prevent theft and access by children, unauthorized users, and anyone who may pose a danger to themselves or others, and that secure gun storage can save children's lives; 2) collaborate with Doctors for America and take the pledge to become a credible messenger to advocate for and promote gun safety and help reduce firearm related injuries; and 3) encourage emergency physicians to function as messengers to their patients, adopting messages from established, credible organizations such as Gun Violence Prevention Experts, the White House Office of Gun Violence Prevention, the National Organization of Black Law Enforcement Executives (NOBLE), and Everytown for Gun Safety.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, U.S. Surgeon General Vivak Murthy, MD, has issued a landmark Surgeon General's Advisory on
2 Firearm Violence, declaring firearm violence in America to be a Public Health Crisis; and
3
4 WHEREAS, Since 2020, Firearm-related injuries have been the leading cause of death for American children
5 and teens ages 1-19 years of age, and injures thousands more annually; and
6
7 WHEREAS, An estimated 4.6 million children live in homes with loaded, unlocked firearms; and
8
9 WHEREAS, More than half of owners acknowledge storing at least one firearm unsafely, without any locks or
10 other safe storage measures, and nearly a quarter of all gun owners report storing all their firearms in an unlocked
11 location in the home; and
12
13 WHEREAS, An unlocked firearm is associated with a higher risk of suicide and unintentional firearm injury
14 among children and adolescents; and
15
16 WHEREAS, Over 80% of child firearm suicides involved a gun obtained from their own home or that of a
17 friend or relative and suicide rates among children who live in homes with firearms are four times higher than among
18 those in homes without firearms; and
19
20 WHEREAS, Most unintentional firearm-related shootings among children occur in or around the home, and
21 most firearms used in school shootings perpetrated by shooters under the age of 18 are acquired from the home or the
22 homes of relatives or friends; and
23
24 WHEREAS, Research indicates that strong child access prevention laws decrease unintentional shootings,
25 suicides, and school shootings; and
26
27 WHEREAS, States with secure storage or child access prevention laws had the lowest rates of injury or death

28 from unintentional child shootings, but only 26 states have secure storage laws; and
29
30 WHEREAS, Evidence strongly suggests secondary prevention which limits access of firearms to children and
31 teens decreases the risk of injury and death and this same evidence indicated that storage of a firearm locked, unloaded,
32 or separate from ammunition can reduce the risk of suicide in children and teens; therefore be it
33
34 RESOLVED, That ACEP create education to raise awareness that secure gun storage, storing guns locked,
35 unloaded and separate from ammunition, can prevent theft and access by children, unauthorized users, and anyone who
36 may pose a danger to themselves or others, and that secure gun storage can save children's lives; and be it further
37
38 RESOLVED, That ACEP collaborate with Doctors for America and take the pledge to become a credible
39 messenger to advocate for and promote gun safety and help reduce firearm related injuries; and be it further
40
41 RESOLVED, That ACEP encourage emergency physicians to function as messengers to their patients,
42 adopting messages from established, credible organizations such as Gun Violence Prevention Experts, the White House
43 Office of Gun Violence Prevention, the National Organization of Black Law Enforcement Executives (NOBLE), and
44 Everytown for Gun Safety.

Background

This resolution seeks for the College to: 1) create education to raise awareness that secure gun storage, storing guns locked, unloaded and separate from ammunition, can prevent theft and access by children, unauthorized users, and anyone who may pose a danger to themselves or others, and that secure gun storage can save children's lives; 2) collaborate with Doctors for America and take the pledge to become a credible messenger to advocate for and promote gun safety and help reduce firearm related injuries; and 3) encourage emergency physicians to function as messengers to their patients, adopting messages from established, credible organizations such as Gun Violence Prevention Experts, the White House Office of Gun Violence Prevention, the National Organization of Black Law Enforcement Executives (NOBLE), and Everytown for Gun Safety.

Firearms were the leading cause of death in children and youth 0 to 24 years of age in the United States in 2020. Among all causes of death, firearms were responsible for the most deaths in this age group, accounting for 10 197 deaths, compared with 8309 motor vehicle-related deaths. Rates of homicides and suicides from firearms in U.S. youth, especially those 15 to 24 years of age, have increased by 14% and 39%, respectively over the past decade. Among all youth firearm deaths, homicides account for 58%, suicides account for 37%, unintentional shootings account for 2%, and legal intervention accounts for 1%. In 2020, more than 6,000 U.S. youth 15 to 24 years of age died by suicide. Firearms, the most lethal means of suicide, are the cause of death in one-third of suicides among those 10 to 14 years of age and half of all suicides among those 20 to 24 years of age. Although youth firearm suicides decreased from 1994 to 2007, they have increased 53% since then. Several studies have demonstrated an independent relationship between access to firearms and suicide. Approximately 80% of firearm-related suicides take place in the home of the youth or a relative, with the firearm belonging to either the youth or parent or caregiver in 90% of cases. Approximately 40% of U.S. households with children have firearms, of which 15% stored at least one firearm loaded and unlocked, the storage method with the highest risk.

Safely storing firearms can reduce gun injuries and deaths, and is supported by researchers, health care professionals, and gun owners alike. Research has demonstrated a decreased risk for suicide among adolescents when guns are stored safely. Safe and secure storage practices also help prevent guns from being stolen, diverted into illegal markets and used in gun crime. Child-protective firearm safety and safe storage systems encompass a variety of measures – safes or lockboxes for handguns, locked gun safes for rifles and shotguns, trigger locks that prevent the trigger from being pulled, cable locks, and separate lockboxes for ammunition, among others. Supporters of child-protective or safe storage policies note growing evidence-based research that such policies are associated with reductions in suicide, unintentional injuries and death, and homicides, including for young adults. The AAP, for example, "…supports a number of measures to reduce the destructive effects of guns in the lives of children and adolescents, including safe storage and CAP laws."

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements. The 2023 Council and the Board of Directors adopted Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems directing ACEP to support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems. ACEP's policy statement "Firearm Safety and Injury Prevention" was revised in June 2024 in response to Resolution 36(23) Mandatory Waiting Period for Firearm Purchases and Resolution 35(23) Declaring Firearm Violence a Public Health Crisis.

The provisions of the "Firearm Safety and Injury Prevention" policy statement include:

ACEP supports legislative and regulatory efforts that:

- Actively support both private and public funding into firearm safety and injury prevention research;
- Protect the duty of physicians to discuss firearm safety with patients"

ACEP supports public health and health care efforts that:

- Provide health care providers with information on the most effective ways to counsel patients and families on proper firearm safety, emphasizing evidence-based methods that are shown to reduce intentional and unintentional injuries;
- Support research into public policies that may reduce the risk of all types of firearm-related injuries, including risk characteristics that might make a person more likely to engage in violent and/or suicidal behavior"

Various studies have shown a strong correlation between firearm safety instruction to children and a reduction in dangerous interactions with firearms. A study published July 2023 in JAMA Pediatrics found that children ages 8-12 were three times more likely to avoid touching a discovered firearm when they had been shown a single one-minute firearm safety video a week prior. They were also three times more likely to tell an adult.

The policy statement "Violence-Free Society" also notes that "ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives."

The Public Health & Injury Prevention Committee developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" that provides information on prevention of firearm injuries, including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs, and listings of community-based firearm violence prevention programs by state.

In addition to the College's own specific efforts, ACEP staff and member representatives also continue to work with the American Medical Association (AMA), American College of Surgeons (ACS) and the ACS Committee on Trauma, the American Academy of Pediatrics (AAP), and other stakeholders to address firearm injury prevention and research. These include, but are not limited to:

- In September 2022, ACEP, ACS, AAP, the American College of Physicians (ACP) and the Council of Medical Specialty Societies (CMSS) cohosted the second Medical Summit on Firearm Injury Prevention, featuring representatives from more than 46 organizations. This meeting served as a follow-up to the inaugural summit held in 2019, in which ACEP also participated. The proceedings, including the key takeaways from the summit, were published in the *Journal of the American College of Surgeons* in March 2023. As a continuation of the summit's efforts, the Healthcare Coalition for Firearm Injury Prevention (HCFIP) has been formed as a multidisciplinary coalition of professional organizations representing medicine and public health to collaborate on firearm injury prevention initiatives, with a focus on non-partisan and evidence-based/data driven solutions. The Steering Committee member organizations of HCFIP are AAP, ACEP, ACP, ACS, and CMSS.

- In February 2023, ACEP participated in a firearm injury prevention roundtable organized by the AMA. The meeting was joined by the ACS, AAP, the American College of Physicians (ACP), American Psychiatric

Association (APA), and the American Academy of Family Physicians (AAFP). As a result of this initial meeting, the AMA has established a Firearm Injury Prevention Task Force on which an ACEP member serves and ACEP staff supports.

- Helped establish and currently serve as both a steering committee member and regular member of the Gun Violence Prevention Research Roundtable (GVPRR), an effort spearheaded by the AAP. The GVPRR is a nonpartisan and national coalition of leading medical, public health, and research organizations focused on advocating for the value for federal funding for firearm violence prevention research.

ACEP worked successfully with other physician specialties, health care providers, and other stakeholders to restore federal funding for firearm morbidity and mortality prevention research, with $25 million split between the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in December 2019, after a more than 20-year hiatus of federal appropriations for this purpose. ACEP continues to advocate for increased funding for the NIH and CDC to continue and expand this research. For many consecutive years now, ACEP has joined an annual appropriations request letter urging Congress to provide continued funding for firearms injury prevention research. ACEP has also met with the National Collaborative on Gun Violence Research (NCGVR), a research collaborative with the mission to fund and disseminate nonpartisan scientific research to provide necessary data to establish fair and effective policies, in a discussion to share ACEP's policy priorities regarding firearms injury prevention.

The U.S. Surgeon General Vivek Murthy, MD, released an advisory on the public health crisis of firearm violence in the U.S. on June 24, 2024. This new advisory is the first publication from the Office of the Surgeon General dedicated to firearm violence and its consequences for the health and well-being of the American public. The advisory details the impact of gun violence beyond death and injury, describing the layers of cascading harm for youth, families, communities, and other populations. The Advisory outlines an evidence-informed public health approach to addressing the crisis of firearm violence. This approach involves critical research funding, implementation of prevention strategies, and increased mental health access and support. In concert with the Surgeon General's Advisory, leaders at nine of the nation's medical organizations and the YWCA issued statements, including ACEP President Aisha T. Terry, MD, MPH, FACEP, who said, "By raising awareness of this public health crisis, The Surgeon General's Advisory on Firearm Violence speaks to the gun violence that emergency physicians observe all too often, as well as the repercussions on the communities they serve."

ACEP's committees continue to address firearms issues during the 2024-25 committee year. The Federal Government Affairs Committee has an objective to continue to serve as subject matter experts to ACEP's efforts to develop and assess potential legislative ideas to address firearm safety and injury prevention. The Public Health Committee has an objective to develop resources for patients on gun safety.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems adopted. Directed that ACEP support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems.

Resolution 36(23) Mandatory Waiting Period for Firearm Purchases adopted. Directed ACEP to advocate for a mandatory federal waiting period prior to firearm purchases; assist state chapters in promoting legislation on mandatory waiting periods at the state level; and add language to the "Firearm Safety and Injury Prevention" policy statement supporting mandatory waiting periods prior to firearm purchases.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted. Directed ACEP to declare firearm violence to be a public health crisis in the United States.

Resolution 14(00) Childhood Firearm Injuries referred to the Board of Directors. Directed ACEP to support legislation that requires safety locks on all new guns sold in the USA and support legislation that holds the adult gun owner legally responsible if a child is accidentally injured with the gun.

Prior Board Action

June 2024, approved the revised policy statement "Firearm Safety and Injury Prevention;" revised and approved October 2019; revised and approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

March 2024, approved ACEP's legislative and regulatory priorities to continue to work with Members of Congress to promote efforts that may prevent firearm-related injuries/deaths and support continued and increased funding for firearms injury research.

Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems adopted.

Resolution 36(23) Mandatory Waiting Period for Firearm Purchases adopted.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

June 2018, reviewed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

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

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

RESOLUTION: 62(24)

SUBMITTED BY: Ugo Ezenkwele, MD, FACEP
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Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section

SUBJECT: Stop the Bleed Education

PURPOSE: Provide education and encourage emergency physicians' awareness of the "Stop the Bleed" initiative and promote activities that foster awareness and empowerment among at-risk youth via collaboration with such entities as Community Violence Intervention Program (CVIP) to take proactive measures in teaching "Stop the Bleed" techniques to youth.

FISCAL IMPACT: Budgeted committee and staff resources. Potential unbudgeted and unknown costs depending on the scope of the promotional, marketing, and outreach needs.

1 WHEREAS, The devastating and far-reaching consequences that traumatic injuries resulting in significant
2 blood loss poses to the health and well-being in many U.S. communities is widely recognized and that some victims
3 could be saved if bystanders given the tools and knowledge to stop life threatening bleeding; and
4
5 WHEREAS, The "Stop the Bleed" campaign is a national awareness effort to educate people about the
6 importance of measures to control bleeding; and the goal of this initiative is to build national resilience by empowering
7 the public to be aware of the simple steps that can be taken to stop or slow life threatening bleeding, and to promote the
8 general public's access to Bleeding Control Kits; and
9
10 WHEREAS, Per the CDC, more than 275,000,000 people die each year (one person every three minutes) from
11 traumatic injuries sustained because of events including motor vehicle collisions, falls, industrial and farm accidents,
12 natural disasters, tragic mass casualties, mass shootings, and violence; and
13
14 WHEREAS, Trauma is the leading cause of death for people ages 1-46 in the U.S.; and
15
16 WHEREAS, The most common preventable cause of death in these situations is the loss of too much blood in
17 the minutes before advance responders arrive; and
18
19 WHEREAS, U.S. military experience has proven that bleeding control techniques result in reduced rates of
20 death from a hemorrhage; and therefore be it
21
22 RESOLVED, That ACEP provide education and encourage emergency physicians' awareness of the "Stop the
23 Bleed" initiative; and be it further
24
25 RESOLVED, That ACEP promote activities that foster awareness and empowerment among at-risk youth via
26 collaboration with such entities as Community Violence Intervention Program (CVIP) to take proactive measures in
27 teaching "Stop the Bleed" techniques to youth.

Background

This resolution requests ACEP to provide education and encourage emergency physicians' awareness of the "Stop the Bleed" initiative and promote activities that foster awareness and empowerment among at-risk youth via collaboration with such entities as Community Violence Intervention Program (CVIP) to take proactive measures in teaching "Stop the Bleed" techniques to youth.

ACEP has been a key stakeholder since the initiation of the "Stop the Bleed" campaign in October 2015, when it was launched by both the White House and the National Security Council. The "Stop the Bleed" campaign had a series of objectives, including public access to bleeding control kits and public training on their utilization. ACEP has engaged and supported these objectives since its inception through various avenues, including promoting the campaign through the EMS Committee, EMS-Prehospital Care Section, other pertinent ACEP sections, and ACEP's National EMS Week Campaign. Concurrently, the American College of Surgeons – Committee on Trauma (ACS-COT) developed a public-focused bleeding control course, with which ACEP was invited and partnered in the promotion of this course.

The recognition of the "Stop the Bleed" course has been enhanced since 2019 with the mentioning of various section content pieces by the Event Medicine Section, Disaster Medicine Section, the Tactical & Law Enforcement Medicine Section, and through various ACEP marketing channels.

ACEP collaborated with the American College of Surgeons Committee on Trauma (ACS-COT) in 2023 on various initiatives to support the "Stop the Bleed" course. The focus of these collaboratives for ACEP was to identify and engage at the various levels of course development, advocacy, and implementation among current initiatives and programs. ACEP received an invitation to join the ACS-COT "Stop the Bleed" Champions group in 2024. Within this group, ACEP will provide representation and support as a member on various initiatives of the "Stop the Bleed" course, including curriculum and course review, implementation, education, community outreach, and other initiatives as determined by the ACS-COT Stop the Bleed Champions Group.

ACEP has brought a greater awareness of the "Stop the Bleed" course within current programs in the College through further collaboration and work with the ACS-COT. May 2024 marked the 50th anniversary of National EMS Week. Each day had a specific theme and the theme for Thursday was "Save a Life Day" where the focus shifted to providing community education and training on various initiatives such as "Stop the Bleed" training and compression-only CPR. ACEP worked closely with the ACS-COT on marketing and content to be utilized as an outreach initiative within National EMS Week. ACS-COT provided an outreach campaign for "Stop the Bleed" that was then shared with 17 national organizations, 6 federal organizations, and 3 media partners who support National EMS Week in their efforts to enhance their reach for EMS Week. The EMS Week 2024 reach through campaign resources and distribution of materials throughout the week was almost 4 million.

ACEP worked with our EMS Week partner, the National Association of Emergency Medical Technicians (NAEMT), as well as DC Fire and EMS, ACS-COT, and GW Hospital Med Star, to hold a large in-person event on the National Mall in Washington, DC, on May 23, 2024, to enhance awareness of various chain-of-survival initiatives such as "Stop the Bleed" and Chest Compression Only CPR. The event included various tables and displays that provided in-person education and training on "Stop the Bleed" and Chest Compression-only programs. These initiatives included various manikins and low-fidelity trainers along with the needed tools and resources to provide on-the-spot training. Additionally, ACS-COT published 500 quick access cards regarding "Stop the Bleed" that included the key steps for applying a tourniquet along with a QR code to access an online free version of the "Stop the Bleed" course. Several speakers presented on National EMS Week and the importance of the community education event, including ACEP's president, the NAEMT president, American College of Surgeons executive director, the DC Fire and EMS medical director, and the National Highway Traffic Safety Administration (NHTSA) Office of EMS.

The EMS Committee continues to bring a heightened awareness, greater visibility, and accessibility to various community education courses and training that can increase the chain of survival in out-of-hospital patient care. The EMS Committee has an objective for the 2024-25 committee year to "collaborate with other organizations to support the accessibility and visibility of community education programs, such as Stop the Bleed, Chest Compression-Only CPR, Narcan, etc., to enhance the chain of survival in patient care."

ACEP staff were tasked in 2018 with developing a new public-focused in-person course that contained bleeding control and lay-person CPR to bring greater awareness to the need for bleeding control in the out-of-hospital setting. Around the same time period, ACEP was approached by staff at the U.S. Department of Health and Human Services (HSS)/Office of the Assistant Secretary for Preparedness and Response (ASPR) to support and help promote a new online bleeding control course they had developed. ACEP partnered with an existing vendor, Simulab, to develop resources for the course, including several different bleeding control kits and a training kit designed specifically for the ACEP course. ACEP released the new Until Help Arrives course, which includes bleeding control and compression-only CPR, during *ACEP19* in Denver, CO. ACEP has now partnered with the American Red Cross to provide Until Help Arrives as a 90-minute online course designed to equip students with the basic knowledge to assist trained responders during a life-threatening emergency. Until Help Arrives is a non-certification course that provides the general public with the basic actions to take during a life-threatening emergency that can help sustain or save a life until EMS arrives.

ACEP Strategic Plan Reference

Member Engagement and Advocacy

Fiscal Impact

Budgeted committee and staff resources. Potential unbudgeted and unknown costs depending on the scope of the promotional, marketing, and outreach needs.

Prior Council Action

Resolution 34(20) Public/School Bleeding Control Kit Access and Training adopted. Directed ACEP to support access and training for bleeding control kits in all schools and public venues.

Prior Board Action

Resolution 34(20) Public/School Bleeding Control Kit Access and Training adopted.

June 2019, approved funding for the Until Help Arrives campaign.

Background Information Prepared by: George Solomon, MHS, FP-C, CCP-C, TP-C
Director, EMS and Disaster Medicine

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

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

Late Resolution

RESOLUTION: 63(24)

SUBMITTED BY: James Augustine, MD, FACEP
Nicholas Genes, MD, PhD, FACEP
Emily Hayden, MD, FACEP

SUBJECT: Commendation for Todd B. Taylor, MD, FACEP

1 WHEREAS, Todd B. Taylor, MD, FACEP, has served the College and the specialty for more than three
2 decades with skill and dedication as a member of ACEP and leader of the Emergency Medicine Data Institute (EMDI);
3 and
4
5 WHEREAS, He has served as the Chief Vision Officer for the EMDI and as the Transition Team Executive for
6 the Clinical Emergency Data Registry; and
7
8 WHEREAS, He has volunteered his time for the last four years, providing more than 6,000 volunteer hours
9 equivalent to $1.5 million of in-kind services; and
10
11 WHEREAS, His dedication and commitment to ACEP and the EMDI has led to the successful transition and
12 advancement of the Clinical Emergency Data Registry to the new EMDI platform; and
13
14 WHEREAS, Dr. Taylor's expertise in informatics and dedication to excellence successfully transitioned more
15 than 30 physician groups to the new EMDI platform; and
16
17 WHEREAS, Dr. Taylor selflessly served as a mentor and was instrumental to the establishment and launch of
18 the EMDI Board of Governors; and
19
20 WHEREAS, Dr. Taylor's expertise, leadership, and vision has led to the development and launch of new
21 products and services; and
22
23 WHEREAS, Dr. Taylor's dedication, hard work, and commitment contributed significantly to ACEP's and the
24 EMDI's success; therefore be it
25
26 RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting
27 impact of the contributions of Todd B. Taylor, MD, FACEP, to the advancement of emergency medicine; and be it
28 further
29
30 RESOLVED, That the American College of Emergency Physicians commends Todd B. Taylor, MD, FACEP,
31 for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

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

Late Resolution

RESOLUTION: 64(24)

SUBMITTED BY: Richelle Cooper, MD, MSHS, FACEP
Gregory Hendey, MD, FACEP
David Schriger, MD, MPH, FACEP
Kabir Yadav, MDCM, MD, MSHS, FACEP
Donald M. Yealy MD, FACEP

SUBJECT: In Memory of Amy H. Kaji, MD, PhD, MPH

1 WHEREAS, Emergency medicine lost a compassionate physician, dedicated educator, mentor, investigator,
2 editor, and colleague in Amy H. Kaji, MD, PhD, MPH, who died on August 1, 2024, at the age of 56; and
3
4 WHEREAS, Dr. Kaji graduated from Harvard-Radcliffe College (*cum laude*) and then attended Thomas
5 Jefferson Medical College (AOA, *summa cum laude* and Valedictorian Class of 1997), then completed her emergency
6 medicine residency at the Harbor-UCLA Emergency Medicine program and completed a Doctor of Philosophy in
7 Epidemiology at the UCLA School of Public Health; and
8
9 WHEREAS, Dr. Kaji served as faculty at Harbor-UCLA Medical Center and the David Geffen School of
10 Medicine at UCLA, served as Vice Chair of Academic Affairs, Interim Chair and Executive Vice Chair at the Harbor-
11 UCLA Department of Emergency Medicine; and
12
13 WHEREAS, Dr. Kaji provided service for more than 20 years on numerous American College of Emergency
14 Physicians (ACEP) committees including the Disaster Preparedness & Response Committee, Public Health & Injury
15 Prevention Committee, Clinical Policies Committee (as Methodological Reviewer), and the Research Committee as
16 well as the Research Forum Subcommittee and served as chair for the Research Committee's Scientific Review
17 Subcommittee and Pipeline Subcommittee, and also served on the Emergency Medicine Foundation Board of
18 Trustees; and
19
20 WHEREAS, Dr. Kaji served on numerous Society for Academic Emergency Medicine (SAEM) committees
21 including the Research Committee, Consensus Conference Steering Committee, Membership Committee, Nominating
22 Committee, Diversity Equity and Inclusion Committee, Boarding Committee, Work Force Committee, Joint ACEP-
23 SAEM Work Force Committee, and served in several leadership roles on the Board of Directors, including Secretary-
24 Treasurer and President of SAEM; and
25
26 WHEREAS, Dr. Kaji improved and elevated published emergency medicine research as a peer-reviewer and
27 editor, including serving on the editorial board of *Annals of Emergency Medicine* for 18 years and for *Academic*
28 *Emergency Medicine,* and she also fostered knowledge sharing as section editor for *Rosen's Emergency Medicine:*
29 *Concepts and Clinical Practice*, and co-editor for the Kaji and Pedigo *Emergency Medicine Board Review* book; and
30
31 WHEREAS, Dr. Kaji advanced the science of emergency medicine and health care with her research and
32 authorship of more than 234 peer-reviewed publications and 15 book chapters; and
33
34 WHEREAS, Dr. Kaji was recognized for her excellence in teaching and service with numerous awards
35 including the UCLA Public Health Student Association Teaching Assistant of the Year, the Harbor-UCLA Medical
36 Center Department of Emergency Medicine Faculty Teaching Award (for multiple years), the American College of
37 Emergency Physicians National Faculty Teaching Award, the UCLA Distinguished Lecturer Award for outstanding
38 contributions to university teaching, the Academy for Women in Academic Emergency Medicine (AWAEM) Early
39 Career Faculty Award, the Harbor-UCLA Medical Center DEM, Academic and Administrative Giant Award; and

40 WHEREAS, Dr. Kaji was an exemplary clinician, compassionate peer, and loving friend who was looked up
41 to by fellow physicians, nurses, physician assistants, EMS personnel, and hospital staff; and
42
43 WHEREAS, Dr. Kaji mentored hundreds of undergraduate (pre-med) students, medical students, resident and
44 fellow trainees, and faculty in emergency medicine with her warm, patient, and caring approach, always making time
45 to help others; and
46
47 WHEREAS, Dr. Kaji put caring about people at the forefront of all her interactions, be it with patients,
48 hospital staff and leadership, medical learners, and her colleagues; and
49
50 WHEREAS, Dr. Kaji supported, advocated for, and sponsored efforts to enhance diversity, equity, and
51 inclusion; and
52
53 WHEREAS, Dr. Kaji touched the lives of countless individuals by setting a quiet, powerful example of how
54 to be a great leader and excellent physician, being a role model for all who knew her; and
55
56 WHEREAS, Dr. Kaji shaped the future of emergency medicine in Los Angeles and nationally with her
57 academic service, research, and editorial work, and with her leadership, vision, enthusiasm, and dedication; therefore
58 be it
59
60 RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many
61 contributions made by Amy H. Kaji MD, PhD, MPH, as one of the leaders in emergency medicine and the greater
62 medical community; and be it further
63
64 RESOLVED, That the American College of Emergency Physicians extends to the family of Amy H. Kaji,
65 MD, PhD, MPH, her friends, and her colleagues our condolences and gratitude for her tremendous service to the
66 specialty of emergency medicine, and to the patients and physicians of California and the United States.

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

Late Resolution

RESOLUTION: 65(24)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: In Memory of Joseph Sabato, Jr., MD, FACEP

1 WHEREAS, Joseph Sabato, Jr., MD, FACEP, who dedicated his life to the field of emergency medicine and
2 the betterment of public health, died on July 9, 2024; and
3
4 WHEREAS, Dr. Sabato pursued his undergraduate education at Boston University and went on to earn his
5 medical degree from the University of Massachusetts (UMASS) Chan Medical School demonstrating his commitment
6 to academic excellence and the pursuit of medical knowledge; and
7
8 WHEREAS, Dr. Sabato's career, spanning over four decades, included serving as an esteemed emergency
9 physician and assistant professor at Parkland Medical Center in Derry, NH; the University of Florida College of
10 Medicine in Jacksonville, FL; and the UMASS Chan Medical School in Worcester, MA; and
11
12 WHEREAS, Dr. Sabato was a dedicated advocate for public health, demonstrating unwavering commitment to
13 injury and illness prevention; and
14
15 WHEREAS, In response to the tragic deaths of 11 teenagers in 1996, Dr. Sabato founded the Community
16 Alliance for Teenage Safety in Derry, NH, and championed the cause to raise the mandatory seat belt age in New
17 Hampshire from 12 to 18 years old; and
18
19 WHEREAS, Dr. Sabato's passion for preventing cardiac deaths led him to tirelessly promote hands-only
20 community CPR and the use of automated external defibrillators; and
21
22 WHEREAS, Dr. Sabato found immense joy in working with and teaching first responders and medical
23 students, thus fostering the next generation of emergency medical professionals; and
24
25 WHEREAS, Dr. Sabato was actively involved in the American College of Emergency Physicians, contributing
26 to the Critical Care, Emergency Medical Services, and Disaster Medicine Sections; and
27
28 WHEREAS, Dr. Sabato's contributions to emergency medicine and public health have left an indelible mark on
29 the communities he served; therefore be it
30
31 RESOLVED, That the American College of Emergency Physicians honors the memory of Joseph Sabato, Jr.,
32 MD, FACEP, and extends its deepest sympathies to his family, friends, and colleagues and acknowledges that his
33 legacy will continue to inspire and guide the emergency medicine community.

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

Late Resolution

RESOLUTION: 66(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Christopher J. Karns, DO

1 WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Christopher
2 J. Karns, DO, passed away tragically in a tractor accident while working on his property, something he found great joy
3 in doing, on August 7, 2024, at the age of 38; and
4
5 WHEREAS, Dr. Karns completed his undergraduate studies at Allegheny College in 2008; and
6
7 WHEREAS, He completed his medical school training at the Des Moines University College of Osteopathic
8 Medicine in 2012; and
9
10 WHEREAS, He then completed his residency in emergency medicine at Saint Vincent Hospital in Erie, PA;
11 and
12
13 WHEREAS, He continued his work in emergency medicine at Saint Vincent Hospital as a faculty member; and
14
15 WHEREAS, He later served as an emergency physician and Vice President of the medical staff at Westfield
16 Memorial Hospital; and
17
18 WHEREAS, Dr. Karns mostly recently was an emergency physician at Titusville Area Hospital; and
19
20 WHEREAS, He and his wife owned and operated Coventina Day and Medical Spa in Waterford where their
21 dedication and innovation brought new services to the area; and
22
23 WHEREAS, Dr. Karns was married to his high school sweetheart, Dawn, in 2010 and they attended college,
24 medical school, and residency together and shared a life filled with love and partnership; and
25
26 WHEREAS, His greatest joy was his family; and
27
28 WHEREAS, He and his wife had three children, loved spending time outdoors with them, created countless
29 cherished memories with them such as building trails, working on their country property, camping, fishing, hunting,
30 enjoying campfires, and spending time at their family's camp; therefore, be it
31
32 RESOLVED, That the American College of Emergency Physicians cherishes the memory of Christopher J.
33 Karns, DO; and be it further
34
35 RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of
36 Emergency Physicians extends to his wife Dawn E. Beemer Karns, their three children Nathan Christopher, Carter
37 Alexander, and Alaina Grace, his parents John and Cynthia Karns, and the rest of his family gratitude for his service as
38 an emergency physician as well as his commitment to the specialty of emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2024 Council

From: Sonja Montgomery, CAE
Governance Operations Director

Date: August 28, 2024

Subj: Compensation Committee Report

The Compensation Committee has not yet developed their recommendations for Board member and officer stipends for FY 2024-25. The committee's recommendations will be presented to the Board at their meeting on September 26. The Compensation Committee's report will be distributed to the Council as soon as it is available. The Council will also be informed if the Board does not adopt the Compensation Committee's recommendations.

The basis for the Compensation Committee resides in the ACEP Bylaws, Article XI – Committees, Section 7 – Compensation Committee:

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

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

The current officer and non-officer stipends are:

President	$148,143
President-Elect	$107,791
Chair	$ 35,930
Vice President (2 positions)	$ 30,403
Secretary-Treasurer	$ 29,021
Immediate Past President	$ 27,639
Speaker	$ 34,272
Vice Speaker	$ 20,729
Non-Officer Board Members	$ 11,055

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Speaker
Michael J. McCrea, MD, FACEP
Vice Speaker

INTERIM EXECUTIVE DIRECTOR
Sandra M. Schneider, MD, FACEP

2024 Town Hall Meeting

Friday, September 27, 2024
Mandalay Bay Convention Center
Oceanside A (Level 2)
1:15 pm – 2:15 pm

A Peak Behind the Curtain: The 2025 RAND Report
Strategies to Sustain Emergency Care in the United States

Moderator: Michael J McCrea, MD, FACEP
Council Vice Speaker

Panelists: Mahshid Abir, MD MSc
Senior Policy Researcher, RAND Corporation
Professor of Policy Analysis, Pardee RAND Graduate School

D.W. "Chip" Pettigrew, III, MD, FACEP
Immediate Past President, EMPI

Thomas J. Sugarman, MD, FACEP
Treasurer, EMPI

Laura Wooster, MPH
ACEP Associate Executive Director, Advocacy and Public Affairs

Session Format: The Town Hall Meeting is open to everyone attending the Council meeting. Seating is open without restriction to the Council floor.

Description: Over a decade has passed since The RAND Corporation released "The Evolving Role of Emergency Departments in the United States." Since then, we have endured a global pandemic, The No Suprises Act, CMS and private payor reimbursement continues to decline, all while facing concerns about the future of the emergency medicine workforce. Given these challenges, the Emergency Medicine Policy Institute (EMPI) Board of Directors commissioned RAND to conduct a new study to focus on the value of emergency care, evaluate impediments to ED resources and capacity, trends in emergency medicine reimbursement, and propose new innovative funding strategies for emergency care.

Objectives:
1. Review the challenges that have emerged in the emergency medicine landscape.
2. Discuss the potential impact of the RAND report on future policy and regulatory advocacy.
3. Explore how ACEP can use the RAND study to advocate for new forms of reimbursement for emergency care.

President-Elect Candidates

acep Scientific Assembly LAS VEGAS 24

2024 President-Elect Candidates

L. Anthony Cirillo, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Jeffrey M. Goodloe, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Ryan A. Stanton, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

2024 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

L. Anthony Cirillo, MD, FACEP

Question #1: **How will you mitigate the threat of losing members of the College when encountering divisive topics that may make large portions of the membership feel alienated or disenfranchised?**

Sometimes, in order to see clearly into the future, you have to look to the past. On August 16, 1968, Dr. John Wiegenstein, MD, and seven other emergency physicians met in Lansing, MI and founded ACEP. The founders had come together with a singular goal to "facilitate the exchange of information among physicians practicing emergency medicine".

The founding of ACEP seems so long ago, and you might think that it was easy to start the specialty of emergency medicine back then, since those were "simpler times". The reality of 1968 however, was anything but simple, and historians have deemed 1968 to be the "worst year of the 20th century". 1968 saw the assassinations of Martin Luther King, Jr, and Bobby Kennedy which prompted month long violent riots in Washington DC, Chicago, and Baltimore. The Vietnam War escalated with the Tet Offensive. Another wave of riots occurred in Chicago after the Democratic National Convention. Governor George Wallace of Alabama ran as the American Independent Party candidate on a segregationist platform winning electoral college votes of five states in the Presidential election. And yet, despite this turmoil, Apollo 8 successfully orbited the moon, the Civil Rights Act of 1968 was passed and signed into law by President Johnson, and yes, the American College of Emergency Physicians was founded.

So, what's with the history lesson? Even during a year of national turmoil, dissention, and violence not seen since the Civil War, the founders of ACEP brought the College to life by focusing on a singular common reason. The founders joined together with a shared common purpose to create an organization that would improve the care of patients seeking emergency care and to establish that those physicians who chose to practice emergency medicine would be recognized for their unique knowledge and skills. Somehow, despite all of the issues that were dividing the country, the founders were able to put aside personal opinions on those topics, and work together to create the specialty of emergency medicine because that was the work that needed to be done for the greater good of the nation and future emergency physicians.

So here we are 56 years later. The nation is once again (or maybe still) divided on a number of issues. Some of the issues are new, and some remain wounds that refuse to heal. These divisive issues have hyperpolarized the nation, fueled by a 24/7/365 social media and news cycle that deliberately stoke the flames of discord and disagreement. Every day, it feels that both our society at large, and our community of emergency medicine are being pulled further apart, especially by those who choose to tear apart rather than build together.

And yet, every day the patients come…and every day we care for them. Despite the myriad of issues that divide us, both as a society, and as a College, everyone in this country needs the emergency care system to be there in their time of need. That's the common thread that binds us…doing the incredibly hard, but rewarding work of being the bedside healers of a nation. In a recent update of our Mission, Vision, and Values, the mission of the College now reads: "To support and advocate for emergency physicians and to promote quality emergency care for our patients and the public". Seems like that although the words may be a little different (who doesn't love a little wordsmithing) ACEP's mission hasn't significantly changed since 1968. Despite all of the difficult and divisive issues that we have faced since 1968, are facing today, and will face tomorrow, ACEP's strength will always come from the work that we all do together, advocating for our patients and our profession. That's why every emergency physician should be a member of the College…because, just like in 1968, we have common work to do to enhance the specialty of emergency medicine and the support the physicians who provide it.

Question #2: **Given that the resources of ACEP are not infinite, how will you determine if ACEP should be involved in issues perceived to be not directly related to emergency medicine?**

The honest answer to this question is that the President of the College does not singularly determine whether ACEP should be involved in issues, and the concept of "perceived to be not directly related to emergency medicine" is very much in the eye of the beholder. In some ways, the increasing breadth and scope of issues that fall under the big tent of emergency medicine is both our greatest blessing and our greatest curse as a member organization. As the specialty has grown and evolved, we have seen emergency physicians become passionate leaders in a vast variety of both clinical and non-clinical topical arenas.

Ultrasound, EMS, Observation Medicine, Reproductive Care, Telehealth, DEI, Wilderness Medicine, Climate Health, Hyperbaric Medicine…the list of "EM" topics goes on and on. In addition, emergency physicians have become experts in arenas like Healthcare Administration, Advocacy, Medical-Legal Practice, and so many others. All of these topical areas of interest within the specialty are reflected in the many ACEP Committees, Sections, and MIGs where our members volunteer their time and efforts. So, how should the College prioritize which issues to devote our limited resources to? Well, the President is elected by the Council to listen to the many voices within the College, and that includes ALL the members of the College. The Council, however, in addition to electing the President-Elect, carries out two other more important duties, that of electing the members of the Board of Directors, and crafting, debating, and voting on Council Resolutions. The process of "getting involved in an issue is really about deciding whether the College should allocate resources, both financial and non-financial to that issue. This decision-making process is reflected in the crafting of a budget for the College, which is the work of many people, and begins with an annual evaluation to ensure that we are spending members dollars in a fiscally prudent and effective way. The budgeting process involves garnering input from stakeholders throughout the College: individual members, the Council, Chapter leaders, Committee/Section/MIG leadership, staff, the Finance Committee, and ultimately the Board of Directors with its ongoing partnership with the Council Officers. Ultimately, the dedication of resources, financial and otherwise, should reflect our values and beliefs and the goals that we have set forth in the Strategic Plan. Within this forward-looking framework, each budget, and concurrent decision of whether or not to engage on an individual issue, must be prioritized to reflect the unique opportunities and threats of the current situations facing our members and the College, and to ensure that we are supporting the core reasons why the College exists, to improve the emergency care of patients and to support our emergency physician colleagues.

Question #3: **What steps would you take to distinguish ACEP membership as having tangible and essential benefits to practicing emergency physicians?**

Every emergency physician wants, needs, and deserves the ***"3 R's"***: to be ***respected*** for the expertise we bring to the bedside, to be ***resourced*** appropriately to provide the care patients need, and to be ***reimbursed*** fairly and appropriately for that care. The primary value that ACEP brings to its members, is demonstrated by its efforts and focus on those 3 core issues. The College is, and always has been, uniquely positioned to be "at the table" in discussions with other key stakeholders on these issues. In today's challenging environment of practice, we are the organization bringing members directly to the discussions on the key topics of Hospital/ED Crowding and Boarding and ED Violence. It was ACEP's leadership, and persistence of efforts, that turned a letter to the White House into our own stakeholder summit on Crowding/Boarding, and now into the Agency for Healthcare Research & Quality (AHRQ) being tasked by the Secretary of HHS to convene all key stakeholders, including hospitals, insurers, physicians, nurses, post-acute care entities and patients to identify real solutions to this complicated issue. ACEP was the lead organization working with Members of Congress to get multiple bills sponsored to increase the protection of healthcare staff in the ED and make our ED's into truly well workplaces. ACEP is ***THE*** voice of emergency medicine within the house of medicine, and we are the only emergency medicine organization with a seat on the AMA RUC, where the value of every ED CPT code is decided. This seat at the RUC table, and the incredible success of our ACEP colleagues and staff who represent us there, has resulted in tens of millions of dollars in additional reimbursement to emergency physicians over the years.

Our greatest challenge in distinguishing what ACEP has never been a lack of the "what". We do the hard work to improve the care of patients, and improve the lives of every emergency physician. Our next steps need to be focused on ensuring that every emergency physician, especially those in medical school and residency know that ACEP is, and always has been fighting for them and the future of the specialty. This message of ACEP fighting for you needs to be shared in a variety of formats, including one on one conversations with the future members of the College at medical schools and residency training programs.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

L. Anthony Cirillo, MD, FACEP

Contact Information
91 Woodridge Drive
Saunderstown, RI 02874
Phone: 401-465-0806
E-Mail: lacirillo@acep.org

Current and Past Professional Position(s)
EM Residency Trained Emergency Physician, 1994-Present
Director of Government Affairs, US Acute Care Solutions, 2004-Present
Site Medical Director / Site Quality Director, US Acute Care Solutions, 2011-17
Chief, Center for Emergency Preparedness & Response, State of RI, Department of Health, 2006-08
Medical Director, Hospital Bioterrorism Preparedness Program, State of RI, Department of Health 2003-06
Physician-in-Chief, Department of Emergency Medicine, Memorial Hospital of RI, 1997-2004
Attending Physician, Instructor, Department of Emergency Medicine, Albany Medical Center, 1994-97

Education (include internships and residency information)
George Washington University Hospital, Transitional Internship – 1990-91
UMASS Medical Center, Residency in Emergency Medicine – 1991-94, Co-Chief Resident 1993-94

List Medical Degree (MD or DO) and Year Received Here
University of Vermont College of Medicine, MD, 1990

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM certification, Initial certification 1995, recertifications 2005, 2015

Professional Societies
Emergency Medicine Residents Association, Board of Directors 1992-94, Alumni member
ACEP (see below for years of membership and service)
American Medical Association
American Association for Emergency Psychiatry
Rhode Island Medical Society

National ACEP Activities – List your most significant accomplishments
ACEP, Member 1990–Present
ACEP National Board of Directors 2018-Present, Chair of the Board 2022-23

- Current Committee Liaison Appointments – EM Practice Management, Clinical Resource Review Committee
- Previous Committee Liaison Appointments – Coding & Nomenclature, Reimbursement, Membership
- Section Liaison Appointments – Medical Directors, Emergency Medicine Practice Management & Health Policy, Cruise Ship Medicine, Locum Tenens

Lead, Leadership & Advocacy Conference Innovation Planning Workgroup – 2023-24
Chair, Federal Government Affairs Committee
Chair, State Legislative & Regulatory Affairs Committee
Chair, Membership Committee
NEMPAC, Board of Trustees
ACEP Liaison, Coalition on Psychiatric Emergencies (CPE)
ACEP Representative – ACEP/EDPMA Surprise Medical Billing Task Force Steering Committee

ACEP Chapter Activities – List your most significant accomplishments
Massachusetts Chapter, Member 1990-94
New York Chapter, Councilor
Rhode Island Chapter, Member 1997-Present, Chapter President 1998-99, Councilor 1997-2018

Practice Profile
Total hours devoted to emergency medicine practice per year: **1920** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care **15** % Research ____ % Teaching ____ % Administration **85** %

Other: ______________________________ ____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
I currently do my clinical work as a Regional Traveler for US Acute Care Solutions. Currently I travel to the greater Denver area and work single-coverage 12-hour shifts at free standing Emergency Department/Urgent Care centers that are part of the AdventHealth system.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

I currently serve as the Director of Government Affairs for US Acute Care Solutions. I have served in this role since 2004, when originally employed by Emergency Medicine Physicians (EMP).

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

L. Anthony Cirillo, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

   Employer: US Acute Care Solutions, LLC

   Address: 4535 Dressler Rd, NW
   Canton, OH 44718

   Position Held: Director of Government Affairs / Actively Practicing Emergency Physician

   Type of Organization: Physician-owned multi-specialty group practice

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

   Organization: RI ACEP

   Address: 225 Dyer Street, 2nd Floor
   Providence, RI 02908

   Type of Organization: ACEP State Chapter

   Leadership Position: Chapter President

   Term of Service: 1998-99

   Organization: Emergency Department Practice Management Association (EDPMA)

   Address: 1600 International Drive, Suite 600
   McLean, VA 22102

   Type of Organization: Emergency Medicine Trade Association

   Leadership Position: Board of Directors / Chair of EDPMA PAC

   Term of Service: 2018-22

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☐ NO
☒ If YES, Please Describe: In order to provide my full efforts to the College, if elected as President-Elect, I will relinquish my advocacy responsibilities with US Acute Care Solutions to prevent any potential or perceived conflict of interest.

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

L. Anthony Cirillo, MD, FACEP Date 06-17-2024

American College of Emergency Physicians® — Rhode Island Chapter
ADVANCING EMERGENCY CARE

July 27, 2024

Dear Councillors,

On behalf of the Rhode Island Chapter of the American College of Emergency Physicians, it is my privilege and honor to endorse ***L. Anthony Cirillo, MD, FACEP*** for election as President-elect of the College. Throughout his 30- plus year career in Emergency Medicine, Dr. Cirillo has demonstrated thoughtful leadership and a deep passion for the specialty of emergency medicine and the College. During his many years here in Rhode Island and now as a member of the ACEP Board of Directors, including his term of Chair of the Board, Dr. Cirillo has exhibited his unwavering commitment and dedication to the physicians who have chosen the specialty as their calling and to the specialty of emergency medicine.

Throughout his career, Dr. Cirillo has “walked in many shoes” in emergency medicine. After starting his career in academics, Dr. Cirillo transitioned into emergency department leadership and served as the Chief of Emergency Medicine at one of the independent hospitals here in Rhode Island. In addition to his emergency department leadership roles, Dr. Cirillo took on additional public health responsibilities within the State of Rhode Island and was the founder Director of the Center for Emergency Preparedness and Response at the Rhode Island Department of Health (CEPR). In this role, Dr. Cirillo worked with a dedicated team to develop a coordinated system with the emergency management system, to ensure the state (and New England region) were prepared for all-hazards bioterrorism events. The work of Dr. Cirillo with the CEPR team laid the foundation for Rhode Island’s successful response to the COVID-19 pandemic.

Dr. Cirillo is most passionate about the importance of advocacy. Leading by example, Dr. Cirillo has set a high bar for every emergency physician to be actively engaged in improving our emergency healthcare system. Dr. Cirillo has been a tireless advocate for emergency medicine, both here in Rhode Island and nationally. Dr. Cirillo is the organizer of our annual *RIACEP EM Day on the Hill* event and lectures to our residents and medical students on the importance of using our collective voice to improve the lives of our patients and ourselves. Dr. Cirillo is instrumental at ACEP’s Leadership & Advocacy Conference, building and strengthening relationships with Rhode Island’s Congressional delegation. Being with Dr. Cirillo in Washington DC is like taking a master class in advocacy. He has nurtured strong bonds with the Members of our congressional delegation and has their ear as he advocates for us. He is truly an educator in advocacy as well, motivating, training and mentoring the next generation of emergency physician advocates.

In addition to advocacy and mentoring, Dr. Cirillo has served in leadership roles in Rhode Island including being a Past President of the Rhode Island Chapter of ACEP and a long time Chair of Rhode Island Medical Society’s Political Action Committee. As RI ACEP’s chapter president, I am deeply indebted to Dr. Cirillo’s advice on leadership and advocacy and I frequently find myself asking, “What would Tony do in this situation?”

Given his accomplishments and contributions to the specialty of emergency medicine and the American College of Emergency Physicians, it is with great pleasure that I submit this nomination on behalf of the RI Chapter for Dr. Cirillo’s election as President-Elect of the American College of Emergency Physicians.

Respectfully,

Joseph Lauro, MD, FACEP
President, RI Chapter
American College of Emergency Physicians

L. Anthony Cirillo, MD, FACEP

Member / Past Chair – ACEP National Board of Directors
Candidate for President-Elect

Dear Fellow Councilors and ACEP Friends and Colleagues,
Thank you for your service to the Council, the College, and Emergency Medicine. It is my greatest privilege to work with you, in the spotlight and behind the scenes, on behalf of all emergency physicians, our patients, and the future of our specialty. Over the past six years, I have been honored to represent and serve you as a member and past Chair of the ACEP Board of Directors. As I complete my final year on the Board, I humbly seek your vote to serve as your next ACEP President.

Advocacy for Emergency Physicians and our Patients
Throughout my career, I have been a strong advocate for emergency physicians in Washington, DC and state capitals, fighting on your behalf on issues like boarding, ED violence, reimbursement, scope of practice, and due process. Recently, we have faced new challenges to the sanctity of the emergency physician's role in EMTALA, and who decides when a patient has an "emergency." Ensuring the board-certified EM physician at the bedside remains the final authority on the best care for a patient is a fundamental battle I will continue to fight – and we will win. In over two decades of EM advocacy, I am especially proud of my passionate efforts to improve care for patients with mental illness. Collaborating with ABEM, the Coalition on Psychiatric Emergencies, and other stakeholders, I am helping to create fellowship and career opportunities for emergency physicians interested in behavioral health. With 30+ years of practice to reflect on as I help prepare our specialty for the future, I am driven by my deep love for emergency medicine and you, my colleagues. As ACEP President, my personal goal will be to share my expertise in advocacy by teaching, mentoring, and empowering more emergency physician voices.

The Strength and Power of "US"

Emergency physicians must unite in our crusade against scope creep, inadequate compensation, unsafe working conditions, and the commoditization of our valuable skills and services. We must find strength – not division – in the College's diverse membership of talented and creative individuals who differ in career stages, practice group models, and professional passions. Like a symphony orchestra leveraging a collection of unique instruments, we can best serve our specialty when we harmonize our talents to advocate together. There will always be battles to protect emergency physicians and our patients. As we strengthen our commitment to each other within ACEP, I will also commit to strengthening our alliances with our colleagues in other EM organizations on the issues that are paramount to all emergency physicians.

A "Place" to Be Restored

I believe that ACEP is more than an organization based in Dallas. ACEP is our home within EM. It is a family whose members share unique perspectives, geographical locations, and opinions, but are ultimately bonded as emergency physicians. Only another emergency physician can understand the exhilaration of a successful resuscitation or the pain of a failed one. Only emergency physicians know the personal sacrifices we make to be the guardians of the healthcare system, 24/7/365. Ultimately, I believe the greatest value the College provides is being the "place" where emergency physicians know they are both respected and restored through the strength and support of every other member. More than any other service to our members, I am committed to helping this College be the place where every emergency physician feels that they are with "their people."

I look forward to connecting with you soon, and wish you safe travels to Vegas!

CANDIDATE FOR PRESIDENT-ELECT

VOTE

TONY CIRILLO, MD, FACEP

EXPERIENCE
LEADERSHIP
ADVOCACY
ACCOUNTABILITY

- ACEP Board of Directors 6 years, Past Chair
- ACEP Council for 25+ years
- Chaired 3 ACEP National Committees
- Service on 8 ACEP Committees/Task Forces
- Proven History of Leadership with EMRA, ACEP, NEMPAC, EDPMA, and EM Policy Institute
- 30+ years of active clinical practice

A CAREER OF ADVOCACY FOR EMERGENCY PHYSICIANS AND SERVICE TO THE COLLEGE

TONY CIRILLO, MD, FACEP

FIGHTING FOR "3 R'S" FOR ALL EMERGENCY PHYSICIANS

RESPECT

We deserve to be ***RESPECTED*** for the vital care that we provide 24/7/365

RESOURCES

We need critical ***RESOURCES*** including appropriate staffing, equipment, and a safe workplace to deliver high quality care

REIMBURSEMENT

We have the right to fair ***REIMBURSEMENT*** for our service and sacrifices as the healthcare safety net of this country

VOTE FOR TONY CIRILLO: A CAREER OF ADVOCACY FOR EMERGENCY PHYSICIANS

LEARN MORE ABOUT TONY HERE:

Tony Cirillo, MD, FACEP - CV

RIACEP Endorsement Letter

Tony's "3 P-E Questions"

CURRICULUM VITAE

L. ANTHONY CIRILLO, MD, FACEP

Saunderstown, Rhode Island 02874
401-465-0806

PROFILE

Emergency Physician leader with 30-plus years' experience in transformational leadership roles within a variety of hospital, healthcare, and public health organizations.

- Experienced physician executive leading transformational changes in healthcare delivery through professional advocacy.
- Successful in leading organizations to embrace change through strong relationship-building skills, subject matter expertise, ability to present data clearly, and skill in engaging support through collaboration and partnership with public, private, and governmental entities.
- Strong leadership with excellent interpersonal and communication skills focusing on creation and execution of a vision for organizational improvement.

EMPLOYMENT

2004-Present US Acute Care Solutions, LLC, Canton, Ohio

Director of Government Affairs 2004-Present

- Executing position with responsibility for coordinating all company-wide activities related to health care legislation and regulation affecting the practice of emergency medicine at the federal and state level.
- Developing and implementing strategies for successful advocacy with legislators and regulators in the health policy arena on innovations related to delivery of acute care medical services.
- Working cooperatively with national, state, and local health care organizations to improve the practice environment and healthcare financing models of the practice of emergency medicine and acute care services.

Emergency Physician Clinical Practice 2004-Present

Providing clinical emergency medical services for company specializing in the staffing of hospital-based emergency departments with board-certified emergency medicine physicians.

Clinical Practice Sites

- 2004 – 2008 Roger Williams Medical Center, Providence, RI
- 2004 – 2006 St. Joseph's Medical Center, Syracuse, NY
- 2007 – 2009 St. Francis Medical Center, Tulsa, OK
- 2008 – 2019 Lawrence & Memorial Hospital, New London, CT
- 2009 – 2019 Pequot Health Center, Emergency Department, Groton, CT
- 2014 – 2019 Westerly Hospital, Westerly, RI
- 2019 – 2021 AdventHealth Dade City Hospital, Dade City, FL
- 2021 – 2023 AdventHealth Palm Harbor Emergency Dept, Palm Harbor, FL
- 2023 – Present AdventHealth Meridien and Southmoor ED, Denver, Colorado

Medical Directors / Site Quality Director 2011-17

- Provided physician medical leadership for free-standing Emergency Department within hospital integrated healthcare delivery system.
- Participated in hospital preparation for successful Joint Commission surveys.
- Managed all quality functions for Emergency Department sites at Lawrence & Memorial Main Campus and Pequot Health Center freestanding Emergency Department.
- Performed new provider audits, radiology and laboratory discrepancy audits as well as monthly audits of high-risk clinical conditions.

- Coordinated reporting of all CMS required audits.
- Developed hospital-based OPPE metrics and reporting tool for Emergency Dept. providers.

USACS Political Action Committee **Chair, 2013-Present**

- Managed the development and establishment of federally qualified political action committee for US Acute Care Solutions.
- Responsible for development of overall strategy and tactics for advocacy efforts in supportof legislators and candidates at the federal level.
- Participated in the creation of organizational by-laws and registration and approval of USACS PAC with the Federal Election Commission.

EMP Medical Group Board of Directors **2010-14**

- Elected member of 11-person board serving to represent the more than one thousand (1000) physicians and mid-level providers employed by EMP.
- Served as Chair of Nominations & Elections sub-committee of the Board with responsibility for oversight and management of annual search, nomination, and election process for members of the Board of Directors.
- Developed policies and procedures for election process in accordance with the legal operating agreement for the medical group.

2006-2008 **Chief, Center for Emergency Preparedness & Response**
Rhode Island Department of Health

- Managed the public health emergency preparedness operational unit within the Department of Health with direct supervisory authority for development and coordination of all emergency preparedness and response activities related to all-hazards public health emergency management.
- Served as Principal Investigator for CDC Public Health Emergency Preparedness and ASPR (Assistant Secretary for Preparedness & Response – USHHS) Hospital Preparedness Program grants.
- Represented the State of Rhode Island as the Director of Public Health Preparedness within the Association of State and Territorial Health Officials (ASTHO) organization.
- Served as statewide System Director for the Emergency System for Advanced Registration for Volunteer Health Professionals (ESAR-VHP) supplemental grant program sponsored by ASPR with responsibility for development of an integrated system for identification and pre-registration of healthcare professionals with an interest in responding to a public health emergency.
- Supervised all Pandemic Flu preparedness activities, including direction of federal grant programs for statewide preparation for pandemic influenza.
- Functioned as the principal coordinator of New England regional public health preparedness efforts with goal of developing a collaborative planning, preparedness, and response process related to pandemic influenza and other public health emergencies.

2003-2006 **Medical Director, Hospital Bioterrorism Preparedness Program**
Rhode Island Department of Health

- Provided medical direction (part-time) as a consultant for the Rhode Island Department of Health in support of the development of a comprehensive strategy of public health emergency preparedness.
- Provided content expertise and focused input on operational issues of public health emergency preparedness for hospitals and other healthcare partners.

1997-2003 **Physician-in-Chief, Department of Emergency Medicine**
Memorial Hospital of Rhode Island, Pawtucket, Rhode Island

- Provided supervisory oversight and administrative direction of clinical emergency services provided in the Emergency Department. Represented the Emergency Department internally in a matrixed health care organization on interdisciplinary committees and working groups and in day-to-day operational affairs.
- Represented the Emergency Department and institution to various external private and public organizations on issues related to emergency care and access to care.
- Identified opportunities for and implemented programs to improve quality of patient care and increase efficiency in the delivery of health care services.
- Provided direct clinical patient emergency care services.
- Coordinated the training of health care professional students on clinical rotations in the Emergency Department.

1997-2003 **Medical Director, Barrington Urgent Care Center**
Barrington, Rhode Island

- Provided medical direction and oversight to Memorial Hospital owned free standing facility provided urgent care services to the East Bay communities of Rhode Island.

1994-1997 **Director, Emergency Department**
Hillcrest Hospital, Pittsfield, Massachusetts

1994-1997 **Attending Physician, Instructor**
Department of Emergency Medicine
Albany Medical Center, Albany, New York

EDUCATION

Sep 1986-May 1990 **Doctor of Medicine**
University of Vermont College of Medicine, Burlington, Vermont

Sep 1980-May 1984 **Bachelor of Arts, *cum laude***
Baruch College, City University of New York, New York, New York
Psi Chi, National Psychology Honor Society

Sep 1978-Dec 1979 John Jay College of Criminal Justice, City University of New York, New York

Jul 1978-Sep 1978 United States Military Academy, West Point, New York

POSTGRADUATE TRAINING

Jul 1991-Jun 1994 **Residency in Emergency Medicine**
University of Massachusetts Medical Center, Worcester, Massachusetts

- Flight Physician UMASS Life Flight
- Chief Resident

Jun 1990-Jun 1991 **Preliminary Internship in Internal Medicine**
George Washington University Hospital, Washington D.C.

PROFESSIONAL LICENSURE

1997 - Present State of Rhode Island
2023 – Present State of Colorado
2023 – Present State of Kansas
Inactive Connecticut, Oklahoma, Massachusetts, New York, Florida

PROFESSIONAL MEMBERSHIPS

American College of Emergency Physicians **1990-Present**

- 2018-Present National Board of Directors
  - Chair of the Board, 2022-23
  - Current Committee Liaison Appointments
    - EM Practice Management
    - Clinical Resource Review Committee
  - Previous Committee Liaison Appointments
    - Coding & Nomenclature
    - Reimbursement
    - Membership
  - Section Liaison Appointments
    - Medical Directors
    - Emergency Medicine Practice Management & Health Policy
    - Cruise Ship Medicine
    - Locum Tenens
  - Lead, Leadership & Advocacy Conference Innovation Workgroup
- 2021-Present Coalition on Psychiatric Emergencies – ACEP Representative
- 2021-Present ACEP/EDPMA Surprise Medical Billing Task Force Steering Committee
- 2022 Annals of Emergency Medicine Editor-in-Chief Search Committee
- 2019-2021 Residency Program Engagement Task Force
- 2017-2019 Single Payer Task Force
- 2015- 2017 Quality Clinical Data Registry Committee Subcommittee Chair
- 2002-2008, 2011-2018 Federal Government Affairs Committee Chair 2014-Present
- 2002-2009, 2012-Pres National Emergency Medicine PAC Board
- 2006-2013 State Legislative Affairs Committee Chair 2010-2012
- 2003-2005 Council Tellers and Credentials Committee
- 1997-Present Rhode Island Chapter President 1998-1999
- 1999-2001, 2015-16, 2018-2019 National Nominating Committee
- 1995-1997 Section Grant Task Force Chair 1995-1997
- 1994-1997 Membership Committee Chair 1995-1997
- 1995-1996 Communications Plan Task Force
- 1994-1995 Core Curriculum Task Force
- 1992-1994 Council Steering Committee
- 1995-2000 Young Physicians Section Chair 1997-1998
- 1994-1997 New York Chapter Councilor 1996
- 1990-1994 Massachusetts Chapter

Rhode Island Medical Society **1997- 2010, 2015-Present**

2000-2008 **Rhode Island Medical Political Action Committee - Chairman**

- Coordinated lobbying and political activity efforts for statewide physician organization.
- Collaborated with medical society staff to develop and implement strategies for increasing effectiveness of physician communication with general assembly members and state general officers.
- Provided testimony to various legislative committees and administrative departments on health care related legislation and initiatives.

1997-2008 **Rhode Island Medical Society Council**

- Representative to governing and policy making body of the Rhode Island Medical Society

comprised of representatives from county and specialty medical societies.

Society for Academic Emergency Medicine **1999-2004**

Emergency Medicine Residents Association **1990-Present**

- 1992-1994 Board of Directors, Representative to ACEP
- 2010-Present Alumni Member

American Association for Emergency Psychiatry **2019-Present**

American Medical Association **1997-2010**

Emergency Department Practice Management Association **2015-Present**

- 2017-2019 ACEP/EDPMA Joint Task Force
- 2018-2022 Board of Directors
- 2018-2022 EDPMA PAC, Chairman
- 2018-Present State Regulatory & Insurance Committee
- 2018-Present Federal Health Policy Committee

HOSPITAL COMMITTEE SERVICE

Memorial Hospital of Rhode Island

09/01-08/03 Department of Health Hospital Preparedness Planning Committee - Representative

- Represented Memorial Hospital at organizational and planning group sponsored by the Rhode Island Department of Health and Hospital Association of Rhode Island (HARI) focusing on issues of statewide coordination of Emergency Management and Preparedness.
- Interacted with representatives of various health care institutions and agencies including Rhode Island Emergency Management Agency and the Rhode Island Department of Health.

05/97-08/03 Hospital Association of Rhode Island (HARI) - **Representative EMS Committee**

- Represented Memorial Hospital at HARI sponsored working group of physician, nursing, emergency department administrative leadership and representatives of the public and private sector Emergency Medical Services communities.
- Focused on prospectively identifying common issues to all hospital institutions providing emergency care and making formal recommendations to HARI governing board regarding improvements in emergency medical care.
- Specific issues addressed including hospital emergency department diversion and mandatory equipment exchange.

05/97-08/03 **Hospital Committee Participation**

- Performance Improvement Committee
- Graduate Medical Education Committee
- Internal Medicine Residency Review Committee
- Emergency Management Committee Co-Chair 2001-2003
- Patient Care Committee

Hillcrest Hospital

01/95-04/97 **Hospital Committee Participation**

- Emergency Department Committee Chair 1995-1997
- Medical Staff Executive Committee
- CPR Committee Chair 1995-1997

AWARDS / RECOGNITIONS

- **2018** ACEP Colin Rorrie, Jr. – Excellence in Health Policy Award
- **2023** EDPMA – Leadership Service Award

ACADEMIC APPOINTMENTS

- **2003-Present** Adjunct Professor, University of Rhode Island, College of Nursing
- **2007-2010** Clinical Assistant Professor, Brown Medical School, Department of Community Health
- **2004-2006** Clinical Assistant Professor, SUNY Syracuse Medical School, Department of Emer Medicine
- **1997-2005** Clinical Assistant Professor, Brown Medical School, Division of Emergency Medicine
- **1994-1997** Instructor, Albany Medical College, Department of Emergency Medicine

TRAINING / CERTIFICATIONS

- Emergency Response to Domestic Biological Incidents
- WMD Awareness for First Responders
- Emergency Medical Service Operations and Planning for WMD
- Hospital Emergency Incident Command System (HEICS) Trainer
- Incident Command System (ICS) Level 100, 200, 300, 400, 401
- National Response Plan – IS 700
- National Incident Management Systems – IS 800 / IS-800B
- National Disaster Medical System Response Team Training Program
- Emergency Manager: An Orientation to the Position – FEMA Emergency Management Institute
- Hospital Emergency Management for WMD Incident

LECTURES / GRAND ROUNDS PRESENTATIONS / MEDIA

- Effective Healthcare Advocacy for Emergency Physicians
- Caring for Patients with Mental Illness in the Emergency Department
- "That's Crazy Talk": Improving the Care of Patients with Mental Illness in the Emergency Department
    - ACEP Colin Rorrie, Jr Health Policy Lecture – ACEP19 Conference
- Surprise Medical Billing: Finding Solutions
- Healthcare Spending in our "Senior" Years
- Pandemic Influenza Preparedness
- Hospital Incident Command Systems (HICS)
- Introduction to Biological Terrorism
- Introduction to Chemical Terrorism
- Wound Management
- Intravenous Fluid Resuscitation
- Automated External Defibrillation and Public Access Defibrillation
- Politics and Medicine
- Patient Protection and Affordable Care Act
- Drugs of Abuse and Cardiac Toxicity
- Approach to the Emergency Department Patient with Chest Pain
- Automated External Defibrillators – Channel 10 WJAR – NBC
- Aortic Dissection – Channel 10 WJAR – NBC

INVITED NATIONAL SPEAKING

- ACOEP Scientific Assembly 2023 – Keynote Speaker, The Emergency Physician's Role in Advocacy, August 12, 2023
- Brookings Institute, Washington, DC. Panel Discussion on Out-of-Network/Balance Billing. March 2019

PUBLICATIONS

ACEP *Now – Official Newsletter of ACEP*

- May 2023 – ACEP 2022 Leadership & Advocacy Conference Highlights
- May 2022 – ACEP 2022 Leadership & Advocacy Conference Highlights
- May 2021 – ACEP 2021 Leadership & Advocacy Conference Highlights
- October 2020 – Meet the Five Emergency Physicians Vying for Congress
- May 2019 – ACEP 2019 Leadership & Advocacy Conference Highlights
- September 2018 – The Prudent Layperson Standard Under Attack in Emergency Medicine
- May 2018 – ACEP 2018 Leadership & Advocacy Conference Highlights
- June 2017 - ACEP 2017 Leadership & Advocacy Conference Highlights
- February 2017 – "Not My America"
- June 2016 – ACEP 2016 Legislative Advocacy Conference Highlights
- February 2016 - What Will 2016 Presidential Election Mean for Health Care in the U.S.?
- June 2015 – ACEP Legislative Advocacy Conference & Leadership Summit Highlights
- January 2014 – ACA Roundtable
- February 2014 – The Body Politic – The Government Shutdown and the Blame Games
- March 2014 – The Not So Sustainable Growth Rate

Emergency Physicians Monthly (EP Monthly)

- March 2010 – Healthcare Reform – A First Look
- September 2008 – The Health Care Divide

Books and Book Chapters

- Strauss R, Mayer, T. Emergency Department Management, Second Edition. 2019. Chapter written by Cirillo LA: Chapter 13B: The Mechanics of Advocacy.
- Aghababian R. Emergency Management of Cardiovascular Diseases, First Edition. 1994. Chapter written by Cirillo, LA: Commonly Used Cardiac Medications.

PROFESSIONAL SERVICE

- 2013-2023 ACEP *Now*, Editorial Advisory Board, Official Newsmagazine of ACEP
- 2013-2021 Emergency Medicine Policy Institute (EMPI), Board of Governors (Alternate) Chair, 2020
- 2017-2019 EDPMA / ACEP Balance Billing/OON Joint Task Force
- 2010-2013 Emergency Physicians Monthly (EP Monthly), Editorial Advisory Board
- 2009-2010 American Professional Education Services
  - School of Paramedicine Advisory Board / Medical Director
- 1999-2008 Primary Care Physicians Advisory Council - Rhode Island Department of Health
- 2007-2008 Department of Homeland Security, Federal Emergency Management Agency
  - Region I - Regional Advisory Council
- 2003-2008 Trauma Systems Advisory Committee – Rhode Island Department of Health
- 1997-2003 Lincoln Rescue Service, EMS Medical Director
- 1997-2003 Pawtucket Fire Department, EMS Medical Director
- 1994-1997 Malta Ambulance Corp, Volunteer Medical Director
- 1995-1997 Clifton Park Ambulance Corp, Medical Director

STATE LEGISLATIVE TESTIMONY

- State of Texas, House Insurance Committee. Testimony on Out-of-Network/Balance Billing legislation, March 2019
- State of Ohio, Senate Insurance Committee. Proponent testimony on SB 184 Out-of-Network/Balance Billing legislation, November 2019
- State of Ohio, House Finance Committee. Opponent testimony on HB 388, Out-of-Network/Balance Billing legislation, November 2019

FEDERAL CONGRESSIONAL TESTIMONY

- United States House of Representatives Homeland Security Committee, Subcommittee on Emerging Threats, Cybersecurity, and Science and Technology. "Beyond the Checklist: Addressing Shortfalls in National Pandemic Influenza Preparedness." September 25, 2007.
- United States House of Representatives Doctor's Caucus – Briefing participant - The No Surprises Act. September 21, 2023.
- United States House of Representatives Education & Workforce Committee – Republican caucus briefing participant – No Surprises Act, January 30, 2024.

PUBLIC / COMMUNITY SERVICE

- 2008-2019 Boy Scouts of America
  - Staff Medical Physician 2010 National Jamboree – July 2010
  - Jamboree Troop 128, Narragansett Council, Committee Chair
  - Troop 152, North Kingstown, RI, Assistant Scoutmaster
- 2008 Candidate, RI General Assembly, District 33
- 2008-2102 North Kingstown Flag Football League — Volunteer Referee
- 2007-2010 Karate Instruction Assistance Initiative (KIAI) — Board of Directors
- 2005-2010 YMCA of Greater Providence — Board of Directors
- 2002-2015 Rhode Island Disaster Medical Assistance Team/NDMS — Medical Officer
- 2001-2007 Regional Center for Poison Control (MA & RI) — Advisory Committee Member
- 1998-2005 Coalition for Public Safety Defibrillation — Medical Director
- 1998-2002 North Kingstown School Committee — Vice- Chair 1998-2000
- 1998-2010 North Kingstown Republican Town Committee — Member
- 1998-1999 American Heart Association, RI Affiliate — Board of Directors

NATIONAL SECURITY CLEARANCE

- SECRET LEVEL – United States Department of Homeland Security (Inactive)

REFERENCES (contact info available upon request)

The Honorable Representative James
Langevin Member of Congress (Retired)

The Honorable Representative Raul
Ruiz, MD Member of Congress

The Honorable Representative Joe Heck,
DO Member of Congress (Retired)

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

2024 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Jeffrey M. Goodloe, MD, FACEP

Question #1: **How will you mitigate the threat of losing members of the College when encountering divisive topics that may make large portions of the membership feel alienated or disenfranchised?**

I will not alone; that is for certain. However, WE, working together can make ACEP an even more welcoming organization to any residency-trained, board-certified emergency physician or emergency physician in training ahead and all current members. The foundation of my beliefs – in ACEP, in ACEP's potential, and pointedly in US as ACEP members, is how much WE share in common. Let us acknowledge differences and how what we then share helps us navigate these differences when they occur.

With 40,000 members, we will always realize differences in opinion on practically every issue that impacts emergency medicine and our professional lives. The key to finding advocacy that we can support in advancing our specialty and our futures is to recognize that differences do not have to be oppositional junctures. Differences can prove opportunities for learning. Learning can then bring us to a "stronger together" organization. I commit to continuing transparency in my leadership, encouraging any member to communicate directly with me. If I sense that a member feels alienated or is becoming disenfranchised by an official ACEP policy or an advocacy stance, particularly when in development, that is a prime point in which to ask and listen, not assert and talk. I am a believer that the best response to evident difference(s) are these questions: "Can you help me better understand how you see this topic?" and "What am I missing in evaluating this current position?"

Often, we all simply want to be heard. We can all respect democracy and that none of us gets our first choice every time in life. As long as we can effectively communicate – via email, via text, via social media, via phone, and my favorite way, in person – and do so respectfully to each other, then the end result of hearing multiple perspectives and ideals is a product, service, or advocacy stance that is more informed and more inclusive than trying to champion our causes alone. WE really are stronger together.

WE are literally the first part of "welcome." We should feel comfortable and "welcomed" in our differences as we share so much in common as emergency physicians. If we have never met, though we share membership in ACEP, then I know how much in common we can find. We can trust we each have a genuine interest in helping everyone that needs our skills. We can trust we each have a sincere desire to make a positive difference during some of the most challenging and terrifying moments in someone else's life. We can trust we each had to navigate an appropriately arduous journey of undergraduate and graduate education to become emergency physicians. We can trust we each had to sacrifice a lot of immediate gratification for the "delayed rewards" of being emergency physicians. Those are just a few of the many trusts in each other we can enjoy.

That common ground, through shared values, beliefs, and commitments in selflessly serving others, affords us a wealth in opportunity that is not measured in monetary terms alone. The greatest asset of ACEP is not our headquarters in Texas or any of its physical contents. Our greatest wealth of ACEP is in each other as member emergency physicians. When we pause in our differences in topics that historically divide – reproductive rights, firearms, types of professional practices that are "best" – and in topics that are emerging – unionization, the role of artificial intelligence – we can then realize that our differences are built upon the foundation of shared experiences, values, and beliefs.

At this stage in our careers, listening, sharing, learning, and respecting may seem basic. Let us remember that basic fundamentals done consistently well produce winning teams, in sports and in life. Our often-fractured world confirms that more than ever, we all need a winning team of emergency physicians doing what WE do better than others – advocating for our patients, for our profession, and for each other!

Question #2: **Given that the resources of ACEP are not infinite, how will you determine if ACEP should be involved in issues perceived to be not directly related to emergency medicine?**

Our guiding compass is our strategic plan that notably involved the entirety of the Board of Directors, the Council Officers, numerous staff leaders that included all executive staff, and key member-leaders representing a spectrum of demographics, including active members of later career, mid-career, the young physician section, and the Emergency Medicine Residents'

Association and its Medical Student Council. Further, involved leaders came from a variety of geographical locations, representing multiple practice types, such as community practice, academic practice, small democratic groups, regional/multi-state democratic groups, large/national groups, partner interests in such groups and new employees in such groups. Male and female genders, diverse ethnicities and orientation were included. All this is to affirm our strategic plan represents the whole spectrum of ACEP members. It is written to be readily accessible to any member. Our Board of Directors and executive staff have regularly reported progress to its implementation at national meetings, state chapter meetings as part of "ACEP Update" presentations, at committee and section meetings, and at our Board of Director meetings. I believe our strategic plan to be an "accountability tool" in how we spend our available resources, in monies, in time, in energies, and in focus. I also believe that the President-Elect and President must act in the interests of "the greater good" for members and the College, even when such stance on an issue runs counter to personal belief. I commit to upholding this principle so that any member can rely on me in "speaking for all" in a consistently professional and effective style.

Question #3: **What steps would you take to distinguish ACEP membership as having tangible and essential benefits to practicing emergency physicians?**

For years now, I have found in successfully recruiting members, and in retaining happy members, in ACEP equates to emergency physicians finding tangible and essential value in ACEP. What does that look like? There are at least some commonalities we share as emergency physicians choosing ACEP membership. Unimpeded patient access to our care for time-sensitive emergencies, fair reimbursement for our skilled services, liability protections for our care within reasonable clinical standards, and safe workplaces without discrimination for who we are as individuals are just a few of those values in which we can all find combined advocacy through ACEP to be stronger than ours as lone individuals.

We must better promote what ACEP advocacy at both federal and state levels achieves. Some recent examples of success are found in the passage of the Dr. Lorna Breen Health Care Provider Protection Act (federal), requiring trained security officers in every emergency department (Virginia and North Carolina), requiring physician leadership of emergency departments and a physician being physically present in the emergency department at any hospital (Indiana), and protecting our physician scope of practice that protects our physician practice opportunities from independently practicing nurse practitioners or physician assistants (Louisiana). Each and all these examples are achievements empowered by ACEP and ACEP state chapters. It is unlikely, if not impossible, that any of us could have achieved these important wins for emergency physicians and our patients by individual action alone. These wins highlight the importance of sharing winning strategies in both state ACEP chapter advocacy as well as national ACEP advocacy. I commit in President-Elect and President work to continue highlighting the value of state chapters and to work collaboratively and productively with our state chapter executives, state chapter Boards of Directors, and our ACEP advocacy staff.

Beyond these examples of widely shared goals, each of us as emergency physicians finds parts of our specialty's practice that we focus on for differing reasons, perhaps because we identify with an underrepresented population in our society, we have a family member with a particular illness or injury, or we discover an emergency medicine subspecialty in which we can satisfy our intellectual curiosities. Apart from our roles and abilities as emergency physicians, we may develop a passion for non-medical aspects of life (travel, history, writing, etc.). Any of these more individualized choices can be enriched through the ACEP community, be it through clinical education resources, speaking opportunities at conferences or via webinars, or one of the latest College services, member interest groups that connect us with like-minded colleagues. I commit in President-Elect and President work to continue developing these products and forums as well as championing emerging technologies to make communication within our emergency physician community productive and enriching.

The key in helping a member and/or a potential member is to first listen to the answer to this question, "What excites you about emergency medicine?" The answer, or more likely answers, can then lead to discovering how much ACEP is doing today and might include in future products and services. While the College cannot realistically be all things to every member, the reality is we each can benefit by the College growing in membership. A growing College is a stronger College, with capabilities for additional member resources. As your current Chair of the Board of Directors and a past Secretary-Treasurer, I am significantly educated on our annual budget. Membership dues are currently the second largest revenue source, trailing only educational meetings. The Board of Directors is wisely focused on growing non-dues revenue sources. While accreditation programs for geriatric emergency medicine, pain and addiction care in the emergency department, and emergency departments in general are primarily designed to improve resources and capabilities to benefit both patients and emergency physicians, these each represent non-dues revenue streams to enable ACEP to create more tangible resources for members, from enhanced smartphone apps to significant wins in reimbursement, liability protection, and work opportunities. Each and all these products and services must positively answer this question, "How does this have real value to practicing emergency physicians?"

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CANDIDATE DATA SHEET

Jeffrey M. Goodloe, MD, FACEP

Contact Information
3720 E 99th PL,
Tulsa, OK 74137 (Home)
Phone: 918-704-3164 (Cell)
E-Mail: jeffrey-goodloe@ouhsc.edu (Work); jeffreygoodloe911@gmail.com (Personal/ACEP)

Current and Past Professional Position(s)
Attending Emergency Physician – Hillcrest Medical Center Emergency Center – Tulsa, OK
Professor of Emergency Medicine; EMS Section Chief; Director, OK Center for Prehospital & Disaster Medicine
University of Oklahoma School of Community Medicine – Tulsa, OK
Chief Medical Officer, Medical Control Board, EMS System for Metropolitan Oklahoma City &Tulsa, OK
Medical Director, Oklahoma Highway Patrol
Medical Director, Tulsa Community College EMS Education Programs

Past Positions
Item Writer, EMS Examination & myEMSCert modules; Item Writer & Co-Editor, EMS LLSA, ABEM
Attending Emergency Physician – St. John Medical Center – Tulsa, OK
Attending Emergency Physician – Saint Francis Hospital Trauma Emergency Center – Tulsa, OK
Attending Emergency Physician – Medical Center of Plano – Plano, TX
Medical Director, Plano Fire Department – Plano, TX
Medical Director, Allen Fire Department – Allen, TX

Education (include internships and residency information)
EMS Fellowship – University of Texas Southwestern Medical Center at Dallas (1998-99)
Emergency Medicine Residency – Methodist Hospital of Indiana/Indiana Univ School of Medicine (1995-98)
The Medical School at University of Texas Health Science Center at San Antonio (1991-95)
Baylor University – Waco, TX (1987-91)

MD - 1995

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.)
ABEM Emergency Medicine Initial Certification 1999, Recertification 2009 & 2019
All MOC components current for present cycle recertification in 2029
ABEM EMS Medicine Initial Certification 2013, All MOC components current & certification extended to 2027
factoring service on EMS Subboard for ABEM

Professional Societies
ACEP member since 1991 (medical student, resident, fellow, active, FACEP)
OCEP (Oklahoma College of Emergency Physicians – State ACEP Chapter)
AMA
NAEMSP (FAEMS)
SAEM
ACHE

Prior memberships in Texas College of Emergency Physicians, Indiana ACEP Chapter, Oklahoma State
Medical Association, Tulsa County Medical Society

National ACEP Activities – List your most significant accomplishments
Chair, ACEP Board of Directors (2023-2024 -present)

Secretary-Treasurer, ACEP Board of Directors (2021-2022)
Member, ACEP Board of Directors (2019-present; elected 2019; re-elected 2022)
Member, Council Steering Committee, ACEP Council
Chair, Reference Committee, ACEP Council
Member, Reference Committee, ACEP Council
Councillor, Oklahoma College of Emergency Physicians
Councillor, EMRA
Chair, EMS Committee
Member, EMS Committee
Member, Bylaws Committee
Member, Internal & External Membership Committee Taskforces

ACEP Chapter Activities – List your most significant accomplishments
President, Oklahoma College of Emergency Physicians
Vice-President, Oklahoma College of Emergency Physicians
Councillor & Board Member, Oklahoma College of Emergency Physicians

Practice Profile
Total hours devoted to emergency medicine practice per year: **3120** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care **40** % Research **5** % Teaching **10** % Administration **45*** %
Other: ***Predominantly EMS medical oversight & national ACEP duties** ____%

Describe current emergency medicine practice. (e.g., type of employment, type of facility, single or multi-hospital group, etc.)
I am employed full time by the University of Oklahoma School of Community Medicine. My roles include serving as medical school faculty as a professor of emergency medicine and clinically as an attending faculty physician in the Hillcrest Medical Center Emergency Center (Comprehensive Stroke Center, full-service cardiovascular institute site – including ECMO and VAD surgeries, Level III Trauma Center, regional burn center for geographical areas of four states, Level III NICU) supervising residents in Emergency Medicine, Internal Medicine, Family Medicine, OB/GYN, fellows in Pediatric Emergency Medicine, and medical students. The University of Oklahoma Department of Emergency Medicine faculty partially staffs four emergency departments in Tulsa and Oklahoma City, employing a university academic group/regional democratic private group collaborative structure. I am staff credentialed at Hillcrest Medical Center in Tulsa, the base hospital for the EM residency, though I have been staff credentialed in prior years at two other teaching community hospitals in Tulsa. I also serve as the Chief Medical Officer for the EMS System for Metropolitan Oklahoma City and Tulsa, clinically leading over 2,800 credentialed EMS professionals working in an ambulance service, fire departments, law enforcement agencies, industrial emergency response teams or emergency communications centers. I further serve as a tactical emergency physician and Medical Director for the Oklahoma Highway Patrol, responding on emergency tactical missions across the entire state. Additional practice roles include special events medical support planning for metropolitan Oklahoma City and Tulsa and as an educational program medical director for EMT and Paramedic education at Tulsa Community College. I also frequently lecture at national educational meetings, such as the EMerald Coast Conference (multiple ACEP state chapter annual conference in Florida) and EMS State of the Science – A Gathering of Eagles.

Expert Witness Experience (I am interpreting such as courtroom testimony – JG)
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony
.

Defense Expert 1 Cases Plaintiff Expert 0 Cases

No expert witness work since election to the ACEP Board of Directors in 2019.

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Jeffrey M. Goodloe, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: University of Oklahoma School of Community Medicine

Address: Department of Emergency Medicine, 1145 S. Utica Ave, 6th Floor

Tulsa, OK 74104

Position Held: Professor; EMS Section Chief; Director – OK Ctr for Prehospital/Disaster Med

Type of Organization: Medical School

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: American College of Emergency Physicians

Address: 4950 W. Royal Ln

Irving, TX 75063

Type of Organization: Medical Specialty Society

Leadership Position: Chair, Secretary-Treasurer & Member, Board of Directors

Term of Service: 2023-present (Chair); 2019-present (Member); 2021-2022 (Sec-Treas)

Organization: Emergency Medicine Foundation

Address: 4950 W. Royal Ln

Irving, TX 75063

Type of Organization: 501(c)3 Nonprofit Organization for Funding Emergency Medicine Research

Leadership Position: Chair & Member, Board of Trustees

Term of Service: 2018-present (Member);2021 (Treasurer);2022 (Chair);2023 (Immed Past Chair)

Organization: Emergency Medical Services Authority

Address: 6205 S. Sooner Road

Oklahoma City, OK 73135

Type of Organization: Public Utility Model Ambulance Service

Leadership Position: Ex-officio as Chief Medical Officer/Medical Director

Term of Service: 2009-present

Organization: American Board of Emergency Medicine

Address: 3000 Coolidge Road

East Lansing, MI 48823

Type of Organization: Medical Specialty Board Certification Organization

Leadership Position: Member, Item Writer & LLSA Co-Editor, EMS Subboard

Term of Service: 2019-2022 (Member & Item Writer); 2022 (LLSA Co-Editor)

Organization: Oklahoma College of Emergency Physicians

Address: No physical office address for OCEP

Executive Director is Gabe Graham at gabegraham11@gmail.com

Type of Organization: State Chapter of ACEP

Leadership Position: Immediate Past President & Member, Board of Directors

Term of Service: 2007-present (Member); 2012-2016 (Vice President); 2016-2019 (President); 2019-2023 (Immediate Past President)

Organization: Emergency Medicine Residents' Association

Address: 4950 W. Royal Ln

Irving, TX 75063

Type of Organization: Professional Medical Association

Leadership Position: Past President & Past Member, Board of Directors

Term of Service: 1995-1998 (Member); 1995-1996 (President-Elect); 1996-1997 (President); 1997-1998 (Immediate Past President)

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE

☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Jeffrey M. Goodloe, MD, FACEP Date June 16, 2024

July 19, 2024

Re: Endorsement of Jeffrey M. Goodloe, MD, FACEP for election to ACEP President-Elect

Dear Councillors,

On behalf of the Oklahoma College of Emergency Physicians (OCEP), I write to enthusiastically endorse election of Dr. Jeffrey M. Goodloe as ACEP's next President-Elect.

Dr. Goodloe is well known nationally within ACEP due to his dynamic, servant leadership. Dr. Goodloe's fellow board members agree, electing him as Board Chair during this pivotal year in College executive leadership. Results-focused, team-building, clear-speaking leadership is a decades-long "Jeff Goodloe hallmark." He has been a 15-year plus active councillor, serving on the Council Steering Committee and reference committees, including chairing a reference committee.

Dr. Goodloe is relentlessly active in advocacy at both state and federal levels, respected among Oklahoma's State and US Representatives and Senators. Tellingly, both Representative Kevin Hern (OK-01) and Senator Markwayne Mullin (OK) have designated him as the "emergency medicine expert" on their respective healthcare panels. Dr. Goodloe has personally hosted both legislative leaders at his local emergency department, including arranging time with emergency medicine residents at the University of Oklahoma School of Community Medicine. Sen. Mullin counts on Dr. Goodloe's insights to help frame his own advocacy for constituents struggling with opioid use disorder. With Dr. Goodloe at his immediate side in multiple town halls in Oklahoma, then Rep. Mullin pointed out, "Clearly, emergency medicine is not the problem; they (emergency medicine physicians) are part of our answer!"

Dr. Goodloe is an active promoter of Emergency Medicine's future, speaking candidly and passionately about the importance of emergency physicians and their career fulfillment to the health of our communities and nation. He is dependably a "first call" by ACEP's public relations team when complicated, politically charged issues need a scientifically sound and layperson relatable voice amidst the chaos. Repeatedly, Jeff has proven that resource that we need to reassure our patients and the public that emergency physicians are their allies in health. When much of our society is understandably cynical, it is a trusted leader like Dr. Goodloe that we need speaking as our national President.

Jeff Goodloe's critical thinking and ability to manage dynamic situations has been trusted by generations of ACEP leaders, including multiple ACEP presidents, evidenced in part by a committee chair appointment, multiple appointments to other committees and task forces, and as our national liaison voice to multiple professional organizations, including the American College of Surgeons Committee on Trauma and the American Academy of Emergency Nurse Practitioners to name just a few.

Board of Directors

President
James R. Kennedye, MD, MPH, FACEP

Vice-President
Cecelia Guthrie, MD, FACEP

Treasurer
Timothy Hill, MD, PhD, FACEP

Immediate Past President
Chad Phillips, MD, FACEP

Members
Jeffrey Johnson, MD, FACEP
Kurtis Mayz, MD, JD, MBA, FACEP
Craig Sanford, MD, FACEP
Jeffrey M. Goodloe, MD, FACEP
Derek Martinez, MD

Executive Director
Gabe Graham, CPA gabegraham11@gmail.com

Within The Sooner State, Dr. Goodloe has effectively led OCEP as a Board Member since 2007 and as our President in 2016-2019, helping create a resurgence in engaged chapter membership. Jeff's tireless encouragement of chapter members to be involved in OCEP and ACEP is a difference maker. Further, Jeff led OCEP in electing our first resident member to full Councillor status with concurrent election to our board of directors. We are excited to promote the next generation of emergency medicine leaders in Oklahoma.

We are certain that Dr. Goodloe would verify the above, though reluctantly, given his modest, shining the light on others leadership style. I submit to you that it is hard to find a more giving, humble leader with unquestionable integrity and ethics.

In closing, OCEP respectfully and strongly encourages the ACEP Council to elect Jeffrey M. Goodloe, MD, FACEP as ACEP President-Elect and in becoming the first Oklahoma-based President-Elect in ACEP history.

Kindest professional regards,

James R. Kennedye, MD, MPH, FACEP
President, Oklahoma College of Emergency Physicians

Board of Directors

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Vice-President
Cecelia Guthrie, MD, FACEP

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Jeffrey M. Goodloe, MD, FACEP
Derek Martinez, MD

Executive Director
Gabe Graham, CPA gabegraham11@gmail.com

Jeffrey M. Goodloe, MD, FACEP

Councillors,

I am humbled and encouraged by your support as I serve you on the Board of Directors, guiding its deliberations as your current Chair.

As emergency physicians, we deliver more than unscheduled acute care when patients need it most. In an ever more cynical, stressed, and depressed world, we represent hope itself. We all know the motto, "No shirt? No shoes? No problem." In reality, we welcome the frayed and afraid souls in need of far more than clothing. "No resources? No hope? We will help!" is what I sense in an increasing number of patient – physician relationships in my busy clinical practice.

Twenty-five years post emergency medicine residency and EMS fellowship, I am sometimes asked, "Still work shifts?" Though emergency medicine takes multiple forms, a large part of my practice has always been directly treating patients in a hospital-based emergency department. I genuinely love "the magic of emergency medicine" that happens at the bedside. Immediate trust by patients, their loved ones, their families, and others bestowed in me is not because of "J M Goodloe, MD. FACEP" on the scrubs and white coat; it is because of these words that follow that you and I share, "Emergency Physician."

At home, I am blessed beyond my dreams with an extended family of girls and their mothers, including the matriarch, my better 99.5%. They all affectionately call me "Doc." Many times when heading to work, in scrubs, in EMS chief uniform, or in suit and tie, one or more will ask me, "Doc, are you going to save the world today?" The vision of young children is profound at times.

As I think upon how we endeavor in our craft's unique ways to save the world, I am dedicated through servant leadership to emphasize two missions: 1) promoting the value of emergency physicians; and 2) growing the strength of our College in advocacies in which we must succeed. In pragmatic terms, we cannot save the world without first saving our own world.

As I have worked on incredible ACEP teams – committees, task forces, sections, and with fellow Board of Directors members, there is commonality in our challenges: we are fighting the progressive devaluing of the emergency physician.

Private insurance quarterly profits soar while our reimbursement shrinks through automatic denial and/or downcoding schemes. Governmental calculations considering inflation in payments to hospital systems leave physicians underpaid. State laws reward non-physicians with independent scope of practice, threatening our career options at best and outright replacing us by the notably less experienced and less educated at worst. All the while, our halls can fill with patients faster than any of us can see them with the attention and humanity we prefer.

And still, we rise.

In the history of emergency medicine and its physicians, the brightest stories are not fading as time passes; our best days are found ahead. How am I unmistakably unshakably so certain about this?

I have traveled across our country, listening at state chapter meetings, conversing with myriads of emergency physicians. I see our wise distillation of the complex forces against us. I see in unifying resilience that we will prove victorious in valuing ourselves, in effectively enlisting a public that too often passively takes us for granted, and certainly in overcoming those actively committed to devaluing us.

As we gather in Las Vegas, a city associated with oddsmakers, I am "all in" on us! With our collective wisdom, perseverance, and dedication, we will prevail – for our patients, for our families, for ourselves, for our specialty, and yes, for the world we serve.

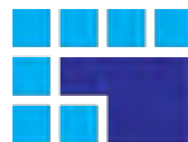
JEFFREY M. GOODLOE, MD, FACEP

For Election as ACEP President-Elect

Accountable service
Consensus builder
Enthusiastic commitment
Proven leadership

ACEP Board Chair 2023 – Present
ACEP Secretary-Treasurer 2021-2022
Board Service: Elected 2019 & 2022
  Task Forces: Hyperactive Delirium & Rural
  Committees: Membership, Bylaws, EMS, Pediatric EM
  Sections: EMS, Pediatric EM, Geriatric, Tactical/Law Enforcement, Sports Med
  Amer Coll Surgeons Comm on Trauma
  Geriatric ED Accred Board of Governors
Past Council Steering Committee Member
Past Council Reference Committee Chair
Past EMS Committee Chair
Past State Chapter President & Councillor
Past EMRA President & Councillor

Proudly endorsed by:



Oklahoma College of EMERGENCY PHYSICIANS

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Fax: (918) 579-2369 (Department Fax)

E-mail: jeffrey-goodloe@ouhsc.edu (EMS/EM/University)
jeffreygoodloe911@gmail.com (ACEP/Special Projects)

II. EDUCATION

School/College	Field of Study	Degree Earned	Year
The University of Texas Medical School at San Antonio	Medicine	MD	1991-95
Baylor University Waco, Texas	Biology	BS, cum laude	1987-91
Scott & White Memorial Hospital Texas A&M University Health Science Center Temple, Texas	EMS	EMT-Paramedic	1990
Oklahoma City Community College Oklahoma City, Oklahoma	EMS	EMT-Intermediate	1989
McLennan Community College Waco, Texas	EMS	EMT-Basic	1988

POST-DOCTORAL TRAINING:

Institution	Field	Type	Year
The University of Texas Medical School at Southwestern Medical Center at Dallas	EMS	Fellowship	1998-99
Indiana University School of Medicine Methodist Hospital of Indiana Indianapolis, Indiana	Emergency Medicine Residency		1995-98

III. PROFESSIONAL EXPERIENCE

1. Academic:

2012-Present Professor and EMS Section Chief
Director - Center for Prehospital and Disaster Medicine
Department of Emergency Medicine
The University of Oklahoma School of Community Medicine

2007-2012 Associate Professor and EMS Division Director
Department of Emergency Medicine
The University of Oklahoma School of Community Medicine

2004-2014 Clinical Assistant Professor
Division of Emergency Medicine, Department of Surgery
The University of Texas Medical School
Southwestern Medical Center at Dallas

1998-1999 Assistant Instructor
Division of Emergency Medicine, Department of Surgery
The University of Texas Medical School
Southwestern Medical Center at Dallas
Faculty Clinical Duties at Parkland Memorial Hospital

1994-1995 Clinical Instructor
Department of Emergency Medical Technology
School of Allied Health
The University of Texas Health Science Center at San Antonio

1994-1995 Instructor
Emergency Medicine Collaborative Teaching Program
Department of Emergency Medicine
The University of Texas Medical School
The University of Texas Health Science Center at Houston

2. Administrative:

2018-Present Medical Director
2010-2016 Oklahoma Highway Patrol Special Response Teams
Tactical, Emergency Medical Services Unit
Riot Control, Bomb, Dive

2014-Present Medical Director
Tulsa Community College
Emergency Medical Services Education Program

2011-Present Emergency Medicine Advisor
Oklahoma City Thunder Professional Basketball Club
National Basketball Association

2010-Present Medical Director
Special Operations Medical Oversight and Support (SOMOS)
Department of Emergency Medicine, EMS Section
University of Oklahoma School of Community Medicine

2009-Present Chief Medical Officer & Medical Director
Medical Control Board, Emergency Medical Services System for Metropolitan Oklahoma City & Tulsa, Oklahoma
Metropolitan Medical Response System

2008-2009 Associate Medical Director
Medical Control Board, Emergency Medical Services System for Metropolitan Oklahoma City & Tulsa, Oklahoma
Metropolitan Medical Response System

2003-2007 EMS Medical Director
Allen Fire Department
Allen, Texas

2001-2007 Medical Director, Emergency Response Team
Plano Police Department
Plano, Texas

2000-2007 Medical Director, Automated External Defibrillation Program
City of Plano, Texas

2000-2007 Medical Director, Emergency Medical Technician Education
Plano Independent School District
Plano, Texas

1999-2007 EMS Medical Director
Plano Fire Department
Plano, Texas

1996-1998 Associate EMS Medical Director
Hendricks County EMS Consortium (Avon Fire Department, Brownsburg Fire Department, Danville Fire Department, Plainfield Fire Department)
Hendricks County, Indiana

3. Hospital/Agency

2011-Present Hillcrest Medical Center, Tulsa, Oklahoma
Emergency Medicine Residency Faculty & Emergency Physician

2009-2011 St. John Medical Center, Tulsa, Oklahoma
Emergency Medicine Residency Faculty & Emergency Physician

2007-2009 St. Francis Hospital, Tulsa, Oklahoma
Emergency Medicine Residency Faculty & Emergency Physician

2006-2011 International Hot Rod Association, Norwalk, Ohio
Track Rescue Team Physician

2000-2019 Texas Motor Speedway/North Hills Track Hospital
Fort Worth, Texas
Track Physician for:
- NASCAR Monster Energy Cup Series
- NASCAR Xfinity Series
- NASCAR Camping World Truck Series
- IndyCar Series

1999-2007 Medical Center of Plano, Plano, Texas
Emergency Physician

1997-1998 Indianapolis Motor Speedway/Hanna Emergency Medical Center
Track Physician for:
- Indy Racing League & NASCAR Winston Cup Series

1996-1998 Hendricks Community Hospital, Danville, Indiana
Emergency Resident Physician

1996-1998 Indianapolis Raceway Park, Clermont, Indiana
Track Physician for:
- National Hot Rod Association US Nationals

1996-1998 Methodist Hospital of Indiana, Methodist Health Group
Indianapolis, Indiana
LifeLine Helicopter EMS, Flight Physician

1992-1995 American Medical Transport, Rural/Metro Corporation
Pasadena, Texas
EMT-Paramedic

1989-1991 American Medical Transport, Rural/Metro Corporation
Waco, Texas
EMT-Intermediate & Paramedic

IV. MILITARY EXPERIENCE

None

V. BOARD CERTIFICATION

Emergency Medicine, American Board of Emergency Medicine
Initial Certification 1999; Recertification 2009, 2019 (expires 12/31/2029)
Emergency Medical Services Medicine, American Board of Emergency Medicine
Initial Certification 2013 (expires 12/31/2027)

VI. LICENSES/CERTIFICATIONS

Physician Licenses:

July 1996 - Present	Indiana
August 1998 - Present	Texas
July 2007 - Present	Oklahoma

EMS Licenses/Certifications:
National Registry of Emergency Medical Technicians
Paramedic (active status)
EMT-Tactical (active status)

Lean/Six Sigma Certifications (accredited by IASSC):
Black Belt
Creative Insights, Inc.
Green Belt
University of Oklahoma Gallogly College of Engineering
White/Yellow Belt – Fundamentals of Lean/Six Sigma
University of Oklahoma Gallogly College of Engineering

VII. RESEARCH AND SCHOLARSHIP

1. Grants/Funded Projects

a. 2015 EMS Medical Director Course and CQI Practicum. Principal Instructor and Course Coordinator for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Section. Under contract with Rogers EMS Consulting. Project was completed in June 2015 and entailed delivery of the State of Oklahoma EMS Medical Director Course and CQI Practicum in Antlers, Altus, and Fairview. Direct funding at $6,000 by Rogers EMS Consulting.

b. 2014 EMS Medical Director Course and Practicum. Principal Instructor and Course Coordinator for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Section. Under contract with Rogers EMS Consulting. Project was completed in June 2014 and entailed delivery of the State of Oklahoma EMS Medical Director Course and Practicum in Ardmore and Lawton. Direct funding at $12,500 by Rogers EMS Consulting.

c. 2013-14 Update State of Oklahoma EMS Treatment Protocols and EMS Medical Director Course and Practicum. Principal Developer for University of Oklahoma School of Community Medicine, Department

of Emergency Medicine, EMS Section. Under contract with the Oklahoma State Department of Health Protective Health Services EMS/Trauma Division. Project was completed in April 2014 and entailed development of EMS treatment protocols that are endorsed as the official 2014 State of Oklahoma EMS treatment protocols for use by all ground-based EMS agencies. Additional deliverable components included development of update methodologies and curriculum refinement and delivery of the State of Oklahoma EMS Medical Director Course and Practicum in Muskogee and Stillwater. Direct funding at $40,000 by Oklahoma State Department of Health.

d. 2011-12 Development of State of Oklahoma EMS Treatment Protocols and EMS Medical Director Course and Practicum. Principal Developer for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Division. Under contract with the Oklahoma State Department of Health Protective Health Services EMS/Trauma Division. Project was completed in September 2012 and entailed development of EMS treatment protocols that are endorsed as the official State of Oklahoma EMS treatment protocols for use by all ground-based EMS agencies. Additional deliverable components included development of update methodologies and curriculum refinement and delivery of the State of Oklahoma EMS Medical Director Course and Practicum. Direct funding at $169,000 by Oklahoma State Department of Health.

e. 2010-11 Development of a white paper on EMS System Design. Principal Editor for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Division. Project was completed in July 2011 with deliverable exceeding expectation of commissioning entity. Authors were personally recruited from Los Angeles, Salt Lake City, Indianapolis, Birmingham, and Charlotte. Co-Editor is Dr. Stephen H. Thomas. Direct funding at $27,000 by Emergency Medical Services Authority in Tulsa, Oklahoma.

2. Research Projects

a. IRB Waived/662445. Paramedic Compliance with a Novel Defibrillation Strategy in a Large, Urban EMS System in the United States. Principal Investigator. Accepted for poster presentation at Canadian Association of Emergency Physicians 2017 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involves one EM resident.

b. IRB Waived/662516. Morbid Obesity Association with Return of Spontaneous Circulation from Sudden Cardiac Arrest Treated in a Large, Urban EMS System in the United States. Principal Investigator. Accepted for poster presentation at Canadian Association of Emergency Physicians 2017 Annual Meeting. Abstract

published in Canadian Journal of Emergency Medicine. Project involves one EM resident.

c. IRB Waived/603842. Prevalence and Survival Impact of Bystander Cardiopulmonary Resuscitation in Sudden Cardiac Arrest Victims Treated by a Large, Urban EMS System in North America. Principal Investigator. Accepted for oral presentation at Canadian Association of Emergency Physicians 2015 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine.

d. IRB Waived/603842. Demographics of Twenty-One Years of Sudden Cardiac Arrest Victims Treated by a Large, Urban EMS System in North America. Principal Investigator. Accepted for poster presentation at Canadian Association of Emergency Physicians 2015 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine.

e. IRB Waived/603842. The Prevalence and Impact of Ventricular Fibrillation as the Initial Cardiac Arrest Dysrhythmia over Twenty Years in a Large, Urban EMS System. Principal Investigator. Accepted for poster presentation at National Association of EMS Physicians 2015 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for poster presentation at Canadian Association of Emergency Physicians 2015 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine.

f. Other IRB Waived. The Effect of CPR Quality: A Potential Confounder of CPR Clinical Trials and Important National Healthcare Issue. Co-Investigator. Accepted for poster presentation at National Association of EMS Physicians 2015 Annual Meeting. Abstract published in Prehospital Emergency Care.

g. IRB Waived/3472. Epinephrine Usage for Allergic Reactions and Anaphylaxis in a Large, Urban EMS System. Principal Investigator. Accepted for poster presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Accepted for poster presentation at International Conference on Emergency Medicine 2014. Project involves one medical student and one EM resident.

h. IRB Waived/3319. Tourniquet Utilization in a Large, Urban EMS System. Principal Investigator. Accepted for poster presentation at National Association of EMS Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for poster presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Accepted at International Conference on Emergency Medicine 2014. Project involves one EM resident.

i. IRB Waived/3330. Airway Management in Adult, Non-Traumatic Cardiopulmonary Arrest in a Large, Urban EMS System. Principal

Investigator. Accepted for poster presentation at National Association of EMS Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for 2 poster presentations at Canadian Association of Emergency Physicians 2014 Annual Meeting. Both abstracts published in Canadian Journal of Emergency Medicine. Accepted for 2 poster presentations at International Conference on Emergency Medicine 2014. Project involves one undergraduate student, one medical student, and one EM resident.

j. IRB Waived/3320. Adenosine Usage for PSVT Cardioversion in a Large, Urban EMS System. Principal Investigator. Accepted for poster presentation at National Association of EMS Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for poster presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Accepted for poster presentation at International Conference on Emergency Medicine 2014. Project involves two undergraduate students.

k. IRB Approved. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Longitudinal Analysis of Contributing Factors and Resultant Injuries. Senior Investigator. Poster presentation at National Association of EMS Physicians 2013 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involves one medical student.

l. IRB Approved 16247/1256. Emergency Medical Technician Acquisition and Transmission of 12-Lead ECG Using a Novel Device (ReadyLink). Principal Investigator. Project involves one EM resident and one medical student. Poster presentation at American College of Cardiology 2013 Annual Meeting. Abstract published in Journal of the American College of Cardiology. Poster presentation at Society for Academic Emergency Medicine 2013 Annual Meeting. Poster presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Manuscript in progress. Project involves one undergraduate student and one EM resident.

m. IRB Waived. US Metropolitan Municipalities EMS Medical Directors Consortium (Eagles) Traumatic Shock and Hemorrhage Control Standards of Care Survey. Principal Investigator.

n. IRB Waived. US Metropolitan Municipalities EMS Medical Directors Consortium (Eagles) Neurologic Emergencies Standards of Care Survey. Principal Investigator.

o. IRB Approved 16038. Prehospital Barriers to the Use of Therapeutic Hypothermia for Cardiac Arrest. Senior Investigator. Poster

presentation at National Association of EMS Physicians 2012 Annual Meeting. Abstract published in Prehospital Emergency Care. Oral presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involved one EM resident and one medical student.

p. IRB Waived. Parenteral Dextrose Utilization in a Large, Urban Emergency Medical Services System. Senior Investigator. Poster presentation at National Association of EMS Physicians 2012 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involved one EM resident that presented the poster and one medical student.

q. IRB Waived. US Metropolitan Municipalities EMS Medical Directors Consortium (Eagles) State of Cardiopulmonary Resuscitation Practices Survey. Principal Investigator. Poster presentation at Society for Academic Emergency Medicine 2012 Annual Meeting and American College of Cardiology 2012 Annual Meeting. Oral presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involved one EMS fellow.

r. IRB Approved. A Statewide Survey of Emergency Department Standards of Care for Acute Coronary Syndromes - Variability and Opportunity for Advancement. Senior Investigator. Poster presentation at American College of Cardiology 2012 Annual Meeting. Project involved two EM residents and two medical students.

s. IRB Approved 15336. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Descriptive Analysis of Contributing Factors and Resultant Injuries. Principal Investigator. Poster presentation at National Association of EMS Physicians 2011 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster Presentation at OU-Tulsa 2011 Research Day. Poster presentation at the Texas Department of State Health Services 2011 EMS Conference Research Forum. Manuscript completed and published in EM International – Special Edition Focus on Prehospital Care. Project involved a medical student that presented the poster and wrote the first draft of the manuscript as well.

t. IRB Approved 15335. Use of an Ambulance Siren Low Frequency Enhancer, Howler™ in a Large, Urban Emergency Medical Services (EMS) System - Do Collision Rates Decrease? Principal Investigator. Poster presentation at National Association of EMS Physicians 2011 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster Presentation at OU-Tulsa 2011 Research Day. Poster

presentation at the Texas Department of State Health Services 2011 EMS Conference Research Forum. Project involved an EM resident that presented the poster as well.

u. IRB Approved. A Statewide Survey of Emergency Medical Services Standards of Care for Acute Coronary Syndromes - Variability and Opportunity in a State without Mandatory Statewide Treatment Protocols. Principal Investigator. Poster presentation at National Association of EMS Physicians 2011 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster Presentation at OU-Tulsa 2011 Research Day. Poster presentation at the Texas Department of State Health Services 2011 EMS Conference Research Forum. Project involved an EM resident.

v. IRB Approved 14838. EMS Override of Emergency Department EMS Diversion Requests for Clinically Stable Patients with Pre-Existing Health Care Network Relationships - Effects of an Administrative Change. Principal Investigator. Poster Presentation at OU-Tulsa 2010 Research Day. Project involved an EM resident.

w. IRB Approved 14839. Timeliness of post-intubation capnography application - effects of educational intervention on paramedic performance. Principal Investigator. Poster Presentation at National Association of EMS Physicians 2010 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster Presentation at OU-Tulsa 2010 Research Day. Project involved an EM resident. Project involved an EM resident that presented the poster and wrote a first draft manuscript.

3. Teaching Materials Developed

a. State of Oklahoma EMS Medical Director Course and Practicum for Oklahoma State Department of Health. Full course developed and delivered in Muskogee, Stillwater, Ardmore, and Lawton in March – June 2014, McAlester, Tulsa, Lawton, and Enid in July/August 2012. Beta course developed and delivered in Oklahoma City in June 2010.

b. Oklahoma Trauma Education Program (OTEP) 2008. Materials on multi-systems trauma management and transfer, and hand injury management and transfer. Peer reviewed within the Department of Emergency Medicine.

4. Invited Participation in Academic Conferences

a. National EMS Board Certification Review Course – Dallas, Texas (August 2017 & September 2015), Tucson, Arizona (January 2014), Seattle, Washington (October 2013), and Las Vegas, Nevada (September 2013). Sponsored by ACEP and NAEMSP. Served as course curriculum developer and faculty lecturer.

b. National EMS Medical Director's Course – Bonita Springs, Florida – (January 2013). Sponsored by NAEMSP. Served as faculty lecturer, panelist, and case study discussion leader.

c. National EMS Information System (NEMSIS) 3.0 Development Review in Conjunction with EMS Benchmarking in ST Elevation Myocardial Infarction, Out of Hospital Cardiac Arrest, and Stroke – Atlanta, Georgia - (March 2010). Sponsored by the CDC and EMS Performance Improvement Center at University of North Carolina Chapel Hill. Served as an expert opinion contributor, representing The US Metropolitan Municipalities EMS Medical Directors Consortium.

d. Patient Safety in EMS Roundtable - Niagara Falls, Ontario, Canada - (June 2009). Sponsored by The Canadian Patient Safety Institute (CPSI), the Emergency Medical Services Chiefs of Canada (EMSCC), the Calgary EMS Foundation, and members from a pan-Canadian Patient Safety in EMS Advisory Group. Served as an expert opinion contributor and led discussion group.

5. Other Academic Activity

a. Staphylococcal Toxic Shock Syndrome: Forgotten Foreign Body. Poster presentation. Scarborough J (resident) and **Goodloe JM**. OU Clinical Vignettes Symposium. May 2020 – Tulsa, Oklahoma.

b. Gradenigo's: A Forgotten Syndrome. Oral presentation. Milman B (resident) and **Goodloe JM**. OU Clinical Vignettes Symposium. May 2019 – Tulsa, Oklahoma. Awarded most outstanding oral presentation.

c. 2nd Annual Oklahoma Resuscitation Academy – April 2015, Oklahoma City. Course Coordinator for 2-day national resuscitation conference.

d. Mass Gathering Medical Care in a Motorsports Event-Based Collaborative Training Program**.** Accepted for poster presentation at Innovations in EMS Fellow Education Symposium at National Association of EMS Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for oral presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Physicians.

e. Tactical Emergency Medicine Care in a Military Medicine, Law Enforcement, and Emergency Medicine Collaborative Training Program**.** Accepted for poster presentation at Innovations in EMS Fellow Education Symposium at National Association of EMS

Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for oral presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Physicians.

f. Oklahoma Resuscitation Academy – April 2014, Oklahoma City. Course Coordinator for 2-day national resuscitation conference.

VIII. PUBLICATIONS

1. Peer-Reviewed

2023 Callahan JM, Baldwin S, Bodnar C, Fuchs S, Krug S, Lightfoot C, Raskas M, Weinberg S; AMERICAN ACADEMY OF PEDIATRICS; Committee on Pediatric Emergency Medicine; Council on Clinical Information Technology; Council on Children and Disasters; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; Pediatric Emergency Medicine Committee (**Goodloe JM – Board Liaison**); Policy Statement; Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children. Access to Critical Health Information for Children During Emergencies: Emergency Information Forms and Beyond. Ann Emerg Med. 2023 Mar;81(3):e27-e36. doi: 10.1016/j.annemergmed.2022.12.005. PMID: 36813444.
See also:
Pediatrics. 2023 Mar 1;151(3):e2022060970. doi: 10.1542/peds.2022-060970.PMID: 36807981

2022 Dodson CA, **Goodloe JM**. Headache and weakness in a young adult female. J Am Coll Emerg Physicians Open. 2022 Jun 30;3(4):e12772. doi: 10.1002/emp2.12772. PMID: 35782347; PMCID: PMC9244344.

Aldeeb B, **Goodloe JM**. Abdominal pain in an adolescent female. J Am Coll Emerg Physicians Open. 2022 Jun 2;3(3):e12759. doi: 10.1002/emp2.12759. PMID: 35662898; PMCID: PMC9161699.

Kupas DF, Zavadsky M, Burton B, Baird S, Clawson JJ, Decker C, Dworsky PI, Evans B, Finger D, **Goodloe JM**, LaCroix B, Ludwig GG, McEvoy M, Tan DK, Thornton KL, Smith K, Wilson BR. Joint Statement on Lights & Siren Vehicle Operations on Emergency Medical Services Responses. Prehosp Emerg Care. 2022 May-Jun;26(3):459-461. doi: 10.1080/10903127.2022.2044417. PMID: 35475941.

Newgard CD, Fischer PE, Gestring M, Michaels HN, Jurkovich GJ, Lerner EB, Fallat ME, Delbridge TR, Brown JB, Bulger EM; Writing Group for the 2021 National Expert Panel on Field Triage (**Goodloe JM**). National guideline for the field triage of injured patients: Recommendations of the National Expert Panel on Field Triage, 2021. J

Trauma Acute Care Surg. 2022 Aug 1;93(2):e49-e60. doi: 10.1097/TA.0000000000003627. Epub 2022 Apr 27. PMID: 35475939; PMCID: PMC9323557.

Medrano NW, Villarreal CL, Mann NC, Price MA, Nolte KB, MacKenzie EJ, Bixby P, Eastridge BJ; MIMIC Study Group (**Goodloe JM**). Activation and On-Scene Intervals for Severe Trauma EMS Interventions: An Analysis of the NEMSIS Database. Prehosp Emerg Care. 2023;27(1):46-53. doi: 10.1080/10903127.2022.2053615. Epub 2022 Apr 15. PMID: 35363117.

2021 **Goodloe JM**, Topjian A, Hsu A, Dunne R, Panchal AR, Levy M, McEvoy M, Vaillancourt C, Cabanas JG, Eisenberg MS, Rea TD, Kudenchuk PJ, Gienapp A, Flores GE, Fuchs S, Adelgais KM, Owusu-Ansah S, Terry M, Sawyer KN, Fromm P, Panczyk M, Kurz M, Lindbeck G, Tan DK, Edelson DP, Sayre MR. Interim Guidance for Emergency Medical Services Management of Out-of-Hospital Cardiac Arrest During the COVID-19 Pandemic. Circ Cardiovasc Qual Outcomes. 2021 Jul;14(7):e007666. doi: 10.1161/CIRCOUTCOMES.120.007666. Epub 2021 Jun 23. PMID: 34157848; PMCID: PMC8288195.

Brown KM, Ackerman AD, Ruttan TK, Snow SK; AMERICAN ACADEMY OF PEDIATRICS, Committee on Pediatric Emergency Medicine; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, Pediatric Emergency Medicine Committee (**Goodloe JM – Board Liaison**); EMERGENCY NURSES ASSOCIATION, Pediatric Committee; 2019 Pediatric Committee Members; Policy Statement; Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children. Access to Optimal Emergency Care for Children. Ann Emerg Med. 2021 May;77(5):523-531. doi: 10.1016/j.annemergmed.2021.03.034. PMID: 33902828. Also published in Pediatrics. 2021 May;147(5):e2021050787. doi: 10.1542/peds.2021-050787. PMID: 33883245.

2020 Woolridge D, Homme J, Amato CS, Pauze D, Rose E, Valente J, Ishimine P, Friesen P, Baldwin S, Joseph M, Saidinejad M, Perina D, **Goodloe JM**. Optimizing the workforce: a proposal to improve regionalization of care and emergency preparedness by broader integration of pediatric emergency physicians certified by the American Board of Pediatrics. J Am Coll Emerg Physicians Open. 2020 Jul 8;1(6):1520-1526. doi: 10.1002/emp2.12114

Moore B, Shah M, Owusu-Ansah S, Gross T, Brown K, Gausche-Hill M, Remick K, Adelgais K, Lyng J, Rappaport L, Snow S, Wright-Johnson C, Leonard J, American Academy of Pediatrics Committee on Pediatric Emergency Medicine, Section on Emergency Medicine EMS Committee and Section on Surgery; American College of Emergency Physicians

Emergency Medical Services Committee (**Goodloe JM – Chair**); Emergency Nurses Association Pediatric Committee; National Association of Emergency Medical Services Physicians Standards and Clinical Practice Committee; National Association of Emergency Medical Technicians Emergency Pediatric Care Committee. Pediatric Readiness in Emergency Medical Services Systems. Prehosp Emerg Care. 2020 Mar-Apr;24(2):175-179. Also published in Ann Emerg Med. 2020 Jan;75(1):e1-e6. doi: 10.1016/j.annemergmed.2019.09.012. Also published in Pediatrics. 2020 Jan;145(1):e20193307. doi: 10.1542/peds.2019-3307.

Delbridge TR, Dyer S, **Goodloe JM**, Mosesso VN, Perina DG, Sahni R, Pons PT, Rinnert KJ, Isakov AP, Kupas DF, Gausche-Hill M, Joldersma KB, Keehbauch JN. The 2019 Core Content of Emergency Medical Services Medicine. Prehosp Emerg Care. 2020 Jan-Feb;24(1):32-45.

Moore B, Shah MI, Owusu-Ansah S, Gross T, Brown K, Gausche-Hill M, Remick K, Adelgais K, Lyng J, Rappaport L, Snow S, Wright-Johnson C, Leonard JC; AMERICAN ACADEMY OF PEDIATRICS, Committee on Pediatric Emergency Medicine and Section on Emergency Medicine EMS Subcommittee; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, Emergency Medical Services Committee (**Goodloe JM – Board Liaison**); EMERGENCY NURSES ASSOCIATION, Pediatric Committee; NATIONAL ASSOCIATION OF EMERGENCY MEDICAL SERVICES PHYSICIANS, Standards and Clinical Practice Committee (**Goodloe JM – Member**); NATIONAL ASSOCIATION OF EMERGENCY MEDICAL TECHNICIANS, Emergency Pediatric Care Committee; Pediatric Readiness in Emergency Medical Services Systems; POLICY STATEMENT; Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children. Pediatric Readiness in Emergency Medical Services Systems. Ann Emerg Med. 2020 Jan;75(1):e1-e6. doi: 10.1016/j.annemergmed.2019.09.012. PMID: 31866028. (

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G**oodloe JM** (presenter), Winham JO, Reginald TJ, Howerton DS, Appleby T, Arthur AO, Roper ED (EM resident), Thomas SH. A Statewide Survey of Emergency Medical Services Standards of Care for Acute Coronary Syndromes - Variability and Opportunity in a State Without Mandatory Statewide Treatment Protocols. Poster Presentation, National Association of EMS Physicians Annual Meeting. Bonita Springs, Florida. Abstract in Prehospital Emergency Care 15(1), 131-2.

Goodloe JM, Crowder CJ (presenter/medical student), Arthur AO, Thomas SH. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Descriptive Analysis of Contributing Factors and Resultant Injuries. Poster Presentation, National Association of EMS Physicians Annual Meeting, Bonita Springs, Florida. Abstract in Prehospital Emergency Care 15(1), 116.

Goodloe JM, Swope MS (presenter/EM resident), Arthur AO, Thomas SH. Use of an Ambulance Siren Low Frequency Enhancer, Howler™ in a Large, Urban Emergency Medical Services (EMS) System - Do Collision Rates Decrease? Poster Presentation, National Association of EMS Physicians Annual Meeting, Bonita Springs, Florida. Abstract in Prehospital Emergency Care 15(1), 115-6.

2010 **Goodloe JM** (presenter), Dixon J, Reginald TJ, Phillips M (EM resident), Sacra JC, Thomas, SH. EMS Override of Emergency Department Diversion Requests - Effects of An Administrative Change. Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

Reginald TJ, Phillips M (EM resident), **Goodloe JM** (presenter), Thomas SH. Timeliness of post-intubation capnography application - effects of educational intervention on paramedic performance. Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

Goodloe JM (presenter), Dixon J, Reginald TJ, Phillips M (EM resident), Sacra JC, Thomas, SH. EMS Override of Emergency Department Diversion Requests - Effects of An Administrative

Change. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

Reginald TJ, Phillips M (presenter/EM resident), **Goodloe JM**, Thomas SH. Timeliness of post-intubation capnography application - effects of educational intervention on paramedic performance. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

Reginald TJ, Phillips M (presenter/EM resident), **Goodloe JM**, Thomas SH. Timeliness of post-intubation capnography application - effects of educational intervention on paramedic performance. Poster Presentation, National Association of EMS Physicians Annual Meeting, Phoenix, Arizona. Abstract in Prehospital Emergency Care 14(S1), 32.

2009 Stewart CE (presenter), Synovitz C, **Goodloe JM**, King B, Deal KE, Munn J. Octoberfest Tent Collapse. Poster Presentation, World Congress on Disaster and Emergency Medicine, Victoria, British Columbia.

2008 Stewart CE (presenter), Synovitz CK, **Goodloe JM**, King B, Deal KE, Munn J. Octoberfest Tent Collapse, Poster Presentation, University of Oklahoma, College of Medicine, Tulsa, OK.

1999 **Goodloe JM** (presenter/EMS fellow), Rinnert KJ, Zachariah BS. Attitudes of Urban and Suburban Paramedics Toward EMS Physician Field Response. Poster Presentation, National Association of EMS Physicians Annual Meeting, Marco Island, Florida. Abstract in Prehospital Emergency Care 3(1), 90.

1998 **Goodloe JM** (presenter/EM resident), Zachariah BS, Davis S (medical student). Emergency Medical Services at a Major International Airport: A Descriptive Analysis and Pilot Study to Assess Injury Prevention and Control Capabilities. Poster Presentation, National Association of EMS Physicians Mid-Year Meeting, Lake Tahoe, Nevada. Abstract in Prehospital Emergency Care 2(3), 237. Oral presentation, Emergency Medicine Research Day, Indiana Univ School of Medicine/Methodist Hospital of Indiana.

b. Editorials, position papers, background papers

2021 Hatten BW, Bonney C, Dunne RB, Hail SL, Ingalsbe GS, Levy MK, Millin M, Myers JB, Shih, RD, **Goodloe JM**. ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings. Accessed at https://www.acep.org/by-medical-focus/hyperactive-delirium/

2020 Wadman MC, Camargo CA, Cullen J, Findley S, Fletcher, D, Fleegler M, Gibbons Hallman M, Jameson S, Morrisette L, Rimple D, Sampson C, Sanson T, Wilkinson B, **Goodloe JM**. ACEP Rural Emergency Care Task Force Report. Accessed at: https://www.acep.org/rural/rural-newsroom/rural-news-articles/january-2021/rural-task-force-summary/

2012 Thomas SH, Colwell C, Dyer S, **Goodloe JM**, Deslandes JC. Prehospital Care. Emergency Medicine International, 2012; 2012:965480. Epub Jul 11.

Goodloe JM and Thomas SH. Focusing Energies on Chest Compression Fraction: It's the Forest, Not the Trees. Resuscitation, 83, 535-536.

c. Original invited lectures and presentations published for distribution

2022 **Goodloe JM**. The ACEP Task Force Report on Hyperactive Delirium. **Goodloe JM** and Kumar L. Field Triage and Bleeding Control with a New Twist: New Stop the Bleed and Field Triage Guidelines (from ACS COT, ACEP, NAEMSP and others). **Goodloe JM**, Bronsky ES, Kumar L, Miller B, Persse DE. Don't Fear the Tier: Why Many EMS Systems are now Following Classic BLS/ALS Deployment Strategies. EMS State of the Science XXIII: A Gathering of Eagles – Hollywood, Florida (June). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Goodloe JM. Best Practices in Online EMS Consults for Emergency Physicians. EMerald Coast Conference. Miramar Beach (Sandestin) Florida (June).

Goodloe JM. EMS Patient Refusals – Isn't It Just Have the Medics Get a Signature? Visiting Professorship/Grand Rounds. Western Michigan University Homer Stryker MD School of Medicine, Department of Emergency Medicine. (June)

1) **Goodloe JM** and Wampler D. Optimal Hemorrhage Control in EMS and Utilization of Whole Blood in EMS. 2) Myers JB, Dunn W, Antevy P, **Goodloe JM**, Bourn S. Hyperactive Delirium in EMS Panel Discussion. ESO Wave Conference. Austin, Texas (April)

Goodloe JM. Hot or Not? Rethinking the RLS Response. National EMS Quality Improvement Partnership. Reducing Lights-and-Siren Use in EMS. Webinar (February)

2021 **Goodloe JM**. Grand Rounds/Visiting Professorship. FDNY/Northwell Health EMS Fellowship. Life Advice for an EMS Physician. Webinar (August)

Goodloe JM. Until Help Arrives. American College of Emergency Physicians Seminar Program. Irving, Texas. (August)

Augustine JJ, **Goodloe JM**, Roach JP. Cutting Edge Remarks: What Are The Best Practices for Field Amputation – and Could EMS Do Them? **Goodloe JM**. Prevent Deaths from "Natural" Causes: Why is Preparation for Natural Disasters More Than Just a Priority? EMS State of the Science XXII: A Gathering of Eagles – Hollywood, Florida (June). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Goodloe JM, Gallagher JM, Duerring S, Ferguson W. EMS Panel Discussion. EMerald Coast Conference. Miramar Beach (Sandestin) Florida (June).

2019 **Goodloe JM**. 1) Sweetening Up the CPR Sweet Spot: Identifying Optimal Combinations of Compression Rate & Depth. 2) Concise Device Advice: Examining CPR Quality-Device Interactions. 2nd Annual International State of the Future of Resuscitation Conference. Paris, France (October)

Goodloe JM. Tornadoes in Oklahoma: Implications for "Vulnerable" Populations. SAEM Regional Conference UT Southwestern Medical Center – Dallas, Texas (September)

Goodloe JM, Gallagher JM, Duerring S, Ferguson W. EMS Panel Discussion. EMerald Coast Conference. Miramar Beach (Sandestin) Florida (June).

Weber JM, Mason CF, Bronsky ES, **Goodloe JM**. Different Strokes for Different Folks: 2019 On-Going Issues in Stroke Care. Balancing the Scales, 1-Stroke Handicaps & Mobile Cerebral Telepathy. **Goodloe JM** and Pepe PE. Alternative Motives: Destinations Other Than Traditional Hospital-Based EDs. EMS State of the Science XXI: A Gathering of Eagles - Dallas, Texas (March). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Goodloe JM, Knoles C, Howerton DS. Reimagining and Engineering Airway Management in EMS Systems. Pepe PE, Racht E, **Goodloe JM**, Levy MK, McCoy AM, Augustine J, Scheppke K, Banerjee P. The Eagles Panel. EMS Today –

Washington, DC (February). The Journal of Emergency Medical Services Annual Conference.

Goodloe JM. Does Anybody Really Know What Time It Is (That Makes a Clinical Difference AND a People Difference in 2019!). Advanced Topics in Medical Direction Pre-Conference. National Association of EMS Physicians Annual Meeting – Austin, Texas (January)

2018 **Goodloe JM**. 1) Bi-Cycling Pumps: Using Active Compression Decompression (ACD) in CPR. 2) MONA Goes LISA: Changing the Fine Art of STEMI Management. 3) Alternative Motives: Destinations other than Traditional Hospital-Based Emergency Departments. 4) One Stroke Handicap: Escaping the Web of Best Practices in Stroke Care. 1st Annual EMS State of the Science 2018: A Gathering of Seagles Conference. Memorial Healthcare System. Hollywood, Florida (November)

Goodloe JM. Advanced Concepts of "Basic" Airway Management in EMS Medicine. Emergency Medical Services Authority Conference – Advancing the Art & Science of EMS Medicine. Edmond, Oklahoma (October)

Goodloe JM. Termination of Cardiac Arrest Resuscitation – Do We Known When to Say When? Hillcrest Medical Center Fall CME Symposium. Kansas City, Missouri (September)

Goodloe JM, Jobrack J. "EMS Update on Anaphylaxis" 2018 Indiana Emergency Response Conference. Indianapolis, Indiana (September)

Goodloe JM, Gearhart D, Cody P. EMS Medicine Update for the Emergency Physician and Primary Care Physician. Panel Discussion. 21st Annual Emergency Medicine Review Conference. Oklahoma State University Center for Health Sciences, College of Osteopathic Medicine. Tulsa, Oklahoma (June)

Goodloe JM, Gallagher JM, Nafziger S. Things That Drive Me Crazy About EMS and What Can I Do About Them? Panel Discussion. SEC/BIG 12 ACEP Chapters Educational Conference: Emergency Medicine Then & Now. Miramar Beach (Sandestin) Florida (June).

Goodloe JM. 1) The Ranges of Ch-Ch-Ch-Changes! How Often Do Eagle Medical Directors Modify Protocols? 2) MONA Goes LISA: Changing the Fine Art of STEMI Management. 3) Nixing

the Nickel and Dime ("5 to 10") Paradigm: A Reality Check on Scene and Transport Time Intervals. EMS State of the Science XX: A Gathering of Eagles - Dallas, Texas (March). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Goodloe JM (panel moderator), Myers JB, Youngquist S, Jacobs M. The Pressure is on Resuscitation (Intrathoracic Pressure Regulation); Dickinson E, Kivlehan S, Shepherd M, Youngquist S, **Goodloe JM**. Cardiac Arrest: Resuscitation Latest Advances; Pepe PE, Persse D, **Goodloe JM**, Levy M. Youngquist S, Scheppke K, Richmond N. "Does Anybody Really Know What Time It Is…That Makes a Clinical Difference AND a People Difference in 2018" as part of The Eagles Unplugged - Lightning Round. EMS Today – Charlotte, North Carolina (February). The Journal of Emergency Medical Services Annual Conference.

Fowler R, **Goodloe** JM. Stop the Bleed Education Debate. Advanced Topics in Medical Direction Pre-Conference; Gallagher JM, **Goodloe JM**, Howerton DS. Credentialing Pearls: Tales of Bumps, Bruises, & Success. National Association of EMS Physicians Annual Meeting – San Diego, California (January)

2017 **Goodloe JM**. 1) Catalyst for Analysis: Cardiac Arrest Resuscitation Analytic Discoveries. 2) Active Compression Decompression CPR: Bi cycling the Pump in Intrathoracic Pressure Regulation. 3) Tipping the Scales in Defibrillation: Leveraging Weight-Based Energies & Vectors. Eagles Pre-Conference and Eagles Track in Main Conference with Pepe PE, Scheppke K, Antevy P, Colwell C, Elder J, Persse D. Emergency Cardiovascular Care Update (ECCU) 2017 – New Orleans, Louisiana (December).

Goodloe JM. Advances in Sudden Cardiac Arrest Care – Outside & Inside the Hospital. Hillcrest Medical Center Fall CME Symposium. Dallas, Texas (October)

Goodloe JM. Progressive Resuscitation: Advances in Cardiac Arrest & Stroke Care. Saint Francis Hospital Trauma & Stroke Symposium. Tulsa, Oklahoma (September)

Goodloe JM. EMS Response: Hot or Not? Does Anybody Really Know What Time It Is That Makes a Clinical Difference in 2016 AND That Makes a Personnel Difference in 2017? St. Vincent Hospital Emergency Medicine Symposium. Indianapolis, Indiana (May)

Goodloe JM. 1) Demystifying Dialysis Disasters: Best Practices in EMS Care for the Renal Failure Patient. 2) Hematology and Oncology Emergencies in EMS: You Mean There Are Cancer Emergencies? 3) Active Compression/Decompression CPR: Can Doubling Up the Historical One-Stroke Compression Cycle Save More Lives? Wesley K, **Goodloe JM**, Richmond N, Escott MEA. Is It the Holy Grail or Not? The Case Against Ketamine; Pepe PE, Slovis CM, Taillac PP, Holley JE, **Goodloe JM**, Ellis C, Manifold C. Eagles Lightning Round. EMS Today – Salt Lake City, Utah (February). The Journal of Emergency Medical Services Annual Conference.

Goodloe JM. 1) Tallying Total Task Time to Tacitly Tender the Team – Building a Better Scene Coordination Protocol to Improve Morale. 2) An Inversion to the Incursion of Diversion: An Alternative Approach to Re-routing Requests. EMS State of the Science XIX: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Goodloe JM. 1) Code 3 Response: Hot or Not? Does Anybody Really Know What Time It Is That Makes a Clinical Difference in 2016 AND That Makes a Personnel Difference in 2017? Advanced Topics in Medical Direction Pre-Conference. Sahni R, Gallagher JM, Goodloe JM, Rostykus P, Schoenwetter D. Ask the Experts Panel. National Association of EMS Physicians Annual Meeting – New Orleans, Louisiana (January)

2016 **Goodloe JM**. 1) New Insights into the Future of EMS and ACEP EMS Updates. Advanced EMS Practitioners Forum and Workshop. American College of Emergency Physicians 16 – Las Vegas, Nevada (October)

Goodloe JM. Optimal Cardiopulmonary Resuscitation Practices and Active Compression-Decompression CPR. Hillcrest Medical Center Grand Rounds – Tulsa, Oklahoma (July).

Goodloe JM. Optimal Cardiopulmonary Resuscitation Practices and Active Compression-Decompression CPR. Oklahoma EMT Association Annual Conference – Tulsa, Oklahoma (July).

Lurie KG and **Goodloe JM**. Active Compression Decompression CPR. Pepe PE, Slovis CM, Ornato J, Persse DE, **Goodloe JM**, Levy MK, Taillac PP, Colwell CB, Holley JE, Miramontes DA. Lightning Rounds. Ask the Eagles. Update from the Eagles Conference. National Urban EMS Medical Directors. **Goodloe JM** 1) Flash Pulmonary Edema: Drowning in Dogma or Death

Defying in Discovery? 2) EMS TXA in the 2016 USA. EMS Today - Baltimore, Maryland (February). The Journal of Emergency Medical Services Annual Conference.

Goodloe JM. 1) Please Take Time Out: Challenging the Perennial Obsession with Response Intervals. 2) (w. Holley JE co-presenting) Taking the Guessing Out of Decompressing the Pressing: Post-FDA Experience with ACD-ITD CP. EMS State of the Science XVIII: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

2015 **Goodloe JM**. Put a Cork in It. Tranexamic Acid and Hemostatic Agents. Code 3 Conference. Washington University School of Medicine – St. Louis, Department of Emergency Medicine – St. Charles, Missouri (October).

Goodloe JM, Howerton DS, and McAnallen D. Optimal Cardiopulmonary Resuscitation Practices and Active Compression-Decompression CPR. Oklahoma EMT Association Annual Conference – Tulsa, Oklahoma (July).

Goodloe JM. 1) 10 “Take-Homes” from 10 Tense Days of Tornadoes. 2) Tranexamic Acid in EMS Medicine. South Texas Regional Advisory Council (STRAC) Regional Emergency Healthcare Systems Conference – San Antonio, Texas (May).

Goodloe JM. 10 “Take-Homes” from 10 Tense Days of Tornadoes. Keynote Session. **Goodloe JM**, McAnallen D. Optimal Team Dynamics of Pre-Hospital Cardiac Arrest Resuscitation. Tulsa Community College Public Safety and EMS Symposium. Tulsa, Oklahoma (March).

Goodloe JM. Not Much Pause Should Be Your Cause: 2015 Ways to Analyze Cardiac Arrest Performance. EMS State of the Science XVII: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Goodloe JM. Hot Topics: Naloxone Administration by EMTs & Law Enforcement Officers – Panacea or Pandora? National Association of EMS Physicians Annual Meeting - New Orleans, Louisiana (January).

2014 Beck E, Racht E, Beeson J, **Goodloe JM**. Pinnacle Power Seminars. Making Integration Happen: A Playbook for Getting

Your MIHP Up & Running. Pinnacle EMS Leadership Conference – Scottsdale, Arizona (July)

Ossmann E, **Goodloe JM**, Braithwaite SA. Pinnacle Power Seminars. How Evidence-Based Medicine will Reshape the Practice of EMS: A Clinical Update. Pinnacle EMS Leadership Conference – Scottsdale, Arizona (July)

Goodloe JM, Beck EH, and Racht E. 1) Cardiac Arrest Analytics: Constructing and Reading the Dashboard. 2) Optimal Team Dynamics of Pre-Hospital Cardiac Arrest Resuscitation. Emergency Cardiovascular Care Update (ECCU) 2014 – Las Vegas, Nevada (June).

Goodloe JM. 1) 10 "Tentative Take-Homes" from 10 Tense Days of Tenacious Tornadoes…That Took Tens of Homes – All in a Ten-Minute Talk. 2) Drugs Falling into the Wrong Hands – or Not? Naloxone Use by Non-EMS Personnel. EMS State of the Science XVI: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Beck EH and **Goodloe JM**. Cardiac Arrest Team Dynamics: Yes, We Can Save More Lives. **Goodloe JM.** The DNA & ETA of EMS Tranexamic Acid – Where Are We? Beck EH, Myers JB, Beeson J, **Goodloe JM**, Bourne S, White L. New Perspectives and Next Steps: Translating Mobile Integrated Healthcare into Policy. EMS Today – Washington, DC (February). The Journal of Emergency Medical Services Annual Conference & Exposition.

Goodloe JM. 1) Hot Topics: Tranexamic Acid in EMS. 2) Blown Away: 10 Days of Tornados. 3) Tranexamic Acid in EMS – Advanced Topics in Medical Direction Pre-Conference. National Association of EMS Physicians Annual Meeting – Tucson, Arizona (January)

2013 **Goodloe JM**. 1) The EMS Praxis for Anaphylaxis. 2) High-Risk Patients: Case Studies to Keep You on the Leading Edge. 3) Team Dynamics in Cardiac Arrest Resuscitation: Can We Save More Lives? Yes, We Can! North Lake Tahoe Fire Protection District 18th Annual Paramedic Refresher and CE Program – Incline Village, Nevada (December)

Goodloe JM. Pearls in Out of Hospital Mechanical Ventilation. Pre-Conference/Satellite Symposium, Air Medical Transport Conference – Virginia Beach, Virginia (October)

Goodloe JM. 1) A New Praxis for Anaphylaxis: Re-Thinking Its Presentation & Treatment Concepts. 2) A New Twist on the Bleeding Control Issue: Recent Civilian Experiences with Tourniquets. 3) Whatever You Do, Please Don't Be Late! EMS Use of Tranexamic Acid. Advanced EMS Practitioners Forum and Workshop. American College of Emergency Physicians 13 – Seattle, Washington (October)

Goodloe JM. 1) The EMS Praxis for Anaphylaxis. 2) Team Dynamics in Cardiac Arrest: Can We Save More Lives? Yes, We Can! 3) TRANscending a new EXAMination & Understanding of an old ACID: The Role of Tranexamic Acid in EMS – The Ravens Medical Directors/Advisors Pre-Conference. 7th Annual Anchorage RACI Conference: The State of the Art in Cardiac Resuscitation and Critical Care Intervention. Loren Marshall Foundation – Anchorage, Alaska (May)

Goodloe JM. 1) The EMS Praxis for Anaphylaxis. 2) We Don't Know How It Works, But It Works! TRANscending a new EXAMination & Understanding of an old ACID: The Role of Tranexamic Acid in EMS. EMS State of the Science XV: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Goodloe JM. The EMS Praxis for Anaphylaxis. American Medical Response eGrand Rounds National Webinar – January.

Goodloe JM. 1) EMS System Design. 2) Political Pitfalls in EMS Medical Direction Panel Forum. 3) EMS Case Study Curriculum Discussion Leader. National EMS Medical Director's Course (NAEMSP) – Bonita Springs, Florida (January)

2012 **Goodloe JM**. 1) Basic Training: BLS Use of the 12-Lead Electrocardiograph. 2) Gadgets, Gizmos of Life-Saving Device: Should We Budget for All Those CPR Adjuncts? 3) Sticking Your Neck Out in Trauma Care: Is Spinal Immobilization Elemental or Detrimental? 4) Basic EMS Capnography: Building Blocks for Airway Management and Patient Assessment. 5) Expanding the BLS Scope of Practice. 6) Advanced EMS Capnography: Where are we? Where can we go? 7) Team Dynamics in Cardiac Arrest Resuscitation: Can We Save More Lives? You Bet Your Keister We Can! Texas EMS Conference – Austin, Texas (November). Texas Department of State Health Services.

Goodloe JM. 1) It Ain't Over till It's Over: 2012 Ways for Terminating Resuscitative Efforts. 2) We're Just Getting Started: Post-Resuscitation Management – Constructing and Navigating the

Dashboard for Survival. Emergency Cardiovascular Care Update (ECCU) 2012 – Orlando, Florida (September). Citizen CPR Foundation.

Goodloe JM. TRANscending a New Understanding through EXAMination of an Old ACID: The Role of Tranexamic Acid (TXA) in Preoperative Trauma Management. Fifth Annual EMS Conference - Tulsa, Oklahoma (August). EMS Section, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

Goodloe JM. 1) EMS Termination of Resuscitation: Best Practices for a Difficult Task**.** 2) Patient Refusals: Isn't It Just Sign on the Line? 3) Evidenced Based State EMS Protocols – State of Kansas EMS Medical Director's Course. Featured National Speaker. Last Blast of Summer Conference – Wichita, Kansas (August). Kansas EMS Association.

Goodloe JM. 1) High-Risk Patients: Case Studies to Keep You on the Leading Edge. 2) Patient Refusals: Isn't It Just Sign on the Line? 3) Trauma Triage: New CDC/NHTSA Helicopter Guidelines – Conference Keynote Presentation, co-presented with Thomas SH. Missouri State EMS Conference – Branson, Missouri (August). Missouri EMS Association.

Goodloe JM. 1) Basic Training: BLS Use of the 12-Lead Electrocardiograph. 2) It Ain't Over till It's Over: 2012 Ways to End Resuscitative Efforts. 3) We're Just Getting Started: Using a Post-Resuscitation Efforts Dashboard. EMS State of the Science XIV: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Goodloe JM. EMS Standards of Care Alterations in Response to Snowstorm. Mid-America Regional Council Emergency Rescue Committee Meeting – Kansas City, Missouri (February).

Goodloe JM. Regional Centers. Advanced Topics in Medical Direction Conference. National Association of EMS Physicians Annual Meeting & Scientific Assembly – Tucson, Arizona (January).

2011 **Goodloe JM**. 1) EMS Capnography 2011 - Where are we? Where should we be? Texas EMS Conference - Austin, Texas (November). Texas Department of State Health Services.

Goodloe JM, Reginald TJ, Winham JO, Howerton DS. Protocol Development for Advancing Oklahoma's EMS Standards: The

2013 State of Oklahoma EMS Treatment Protocols Journey. Fourth Annual EMS Conference - Tulsa, Oklahoma (August). EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

Goodloe JM. EMS Standards of Care Alterations in Response to Snowstorm. National Urban Area Security Initiative (UASI) & Homeland Security Conference - San Francisco, California (June). UASI and Department of Homeland Security.

Goodloe JM. 1) To Tube or Not to Tube: The Role of Intubation in Resuscitation. 2) When to Stop: Termination of Resuscitation Decisions. EMS Regional Conference - Resuscitation Excellence: Building Upon Past Success via the Implementation of the 2010 American Heart Association Guidelines - New York, New York (May). Fire Department New York (FDNY)/FDNY Foundation.

Goodloe JM. The Importance of Regional Collaboration. Heart Alert: Southwest Texas Regional Advisory Council for Trauma Regional Cardiac Summit - San Antonio, Texas (February).

Goodloe JM. 1) It's Important to Make Waves: $EtCO_2$ Analysis as the Airway Gold Standard. 2) Rockin' the Stockin': OK(lahoma) Approaches to Tracking Drug Utilization. EMS State of the Science XIII: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Goodloe JM and Thomas SH. Hypothermie thérapeutique en préhospitalier, experience américaine. Thomas SH and **Goodloe JM**. Prehospital analgesia. Secours Santé – Nice, France (February). Journeés scientifiques européennes du service médical des sapeurs-pompiers.

2010 **Goodloe JM**. 1) EMS Termination of Resuscitation: Best Practices for a Difficult Task. 2) EMS Capnography 2010 - Where are we? Texas EMS Conference - Austin, Texas (November). Texas Department of State Health Services

Goodloe JM. 1) The State of the State of EMS Emergency Cardiovascular Care in Oklahoma. 2) Panel Discussion: You're Doing What? Best Practices in EMS. 3) EMS: Trapeze Artists, Lion Tamers, & Ringmasters: Sharing Our Circus Without Suiting Up as Human Cannonballs. EMS Medical Directors Seminar - Austin, Texas (October). Texas College of Emergency Physicians.
Goodloe JM, Winham JO, Reginald TJ, Howerton DS. The State of the State of EMS Emergency Cardiovascular Care in Oklahoma.

Third Annual EMS Conference - Tulsa, Oklahoma (August). EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

Goodloe JM. Patient Refusals: Isn't It Just Sign on the Line? **Goodloe JM** and Howerton DS. High Risk Patients: Case Studies to Keep You on the Leading Edge. Medic Update - Enid, Oklahoma (July). Oklahoma EMT Association Annual Conference.

Goodloe JM. The Science & Art of Prehospital Trauma Care - What Does "Clinically Important" Time Management Really Mean? Trauma Symposium: A New Decade of Trauma Care Oklahoma City, Oklahoma (May). OU Medical Center

Goodloe JM and Winham JO. Needlestick at 0300. What Will You Do to Keep Your Personnel (and Yourself!) Safe? **Goodloe JM** and Howerton DS. High Risk Patients: Case Studies to Keep You on the Leading Edge. Pepe PE, Fowler R, **Goodloe JM**, Beeson J. Update from the Eagles Conference - What's Hot? What's Not? Pepe PE, Slovis CM, Fowler R, **Goodloe JM**, Beeson J. Lightning Rounds - Ask the Eagles. National Urban EMS Medical Directors. EMS Today - Baltimore, Maryland (March). The Journal of Emergency Medical Services Annual Conference

Goodloe JM. Getting a Head in Cycle Somatic Injuries: OK(lahoma) Ways to Remove a Helmet. EMS State of the Science XII: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium

2009 **Goodloe JM**. 1) Patient Refusals: Isn't It Just Sign on the Line? 2) Ventilations and Compressions: The Science Behind Blowing Slow and Pumping Fast. Texas EMS Conference - Fort Worth, Texas (November). Texas Department of State Health Services

Thomas SH and **Goodloe JM**. Update in EMS Literature: What's Hot and What's Not? Burstein J and **Goodloe JM**. ALS Versus BLS: What Does the Evidence Say? Scientific Assembly - Boston, Massachusetts (October). American College of Emergency Physicians.

Goodloe JM. EMS Termination of Resuscitation: When We Know That We Know When It's When to Say When (or Do We?). EMS Medical Directors Seminar - Galveston, Texas (September). Texas College of Emergency Physicians.

Goodloe JM. H1N1 Flu: Implications for EMS. Flu Facts for the Frontline Symposium - Tulsa, Oklahoma (September). Oklahoma Institute for Disaster and Emergency Medicine, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

Goodloe JM, Reginald TJ, Howerton DS. The State of the State of Therapeutic Hypothermia in Oklahoma. Second Annual EMS Conference - Tulsa, Oklahoma (August). EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

Slovis CM, Persse D, Schrank K, Locasto D, **Goodloe JM**. Report from the Eagles Panel - What's Hot? What's Not? Slovis CM, Schrank K, Persse D, **Goodloe JM**. Lightning Rounds - Ask the Eagles. EMS Today - Baltimore, Maryland (March). The Journal of Emergency Medical Services Annual Conference.

Goodloe JM. The Importance of Tidal Waves: Continuous Capnography and Patient Safety. EMS State of the Science XI: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

2008 **Goodloe JM**. Patient Refusals: Best Practices When Patients Don't Want You. EMS Medical Directors Seminar - San Antonio, Texas (September). Texas College of Emergency Physicians

Goodloe JM, Reginald TJ, Howerton DS. Capnography. First Annual EMS Conference - Oklahoma City, Oklahoma (August). Oklahoma Institute for Disaster and Emergency Medicine, Department of Emergency Medicine, The University of Oklahoma College of Medicine-Tulsa.

2007 **Goodloe JM**. Advancing the System: Credentialing and Evaluating Personnel. EMS Medical Directors Seminar - Dallas, Texas (September). Texas College of Emergency Physicians

2006 **Goodloe JM** and Griffin R. Needlestick at 0300. What Will You Do to Keep Your Personnel (and Yourself!) Safe? EMS Medical Directors Seminar - Galveston, Texas (September). Texas College of Emergency Physicians.

2005 **Goodloe JM**. Cardiac Arrest 2005: The Advancing Science and Art of Resuscitation. Controversies in EMS Conference - Temple, Texas (November). Department of Emergency Medicine, Texas A&M Health Science Center/Scott & White Hospital.

Goodloe JM. Cardiac Arrest 2005: The Advancing Science and Art of Resuscitation. EMS Medical Directors Seminar - San Antonio, Texas (September). Texas College of Emergency Physicians.

2000 **Goodloe JM**. Pediatric Airway Management & Rapid Sequence Intubation. Medical City Hospital of Dallas Annual EMS Conference. Dallas, Texas (March). Medical City of Hospital of Dallas.

IX. TEACHING ACTIVITIES

1. **Scheduled Teaching Assignments**, 2007-Present
   - **a.** Medical Student & Resident Teaching
     - i. Bedlam Clinic Attending Shifts
     - ii. OU Medical Student Interest Group – Invited speaker on EMS
     - iii. OU Medical Student Emergency Medicine Rotation – attending supervision and teaching in emergency department
     - iv. Basic Disaster Life Support Course
     - v. Advanced Disaster Life Support Course
     - vi. Emergency Resident Core Orientation course on ECGs – 4 hours
     - vii. Emergency Resident Core Orientation course on EMS – 4 hours
     - viii. Emergency Medicine attending supervision and teaching, 10+ ED shifts/month, 10 hours/shift, 4-6 residents/shift, 1-4 medical students/shift.
2. **Teaching Initiatives**
   - **a.** Faculty Teaching

2023 FOUNDATIONS
TRANSITIONS TO POST RESIDENCY CAREER
OUDEM Residency – March

OPTIMAL CARDIAC ARREST RESUSCITATION II
OUDEM Residency – February

2022 OPTIMAL CARDIAC ARREST RESUSCITATION I
OUDEM Residency – December

FOUNDATIONS
PERSONAL FINANCE II
OUDEM Residency – December

EMS INTERN ORIENTATION
OUDEM Residency – July

FOUNDATIONS
PERSONAL FINANCE II
OUDEM Residency – May

EMS MEDICAL OVERSIGHT CLINICAL CASE STUDIES
OUDEM Residency – March

FOUNDATIONS
PERSONAL FINANCE
OUDEM Residency – March

2021 EMS MEDICAL OVERSIGHT CLINICAL CASE STUDIES
OUDEM Residency – December

FOUNDATIONS
PERSONAL DEVELOPMENT: JOBS/CONTRACTS
OUDEM Residency – December

EMS ORIENTATION
IHI Residency – November

EMS ORIENTATION
IHI Residency – October

FOUNDATIONS
PERSONAL DEVELOPMENT: CONTRACTS
OUDEM Residency – September

EMS MEDICAL STUDENT LECTURE
OUDEM Residency – August

EMS INTERN ORIENTATION
OUDEM Residency – July

EMS MEDICAL OVERSIGHT CLINICAL CASE STUDIES
OUDEM Residency – March

FOUNDATIONS
CRITICAL CARE ADVANCED RESUSCITATIONS
OUDEM Residency – March

2020 REIMBURSEMENT UPDATES IN EM
OUDEM Residency – December

FOUNDATIONS
PERSONAL DEVELOPMENT: JOB HUNT II
OUDEM Residency – December

EMS MEDICINE UPDATES
STROKE; COVID; AIRWAY
OUDEM Residency – October

FOUNDATIONS
PERSONAL DEVELOPMENT: PERSONAL FINANCE I
OUDEM Residency – October

EMS INTERN ORIENTATION
OUDEM Residency – July

IMPLICATIONS OF SARS-CoV-2 & COVID-19
OUDEM Residency – March

2019 RUMINATIONS OF ACADEMIC REALITIES
TERMINATION OF RESUSCITATION
OPIOID USE DISORDER
THE EVIDENCE OF EBM
OUDEM Residency - September

EMS INTERN ORIENTATION
OUDEM Residency – July

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2018 EMS INTERN ORIENTATION
OUDEM Residency – July

MASS CASUALTY INCIDENT/DISASTER PLANNING
TORNADO RELATED EMERGENCIES
OUDEM Residency – March

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2017 THE PRACTICE OF EMS MEDICINE
OUDEM Residency – Medical Student Lecture – August

DEFIBRILLATION STRATEGIES
RENAL EMERGENCIES
OUDEM Residency – August

EMS INTERN ORIENTATION
OUDEM Residency – July

2017 EFFICIENCY IN EMERGENCY DEPT DISCHARGE
OUDEM Residency – May

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2016 EMS CASE STUDIES & PROTOCOL REVIEW
OUDEM Residency – November

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2015 CARDIAC ARREST RESUSCITATION PRACTICUM
OUDEM Residency – November

CARDIAC ARREST JOURNAL CLUB
OUDEM Residency – November

EMS INTERN ORIENTATION
OUDEM Residency – July

TRANEXAMIC ACID IN EMERGENCY MEDICINE
OUDEM Residency – April

CARDIAC ARREST ILCOR STANDARDS OF CARE
OUDEM Residency – April

THE PRACTICE OF EMS MEDICINE
OUDEM Residency – Medical Student Lecture – March

2014 EBOLA & EMS/ED CONSIDERATIONS
OUDEM Residency – October

THE PRACTICE OF EMS MEDICINE
OUDEM Residency – Medical Student Lecture – September

THE PRACTICE OF EMS MEDICINE
OUDEM Residency – Medical Student Lecture – August

EMS INTERN ORIENTATION
OUDEM Residency – July

2013 12-LEAD ECG ROUNDS
OUDEM Residency – August

12-LEAD ECG ANALYSIS INTERN ORIENTATION
OUDEM Residency – July

EMS INTERN ORIENTATION
OUDEM Residency – July

EMS RESEARCH UPDATES
OUDEM Residency – June

THE PRAXIS FOR ANAPHYLAXIS
OUDEM Residency – March

12-LEAD ECG ROUNDS
OUDEM Residency – February

2012 EMS & CARDIOVASCULAR EMERGENCIES
OUDEM Residency – December
Review for ABEM In-service Examination

12-LEAD ECG ANALYSIS INTERN ORIENTATION
OUDEM Residency – July

EMS INTERN ORIENTATION
OUDEM Residency – July

JOURNAL CLUB
Clinical Application of Laboratory Diagnostics in ACS (highly sensitive Troponin assay) & Pediatric Fever Without Source
OUDEM Residency – February

ECG CONFERENCE
OUDEM Residency – February

EMS & CARDIOVASCULAR EMERGENCIES
OUDEM Residency - January
Review for ABEM In-service Examination

2011 ECG CONFERENCE
OUDEM Residency – December

BIOTERRORISM
Oklahoma Disaster Institute - November
Basic Disaster Life Support for Oklahoma Highway Patrol EMTs

PSYCHOLOGICAL ASPECTS OF DISASTERS
Oklahoma Disaster Institute - November
Basic Disaster Life Support for Oklahoma Highway Patrol EMTs

EMS TERMINATION OF RESUSCITATION
OSU EM Residency - Oklahoma City - August

2011 EMS INTERN ORIENTATION
OUDEM Residency - July

THE ART AND SCIENCE OF CARDIOPULMONARY RESUSCITATION - ELEMENTAL OR DETRIMENTAL?
OUDEM Residency - July

ARRHYTHMIAS - ECG ANALYSIS
OU School of Medicine - Second Year Medical Students - April
Advanced Cardiac Life Support

TACTICAL COMBAT CASUALTY CARE
OUDEM SOMOS Program - April
Cadaver Lab for Oklahoma Highway Patrol EMTs

CARDIOVASCULAR EMERGENCIES
OUDEM Residency - January
Review for ABEM In-service Examination

2010 EMS BASE STATION
OUDEM Residency - December
OK State EMS Medical Director's Course & Practicum

ECG CONFERENCE
OUDEM Residency - September

ECG CONFERENCE
OUDEM Residency - August

EMS INTERN ORIENTATION
OUDEM Residency - July

ECG CONFERENCE
OUDEM Residency - July

EMS BASE STATION
OUDEM Residency - June
OK State EMS Medical Director's Course & Practicum

ECG CONFERENCE
OUDEM Residency - June

ECG CONFERENCE
OUDEM Residency – March

EMS & CARDIOVASCULAR EMERGENCIES
OUDEM Residency – February

2009 TRAUMA AIRWAY MANAGEMENT SKILLS PRACTICUM
OUDEM Residency – December

ECG CONFERENCE
OUDEM Residency – December

ECG CONFERENCE
OUDEM Residency – August

ECG CONFERENCE
OUDEM Residency - July

EMS INTERN ORIENTATION
OUDEM Residency – July

BIOTERRORISM
Oklahoma Disaster Institute - July
Basic Disaster Life Support

EMS REFUSALS OF CARE CONSIDERATIONS
OUDEM Residency - June

EMS CASE STUDIES
OUDEM Residency - February

2008 CHILDREN WITH SPECIAL HEALTHCARE NEEDS
OUDEM Residency - November

CPAP/NON-INVASIVE VENTILATION
OUDEM Residency - October

12-LEAD ECG ANALYSIS PART III
OUDEM Residency - September

12-LEAD ECG ANALYSIS PART II
OUDEM Residency – August

EMS R2/EM INTERN ORIENTATION
OUDEM Residency - July

12-LEAD ECG ANALYSIS PART 1
OUDEM Residency - July

1999 UROGENITAL TRAUMA
UT Southwestern Emergency Medicine Residency

1998 ACUTE ABDOMINAL AORTIC ANEURYSM
UT Southwestern Emergency Medicine Residency
Morbidity & Mortality Conference

b. Emergency Medical Services Continuing Education Teaching

2021 COVID-19 Updates from Office of the Medical Director
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2020 COVID-19 Updates from Office of the Medical Director
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2018 PROTOCOL UPDATES 2018
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa
Featuring the OMD Team
Limiting epinephrine in ventricular fibrillation cardiac arrest
Limiting oxygen in acute coronary syndromes
Early utilization of double sequential external defibrillation
Early deployment of ResQCPR and efficiencies in resuscitation
Water submersion injuries

2017 CPR TEAM DYNAMICS
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa
Featuring Dr. Keith Lurie
Resuscitation team roles and dynamics
Continuity of chest compressions
Active Compression Decompression CPR
Passive oxygenation in limited rescuer situations
Supportive care strategies
Practical lab and video production

2016 DOUBLE SEQUENTIAL EXTERNAL DEFIBRILLATION
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

ACTIVE COMPRESSION DECOMPRESSION CPR
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2015 SPINAL MOTION RESTRICTION
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2013 TRANEXAMIC ACID
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Hemostasis options in traumatic hemorrhage
What is tranexamic acid (TXA)? Historical uses of TXA
Review of CRASH-2 and MATTERs research studies of TXA
Protocol changes and review & Operational handling of TXA
Interview with Dr. William Havron, OU Trauma Services

PRAXIS FOR ANAPHYLAXIS
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Defining anaphylaxis
Cardiovascular collapse form of anaphylaxis
World Allergy Organization treatment guidelines
Epinephrine treatment of anaphylaxis
Review of recent publications/abstracts regarding anaphylaxis
Protocol changes and review

EMS CAPNOGRAPHY
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Basic of the capnography waveform
Uses of capnography in EMS
Advanced concepts of capnography and research review
Protocol review

2012 CPR TEAM DYNAMICS
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Resuscitation team roles and dynamics
Continuity of chest compressions
Timing of defibrillation
Passive oxygenation in limited rescuer situations
Supportive care strategies
Practical lab and video production

2011 CPR CHEST COMPRESSION TECHNIQUES
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Compression rate with metronome use
Compression techniques
Practical lab

2007 SIMPLE, COOL CHANGES IN PARAMEDIC AIRWAY CARE
Plano Fire Department Paramedic CE
Intubation techniques

Cricoid pressure vs. bimanual laryngoscopy
Airway bougie
Evaluation of a new alternative airway
    When to abandon intubation attempts
    Combitube vs. King LTS-D
Airway Management in Narcotic Overdoses
    Titrating naloxone

EMS OCCUPATIONAL EXPOSURE:
IF IT HAPPENS TO YOU, WHAT WILL YOU DO?
Plano Fire Department EMT & Paramedic CE
Best practices & local experiences
Post-exposure management:
    EMS needlestick injuries
    EMS respiratory exposures
Infectious agents of concern
    Hepatitis B & C; HIV; TB, Meningitis

2006 MASS CASUALTY FUNCTIONAL EXERCISES
Plano & Allen Fire Departments EMT & Paramedic CE
33 Full Scale Fire Rescue/EMS Exercises

CRITICAL THINKING IN PARAMEDIC PATIENT CARE
Plano & Allen Fire Departments Paramedic CE
Critical thinking concepts required to correctly deliver
paramedic level care per EMS treatment protocols

PEDIATRIC CARDIAC CARE
Plano & Allen Fire Departments EMT & Paramedic CE
Pediatric CPR & PALS
Pediatric Vascular Access
Neonatal CPR & NALS
Pediatric Cardiac Arrest Scenario Exercises

TACHY/BRADYDYSRHYTHMIAS
Allen Fire Department Paramedic CE
AHA guidelines for bradydysrhythmias & tachydysrhythmias

ARTIFICIAL CIRCULATION: THE ROLE OF THE
AUTOPULSE
Allen Fire Department EMT & Paramedic CE
Artificial circulations physiology
Suboptimal CPR effect
AutoPulse outcomes trials review & functional exercises

TACHY/BRADYDYSRHYTHMIAS
Plano Fire Department Paramedic CE

AHA guidelines for bradydysrhythmias & tachydysrhythmias
Diltiazem
Case studies

ARTIFICIAL CIRCULATION: THE ROLE OF THE AUTOPULSE
Plano Fire Department EMT & Paramedic CE
Artificial circulation physiology
Suboptimal CPR effect
AutoPulse outcomes trials review
Functional AutoPulse exercises

IMMEDIATE TRIAL: MODULE 2
Allen Fire Department Paramedic CE
Acute Coronary Syndromes
Glucose-Insulin-Potassium Infusion Physiology
Patient Care Enrollment & Logistics

IMMEDIATE TRIAL: MODULE 1
Plano Fire Department Paramedic CE
Acute Coronary Syndromes
12-Lead ECG Interpretation
Glucose-Insulin-Potassium Infusion Physiology

ADVANCED AIRWAY PLACEMENT CONFIRMATION
Allen Fire Department Paramedic CE
Confirmation Devices, Rationale, & Protocol

CHEMICAL RESTRAINT
Allen Fire Department EMT & Paramedic CE
Alternatives to physical and chemical restraint
Indications for physical and chemical restraint
Pharmacology of diazepam & haloperidol

ADULT RESUSCITATION 2006:
INCORPORATING NEW AHA GUIDELINES
Allen Fire Department EMT & Paramedic CE
2005 AHA Guideline Process
Adult CPR
Ventricular Fibrillation/Pulseless Ventricular Tachycardia
Pulseless Electrical Activity & Asystole

ADVANCED AIRWAY PLACEMENT CONFIRMATION
Plano Fire Department Paramedic CE
Confirmation Devices, Rationale, & Protocol

CHEMICAL RESTRAINT
Plano Fire Department Paramedic CE
Alternatives to physical and chemical restraint
Indications for physical and chemical restraint
Pharmacology of diazepam & haloperidol

ADULT RESUSCITATION 2006:
INCORPORATING NEW AHA GUIDELINES
Plano Fire Department EMT & Paramedic CE
2005 AHA Guideline Process
Adult CPR
Ventricular Fibrillation/Pulseless Ventricular Tachycardia
Pulseless Electrical Activity & Asystole

2005 AIRWAY & RESPIRATORY DISTRESS MANAGEMENT
Plano & Allen Fire Departments EMT & Paramedic CE
Airway management devices & techniques
Respiratory distress/arrest scenario exercises

COLD WEATHER EMS MEDICAL MANAGEMENT
Plano & Allen Fire Departments EMT & Paramedic CE
Heat loss mechanisms & body core temperature
EMS treatment of hypothermia
EMS treatment of cold-related tissue injuries
EMS treatment of cold-water immersion
HOLIDAY SEASON TOXICOLOGY
Plano & Allen Fire Departments Paramedic CE
NSAID, ASA, TCA, SSRI, GHB, PCP, LSD

VENOUS ACCESS IN EMS
Plano & Allen Fire Departments Paramedic CE
Goals & anatomy of venous access
Venous access techniques & complications
Difficult venous access tips & “When access fails” management

TOXICOLOGY I
Allen Fire Department Paramedic CE
Acetaminophen, Opiates/Narcotics, Benzodiazepines
Barbiturates, Toxicology Documentation

LAW ENFORCEMENT “LESS LETHAL” TACTICS:
MEDICAL CONCEPTS & CARE
Allen Fire Department EMT & Paramedic CE
Benefits & risks of pepper spray
Basic function of the Taser & removal of Taser probes
Medical consequences with “less lethal” tactics
Medical evaluation & transport priorities of “less lethal” patients

ADULT INTRAOSSEOUS ACCESS
Plano Fire Department Paramedic CE
Anatomy & physiology of intraosseous access
EZ-IO intraosseous access procedure & credentialing

TASERS: MEDICAL CONCEPTS & CARE
Plano Fire Department EMT & Paramedic CE
Basic function of the Taser
Medical events post-Taser use
Risks for post-Taser cardiac arrest & removal of Taser probes
Post-Taser medical evaluation and transport priorities

BURNS & LIGHTNING INJURIES
Allen Fire Department EMT & Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management
Lightning injuries & EMS lightning injury care

EXPLOSIVE EVENT INJURIES
Allen Fire Department EMT & Paramedic CE
Risks identification & complicating factors
Injury prediction based upon type of explosive and patients
Crush syndrome and its field treatment
Primary, secondary, and tertiary explosion injury paradigm

ASSISTED CHEST COMPRESSION: AUTOPULSE INTRODUCTION
Allen Fire Department EMT & Paramedic CE
AutoPulse Resuscitation System overview

BURNS & LIGHTNING INJURIES
Plano Fire Department EMT & Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management
Lightning injuries & EMS lightning injury care

EXPLOSIVE EVENT INJURIES
Plano Fire Department EMT & Paramedic CE
Risks identification & complicating factors
Injury prediction based upon type of explosive and patients
Crush syndrome and its field treatment
Primary, secondary, and tertiary explosion injury paradigm

ASSISTED CHEST COMPRESSION: AUTOPULSE DEPLOYMENT
Plano Fire Department EMT & Paramedic CE
AutoPulse Resuscitation System implementation system-wide

THE ABCDs of CPR: ELEMENTAL OR DETRIMENTAL?
City of Plano Public Safety Communications Annual EMD Training
Critical appraisal of EMS cardiac arrest care
Review of numerous research studies indicating need for changes:
- Pre-arrival instructions – emphasis during this presentation
- Ventilation
- Chest compression (including assistive devices)
- Defibrillation

MEDICATION FACILITATED INTUBATION: PERSPECTIVES, CHALLENGES, & DIRECTIONS
Allen Fire Department Paramedic CE
Span of intubation options
Evaluate intubation options using:
- Anecdotal experience of AFD
- Reviews of relevant research

Future directions of MFI within AFD & protocol changes

2004 VASOPRESSIN UPDATE: NEW HOPE FOR ASYSTOLE PATIENTS?
Allen Fire Department Paramedic CE
Pathophysiology of asystole
Pharmacology of vasopressin
Research review and protocol changes

OPTIMAL EMS OPERATIONS & PATIENT CARE
Allen Fire Department EMT & Paramedic CE
Review of best practices in EMS operations & patient care

MEDICATION FACILITATED INTUBATION: PERSPECTIVES, CHALLENGES, & DIRECTIONS
Plano Fire Department Paramedic CE
Span of intubation options
Evaluate intubation options using:
- Anecdotal experience of PFD
- Reviews of relevant research

Future directions of MFI within PFD & protocol changes

OPTIMAL EMS OPERATIONS & PATIENT CARE
Plano Fire Department EMT & Paramedic CE
Review of best practices in EMS operations & patient care

START TRIAGE
Allen Fire Department EMT & Paramedic CE
Principles of triage in mass casualty incidents
START (simple triage and rapid treatment) triage procedure
Application of START triage to patient scenarios

MEDICAL NECESSITY DOCUMENTATION IN EMS
Allen Fire Department EMT & Paramedic CE
Concept of "medical necessity" documentation in EMS
Detail several specifics of required documentation by insurances
Patient care documentation as a component of customer service
Avoidance of fraudulent billing practices

SAM SLING: NEW STABILIZATION FOR PELVIC FRACTURES
Allen Fire Department EMT & Paramedic CE
SAM Sling indications and usage

MEDICAL NECESSITY DOCUMENTATION IN EMS
Plano Fire Department EMT & Paramedic CE
Concept of "medical necessity" documentation in EMS
Detail several specifics of required documentation by insurances
Patient care documentation as a component of customer service
Avoidance of fraudulent billing practices

SAM SLING: NEW STABILIZATION FOR PELVIC FRACTURES
Plano Fire Department EMT & Paramedic CE
SAM Sling indications and usage

NO TRANSPORT CASE REVIEWS
Plano Fire Department EMT & Paramedic CE
Review of no transport cases for protocol/operations compliance

CHILDREN WITH SPECIAL HEALTH CARE NEEDS
Allen Fire Department EMT & Paramedic CE
Illnesses of CSHCN
EMS assessments and interventions in CSHCN
Improve comfort level with CSHCN, related devices/meds, and parents of CSHCN

THE ABCDs of CPR: ELEMENTAL OR DETRIMENTAL?
Allen Fire Department EMT & Paramedic CE
Critical appraisal of EMS cardiac arrest care
Review of numerous research studies indicating need for changes:
- Pre-arrival instructions & Ventilations
- Chest Compressions & Defibrillation

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

THE ABCDs of CPR: ELEMENTAL OR DETRIMENTAL?
Plano Fire Department EMT & Paramedic CE
Critical appraisal of EMS cardiac arrest care
Review of numerous research studies indicating need for changes:
Pre-arrival instructions; Ventilations
Chest compression (including assist devices); Defibrillation

DEFIBRILLATION: SOONER IS NOT ALWAYS BETTER?
Allen Fire Department EMT & Paramedic CE
Review CPR First Defibrillation research
Pathophysiology benefits of CPR prior to defibrillation
Scenario-based review for protocol changes

SPINAL IMMOBILIZATION: NEW DIRECTIONS IN EMS
Allen Fire Department EMT & Paramedic CE
Perspectives on EMS spinal immobilization
Research on “selective” EMS spinal immobilization
Scenario-based review for protocol changes

CRICOTHYROTOMY
Plano Fire Department Paramedic CE
Anatomy & procedural review
Skill credentialing

TERRORISM RESPONSE & EMERGENCY CARE
Plano Fire Department EMT & Paramedic CE
Suicide bomber identification and incident reviews
Suicide bomber implications for EMS operations
Mass casualty operations in terrorism response

CPAP IN EMS
Allen Fire Department EMT & Paramedic CE
Physiology of CPAP & indications for use
CPAP regulator and mask functional exercises

12-LEAD ECG ANALYSIS
Allen Fire Department Paramedic CE
Functional exercises in 12-lead analysis

DEFIBRILLATION: SOONER IS NOT ALWAYS BETTER?
Plano Fire Department EMT & Paramedic CE
Review CPR First Defibrillation research
Pathophysiology benefits of CPR prior to defibrillation

SPINAL IMMOBILIZATION: NEW DIRECTIONS IN EMS
Plano Fire Department EMT & Paramedic CE
Perspectives on EMS spinal immobilization
Research on "selective" EMS spinal immobilization
Scenario-based review

2003 AIRWAY MANAGEMENT
Allen Fire Department EMT & Paramedic CE
Basic & advanced techniques in airway management
Endotracheal intubation & confirmation
Cricothyrotomy
Capnography in airway management
Airway management scenario exercises

VENOUS ACCESS IN EMS
Plano Fire Department Paramedic CE
Goals & anatomy of venous access
Venous access techniques & complications
Difficult venous access tips
"When access fails" management

NERVE AGENTS & ANTIDOTE TREATMENT
Plano Fire Department EMT & Paramedic CE
Nerve agent types & pathophysiology
Mark I autoinjector pharmacology & use

EMS OCCUPATIONAL EXPOSURE
Plano Fire Department EMT & Paramedic CE
Post-exposure management:
EMS needlestick injuries & EMS respiratory exposures

NEW EMS TREATMENT PROTOCOLS REVIEW
Allen Fire Department EMT & Paramedic CE
New Medical Director Introduction
New EMS protocols orientation & review

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

CHILDREN WITH SPECIAL HEALTH CARE NEEDS
Plano Fire Department Paramedic CE
Illnesses of CSHCN
EMS assessments and interventions in CSHCN
Improve comfort level with CSHCN, related devices/meds, and parents of CSHCN

BURNS & LIGHTNING INJURIES
Plano Fire Department Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management
Lightning injuries & EMS lightning injury care

EXPLOSIVE EVENT INJURIES
Plano Fire Department Paramedic CE
Risks identification & complicating factors
Injury prediction based upon type of explosive and patients
Crush syndrome and its field treatment
Primary, secondary, and tertiary explosion injury paradigm

NERVE AGENTS, ORGANOPHOSPATES, & CYANIDE
Plano Fire Department Paramedic CE
Pathophysiology and field treatments

CAPNOGRAPHY UPDATES IN EMS
Plano Fire Department Paramedic CE
Review of use in intubation confirmation
Use in non-intubated patients
COPD, Asthma, Undifferentiated dyspnea
Review of new capnograph within LP12 monitor

MEGACODE MANAGEMENT
Plano Fire Department Paramedic CE
Tachy/Bradydysrhythmia management using case studies
Megacode functional exercises with SimMan

2002

ORAL INTUBATION
Plano Fire Department Paramedic CE
Review of Intubation CQI Tracking
Oral intubation techniques

EMS MANAGEMENT OF MEDICAL EMERGENCIES
Plano Fire Department Paramedic CE
Case study reviews of PFD EMS incidents

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

TOXICOLOGY III
Plano Fire Department Paramedic CE
Beta-blockers, Calcium channel blockers, Antihistamines
Cocaine, Marijuana, Ecstasy

ARRHYTHMIA RECOGNITION
Plano Fire Department Paramedic CE
Functional exercises in basic ECG arrhythmia recognition

TOXICOLOGY II
Plano Fire Department Paramedic CE
NSAID, ASA, TCA, SSRI, GHB, PCP, LSD

TREATMENT SECTOR OPERATIONS IN MCIs
Plano Fire Department Paramedic CE
Tabletop exercises in designing, deploying, and operating an EMS treatment sector during multiple patient events

TOXICOLOGY I
Plano Fire Department Paramedic CE
Acetaminophen, Opiates/Narcotics, Benzodiazepines
Barbiturates, Toxicology Documentation

2001 WEAPONS OF MASS DESTRUCTION – BIO & CHEM
Plano Fire Department Paramedic CE
Biological classes of WMD and agents
Chemical classes of WMD and agents

SPORTS INJURIES
Plano Fire Department Paramedic CE
Identification & EMS treatment of multiple orthopedic injuries

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

RESUSCITATE: DO OR DO NOT?
Plano Fire Department Paramedic CE
Texas Law relating to: Advance Directives & OOH DNR
Medical Power of Attorney
Applying DNR Texas Law to EMS situations

EMS MANAGEMENT OF THERMAL BURNS
Plano Fire Department Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management

AIRWAY MANAGEMENT
Plano Fire Department Paramedic CE
Basic & advanced techniques in airway management
Airway management scenario exercises

12-LEAD ELECTROCARDIOGRAMS
Plano Fire Department Paramedic CE
ECG lead electrophysiology
Correlating ECG leads with anatomy
Systemic analyzing of the 12-lead ECG
Correlating abnormal ECGs with cardiac pathophysiology

PEDIATRIC CRITICAL CARE
Plano Fire Department Paramedic CE
PALS updates

2000 CARDIAC ARREST MANAGEMENT
Plano Fire Department Paramedic CE
ACLS updates

CPAP IN COPD & CHF MANAGEMENT
Plano Fire Department Paramedic CE
Physiology of CPAP & indications for use
CPAP regulator and mask functional exercises

CHEST PAIN MANAGEMENT
Plano Fire Department Paramedic CE
Differential causes of chest pain
EMS management of the acute chest pain patient

TRAUMA MANAGEMENT II
Plano Fire Department Paramedic CE
BTLS-derived curriculum
Abdominal & extremity trauma
Burns
Pediatric, Elderly, & Pregnancy patients
Effects of alcohol/drugs
Trauma CPR
Trauma scenarios

1999 TRAUMA MANAGEMENT I
Plano Fire Department Paramedic CE
BTLS-derived curriculum
Mechanisms of Injury
Scene Assessment & Initial Trauma Care
Airway Management in Trauma
Thoracic Trauma
Shock Evaluation & Management
Spinal & Head Trauma
Trauma Care in the Cold

12-LEAD ELECTROCARDIOGRAMS
Plano Fire Department Paramedic CE
ECG lead electrophysiology
Correlating ECG leads with anatomy
Systemic analyzing of the 12-lead ECG
Correlating abnormal ECGs with cardiac pathophysiology

AIRWAY MANAGEMENT
Plano Fire Department Paramedic CE
Basic & advanced techniques in airway management
Airway management scenario exercises
(co-taught with Brian Zachariah, MD, FACEP)

CRITICAL CARE PARAMEDIC PHARMACOLOGY I & II
AMR-Dallas Critical Care Paramedic School
Developed & taught 8-hour pharmacology curriculum
(co-taught with Robert Suter, DO, FACEP; Brian S. Zachariah, MD, FACEP; and John Myers, MD, FACEP)

c. Other Teaching

2020 THE ROLE OF EMS SYSTEMS & HOW EMS SYSTEMS CAN "FLATTEN THE CURVE"
COVID-19 Oklahoma Update ECHO (Friday, April 10)

2011 THE STATE OF TULSA TRAUMA CARE
Tulsa Metro Chamber Health Panel
(co-panelists Thomas SH, Yeary E, Sacra J, Williamson S, Dart B)

2000-2007 EMERGENCY MEDICAL SERVICES:
A NATIONAL & LOCAL HISTORY
Plano Fire Department Citizens Fire Academy
- EMS Historical Developments
- City of Plano EMS History
- Modern EMS Capabilities
- EMS Assessment & Treatment Equipment Display
- The Modern MICU Tour
- Citizen Question & Answer Sessions

(co-taught with Ken Klein, RN, EMTP)

1999 TRAUMA REGIONAL ADVISORY COUNCILS:
IMPACT UPON TRAUMA CARE IN TEXAS
University of Texas School of Public Health – Health Policy Presentation

1998 ALTERED MENTAL STATUS
Methodist Hospital of Indiana Emergency Medicine Residency

Case Conference Presentation
Case review of treated otitis media progressing to meningitis with near-fatal outcome. Patient initially seen by me at time of diagnosis with meningitis.

EMS OCCUPATIONAL HAZARDS
Methodist Hospital of Indiana Emergency Medicine Residency Grand Rounds
Infectious disease risks assumed by EMS personnel
Post-exposure management of needlestick injuries, respiratory exposure, and contact exposure involving EMS personnel
Contributing factors and characteristics of EMS vehicle accidents
Risks of violence in the EMS environment
Occupational injuries sustained in EMS
EMS-related stressors
Importance of well-being practices in EMS

1997 MASS CASUALTY INCIDENTS
Methodist Hospital of Indiana Emergency Medicine Residency Grand Rounds
Classification of Mass Casualty Incidents & Notable MCIs
Emergency Physician role in MCIs
Treatment priorities & resource utilization in MCIs

1996 ACUTE ABDOMINAL AORTIC ANEURYSM
Methodist Hospital of Indiana Emergency Medicine Residency
Morbidity & Mortality Conference Presentation
Case review of AAA initially presenting as renal colic.

CHOOSING AN EMERGENCY MEDICINE RESIDENCY
Tulane University School of Medicine
Residency application, evaluation, and interviewing strategies

X. PROFESSIONAL SERVICE

1. Hospital clinical service

a. Hillcrest Medical Center Emergency Department - Tulsa (July 2011 - Present) Academic/clinical emergency medicine in regional referral hospital. Residency faculty and active medical staff responsibilities.

b. St. John Medical Center Emergency Department - Tulsa (August 2009 – September 2011). Clinical emergency medicine in Level II Trauma Center. Residency faculty and active medical staff responsibilities.

c. St. Francis Hospital Trauma Emergency Center - Tulsa (August 2007 - July 2009). Clinical emergency medicine in Level II

Trauma Center. Residency faculty and active medical staff responsibilities.

d. For additional clinical activities, please see section on hospitals.

2. Leadership service to professional societies and organizations

a. Secretary/Treasurer, American College of Emergency Physicians (2021-2022)

b. Member, Board of Directors, American College of Emergency Physicians (2019-Present)

Liaison to:
- Bylaws Committee (2022-Present)
- Geriatric EM Section (2022-Present)
- Geriatric Accreditation BOG (2022-Present)
- Membership Committee (2022-Present)
- Sports Medicine Section (2022-Present)
- Awards Committee (2022-Present)
- Finance Committee (2021-2022)
- Audit Committee (2021-2022)
- American College of Surgeons Committee on Trauma (2020-Present)
- Excited Delirium Task Force (2020-2021
  - FDA CDER Testimony Jan 2021
- Nominating Committee (2020)
- Cruise Ship Medicine Section (2020-2021)
- Trauma & Injury Prevention Section (2020-2021)
- EMS Committee (2019-2022)
- Pediatric Emergency Medicine Committee (2019-Present)
- EMS Section (2019-2022)
- Tactical Medicine Section (2019-Present)
- Pediatric Emergency Medicine Section (2019-Present)
- Rural Emergency Medicine Task Force (2019-2020)
- American Academy of Emergency Nurse Practitioners (2021-Present)

c. Board of Trustees, Emergency Medicine Foundation
- Immediate Past Chair (2023)
- Chair (2022)
- Chair-Elect (2021)
- Secretary-Treasurer (2021)
- Member (2019-Present)

d. Candidate, Board of Directors, American College of Emergency Physicians (2019)

e. EMS Subboard, American Board of Emergency Medicine
LLSA Co-Editor (2021-2022)
Member (2019-2022)

f. Member, Bylaws Committee, American College of Emergency Physicians (2018-2019)

g. Candidate, Board of Directors, American College of Emergency Physicians (2018)

h. Member, Advocacy Committee, National Association of EMS Physicians (2016-Present)

i. Member, Standards & Practice Committee, National Association of EMS Physicians (2016-2021)

j. President, Oklahoma College of Emergency Physicians (2016-2019).

k. Chair, EMS Committee, American College of Emergency Physicians (2016-2018)

l. President-Elect, Oklahoma College of Emergency Physicians (2015-2016).

m. Member, Advocacy, Clinical Standards and Practices, and Mobile Integrated Healthcare Committees, National Association of EMS Physicians (2015 – Present).

n. Vice President (2012-2016) Oklahoma Chapter, American College of Emergency Physicians.

o. Member, Council Steering Committee & Council Subcommittees for Annual Meeting and Non-Bylaws Resolutions. American College of Emergency Physicians (2011-2012). Active participant in developing 2012 Council Annual Meeting and promoting development and submission of non-bylaws resolutions. Selected as Reference Committee Chairman.

p. Member, EMS Committee, American College of Emergency Physicians (2011-present). Leading nationwide effort to improve EMS Medical Director understanding of Drug Enforcement Administration regulations regarding controlled substances. Working in multi-association taskforce to bring EMS Medical Director concerns to the DEA lead office in Washington, DC.

q. Member, Council Steering Committee & Council Standing Rules Subcommittee, American College of Emergency Physicians (2010-2011). Active participant in revising 2011-2012 Council Standing Rules. Presented the Council Standing Rule Subcommittee Report to the Council Steering Committee in May 2011. Served as Member of Reference Committee A for 2011 Annual Council Meeting, hearing testimony on bylaws-related resolutions and drafting summary recommendations to the Council.

r. Member, EMS Committee, American College of Emergency Physicians (2010-2011). Led the extensive revision of ACEP Policy: "Leadership in EMS", approved by ACEP Board of Directors without editing. Also, reviewed for subsequent revision

of ACEP Policy "Interfacility transportation of the critical care patient and its medical direction."

s. Councillor, American College of Emergency Physicians
OCEP (2018-2019)
OCEP Alternate Councillor (2017)
Oklahoma Chapter Board of Directors (2008-2016)
Emergency Medicine Residents' Association (1996-1999)
Service as a councillor involves representing the physicians from the respective chapter/organization at the ACEP Council Annual Meeting. The ACEP Council considers and acts upon business matters and clinical positions of the College in a manner like a "House of Representatives" of a state/national government.

t. Site Reviewer, Commission on Accreditation of Ambulance Services (2001-2012). Perform on-site review of EMS organizations seeking to meet CAAS accreditation. Each review involves 2-3 days of extensive administrative and clinical operations review, with numerous interviews of leadership and front-line clinical personnel to evaluate compliance with over 200 standards.

u. Organization and Course Reviewer, Continuing Education Coordination Board for Emergency Medical Services (2000-2012). Review submissions for individual courses and organizations seeking CECBEMS accreditation and/or accreditation granting privileges. Multiple courses/organizations have been personally reviewed each year of service.

v. Member, Research Committee, National Association of EMS Physicians (1998-2000)

w. Member, Fellows Task Force, National Association of EMS Physicians (1998-1999)

x. Member, Mentoring Task Force, American College of Emergency Physicians (1998-1999)

y. Member, Membership Committee, American College of Emergency Physicians (1997-1998)

z. Board of Directors, Emergency Medicine Residents' Association
Immediate Past President (1997-1998)
President (1996-1997)
President-Elect/Treasurer (1995-1996)

aa. Vice President, Board of Directors, Indiana State Medical Association Resident Medical Society (1996-1998)

bb. Vice Chair and Delegate, Indiana Delegation, American Medical Association Resident Physician Section House of Delegates (1996-1998)

cc. Member, Commission on Legislation, Indiana State Medical Association (1996-1998)

dd. Member, Internal Communications Task Force, American College of Emergency Physicians (1996-1998)

ee. Member, Section Affairs Committee, American College of Emergency Physicians (1996-1997)
ff. Member, LifeLine/EMS Committee, Methodist Hospital of Indiana (1995-1998)
gg. Member, EMS Committee, Texas College of Emergency Physicians (1994-1995)
hh. Emergency Medicine Student Association, The University of Texas Medical School at San Antonio
President (1994-1995)
Vice President (1992-1993)
Secretary and Founding Officer (1991-1992)

3. Editorial service

a. Editorial Board, Prehospital Emergency Care (2015-Present)
b. Reviewer, International Journal of Chronic Obstructive Pulmonary Disease (2014-Present)
c. Reviewer, Risk Management and Healthcare Policy (2013-Present)
d. Reviewer, Journal of Bioanalysis & Biomedicine (2013-Present)
e. Reviewer, Canadian Journal of Emergency Medicine (2012-2018)
f. Guest Associate Editor, EM International (2011)
g. Editorial Board, Journal of Emergency Medical Services (2010-Present)
h. Reviewer, Internal and Emergency Medicine (2010-Present)
i. Reviewer, Access Emergency Medicine (2009-Present)
j. Reviewer, Critical Care (2009-Present)
k. Reviewer, Prehospital Emergency Care (2009-Present)

4. Educational symposia development service

a. Chairman & Course Coordinator, 5th Annual EMS Symposium – 2012 EMS Ways to Treat Trauma & Advance Trauma Care. EMS Section, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2012 in Tulsa, Oklahoma. Keynote Speaker – Paul Pepe, Chair of Emergency Medicine, University of Texas Southwestern Medical Center & Medical Director, Dallas Metropolitan Area BioTel (EMS) System.
b. Chairman & Course Coordinator, 4th Annual EMS Symposium - EMS Expanding Scopes of Practice & The Future of Oklahoma EMS, EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2011 in Tulsa, Oklahoma. Keynote Speaker - John Freese, Chief Medical Director, Fire Department New York.
c. Chairman & Course Coordinator, 3rd Annual EMS Symposium - EMS Cardiovascular Emergencies, EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2010 in Tulsa, Oklahoma. Keynote Speaker, Corey Slovis, Chair of Emergency Medicine, Vanderbilt

University School of Medicine & Medical Director, Nashville Fire Department.

- **d.** Course & Curriculum Developer - State of Oklahoma EMS Medical Director's Course & Practicum - Initial Course June 2010 in Oklahoma City, Oklahoma.
- **e.** Chairman & Course Coordinator, 2nd Annual EMS Symposium - Therapeutic Hypothermia, EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2009 in Tulsa, Oklahoma. Keynote Speaker, Brent Myers, Director & Medical Director, Wake County, North Carolina EMS System.
- **f.** Chairman & Course Coordinator, 1st Annual EMS Symposium - Airway Management, Oklahoma Institute for Disaster and Emergency Medicine, Department of Emergency Medicine, The University of Oklahoma College of Medicine - Tulsa, August 2008 in Oklahoma City, Oklahoma. Keynote Speakers, Allen Sims and Kelly Curry, Montgomery County, Texas Hospital District EMS System.

5. Professional service

- **a.** Exam Writer, National Registry of Emergency Medical Technicians (2011)
- **b.** Member, Oklahoma Emergency Medical Services for Children Advisory Committee (2011-Present).
- **c.** Member, Oklahoma Emergency Response Systems Development Advisory Council (2009-2013). Direct appointment by Speaker of the House, State Oklahoma House of Representatives.
- **d.** Member, Medical Audit Committee, Oklahoma State Department of Health, Trauma Division (2008-2013)
- **e.** Interim Medical Advisor, Oklahoma State Department of Health, EMS Division (2008-2009)
- **f.** Member, University of Oklahoma College of Medicine - Tulsa, Department of Emergency Medicine Chair search committee (2008)
- **g.** Member, Medical Direction Subcommittee, Oklahoma Emergency Response Systems Development Advisory Council (2007-2013)

6. Volunteer clinical service

- **a.** The University of Oklahoma School of Community Medicine Bedlam Clinic
  - Attending Physician (2011-2014)
- **b.** Baylor University Volunteer EMS
  - Director of Communications (1990-1991)
  - Lieutenant/Paramedic (1990-1991)
  - EMT-Intermediate (1989-1990)
  - Emergency Medical Dispatcher (1988-1989)

7. Grant review service

a. Emergency Medicine Foundation COVID-19 (2020)
b. MedEvac International Foundation (2010)

8. Research abstract review service

a. Society for Academic Emergency Medicine - EMS (2010)
2011 Annual Meeting & Regional Meetings
b. National Association of EMS Physicians (2009)
2010 Scientific Assembly

XI. ADMINISTRATION [College and University Service]

2007-Present Chief, EMS Section, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine

XII. MEMBERSHIPS, HONORS, AWARDS and SPECIAL RECOGNITION

1. Memberships

a. American College of Healthcare Executives (2019-Present)
b. Texas Medical Association (2017-2019)
c. Tarrant County Texas Medical Society (2017-2019)
d. American College of Emergency Physicians (1991-Present)
Oklahoma Chapter (2007-Present)
Texas Chapter (1998-Present; 1991-1995)
Indiana Chapter (1995-1998)
e. American Medical Association (2007-2013; 1995-1998)
f. Oklahoma State Medical Association (2007-2013)
g. Oklahoma County Medical Society (2009-2013)
h. Tulsa County Medical Society (2007-2013)
i. Indiana State Medical Association (1995-1998)
j. Emergency Medicine Residents' Association (1991-Present/Life Member)
k. Society for Academic Emergency Medicine (1994-1999; 2010 - 2014;2019-Preent)

2. Honors

a. Fellow of the Academy of EMS (2017-present)
b. US Metropolitan Municipalities EMS Medical Directors Consortium Corey M. Slovis Award recognizing excellence in EMS education (2014)
c. Fellow of the American College of Emergency Physicians (2002-present)
d. American Medical Association/Glaxo Wellcome Achievement Award recognizing leadership in organized medicine (1997)

e. Texas College of Emergency Physicians Outstanding Senior Medical Student in Emergency Medicine (1995)

XIII. PROFESSIONAL GROWTH AND DEVELOPMENT

1. Continuing Education

a. NIHSS Certification 2023
b. ACEP E-QUAL Stroke CME 2021
c. LVAD CME 2023
d. Pain Mgmt Pearls: Opioids & Culture
e. Human Trafficking & Exploitation
f. NAEMSP PEC Manuscript Reviews (Editorial Board)
g. NIHSS Certification 2022
h. ACEP E-QUAL Stroke CME 2020
i. ABEM EMS Subboard Exam Meeting 2022
j. LVAD CME 2022
k. EMS State of the Science XXIII Meeting 2022
l. EMerald Coast Conference 2022
m. NIHSS Certification 2021
n. ABEM EMS Subboard Exam Meeting 2021
o. EMS State of the Science XXII Meeting 2021
p. Opioid Analgesics in the Management of Acute and Chronic Pain 2021
q. Clinician's Guide Recognizing & Responding to Human Trafficking 2021
r. Preventing Clinician Burnout 2021
s. Suicide Assessment & Prevention 2021
t. EMerald Coast Conference 2021
u. EMS State of the Science Weekly Webinars 2020 – Present
v. National Association of EMS Physicians Annual Meeting 2021
w. ABEM EMS Subboard Exam Meeting 2020
x. National Whole Blood in EMS Academy
y. National Association of EMS Physicians Annual Meeting 2020
z. EMS State of the Science XXI Meeting 2019
aa. National Association of EMS Physicians Annual Meeting 2019
bb. EMS State of the Science XX Meeting 2018
cc. National Association of EMS Physicians Annual Meeting 2018
dd. EMS State of the Science XIX Meeting 2017
ee. National Association of EMS Physicians Annual Meeting 2017
ff. EMS State of the Science XVIII Meeting 2016
gg. National Association of EMS Physician Annual Meeting 2016
hh. National EMS Board Review Certification Course 2015
ii. National EM Board Review Certification Course 2015
jj. EMS State of the Science XVII Meeting 2015
kk. National Association of EMS Physicians Annual Meeting 2015
ll. National Association of EMS Physicians Annual Meeting 2014
mm. EMS State of the Science XVI Meeting 2014
nn. National EMS Board Review Certification Course 2013

oo. RACI Conference on Resuscitation and Critical Care 2013
pp. EMS State of the Science XV Meeting 2013
qq. National Association of EMS Physicians Annual Meeting 2013
rr. Advanced Trauma Life Support Instructor Course 2012
ss. EMS State of the Science XIV Meeting 2012
tt. National Association of EMS Physicians Annual Meeting 2012
uu. Oklahoma ACEP Annual Meeting 2011
vv. ACEP Scientific Assembly 2011
ww. National Association of EMS Physicians Annual Meeting 2011
xx. Texas College of Emergency Physicians EMS Med Director Seminar 2010
yy. National Association of EMS Physicians Annual Meeting 2010
zz. Oklahoma ACEP Annual Meeting 2009
aaa. Texas College of Emergency Physicians EMS Med Director Seminar 2009
bbb. National Association of EMS Physicians Annual Meeting 2009
ccc. Oklahoma ACEP Annual Meeting 2008
ddd. Texas College of Emergency Physicians EMS Med Director Seminar 2008
eee. National Association of EMS Physicians Annual Meeting 2008.
fff. Oklahoma ACEP Annual Meeting 2007
ggg. Texas College of Emergency Physicians EMS Med Dir Seminar 2007.
hhh. National Association of EMS Physicians Annual Meeting 2007.
iii. ATLS Instructor
jjj. ACLS renewal
kkk. BCLS renewal
lll. FEMA NIMS ICS course 100
mmm. FEMA NIMS ICS course 200
nnn. FEMA NIMS ICS course 300
ooo. FEMA NIMS ICS course 400
ppp. FEMA NIMS ICS course 700
qqq. FEMA NIMS ICS course 800
rrr. BDLS
sss. ADLS
ttt. NDLS Instructor
uuu. ABEM Lifelong Learning Self-Assessment Test 2021
vvv. ABEM Lifelong Learning Self-Assessment Test 2020
www. ABEM EMS Lifelong Learning Self-Assessment Test 2018
xxx. ABEM Lifelong Learning Self-Assessment Test 2018
yyy. ABEM Lifelong Learning Self-Assessment Test 2017
zzz. ABEM Lifelong Learning Self-Assessment Test 2016
aaaa. ABEM EMS Lifelong Learning Self-Assessment Test 2016
bbbb. ABEM Lifelong Learning Self-Assessment Test 2015
cccc. ABEM ConCert Board Recertification Test 2015
dddd. ABEM EMS Lifelong Learning Self-Assessment Test 2014
eeee. ABEM Lifelong Learning Self-Assessment Test 2014

ffff. ABEM Lifelong Learning Self-Assessment Test Patient Safety
gggg. ABEM Lifelong Learning Self-Assessment Test 2013
hhhh. ABEM Lifelong Learning Self-Assessment Test 2012
iiii. ABEM Lifelong Learning Self-Assessment Test 2011
jjjj. ABEM Lifelong Learning Self-Assessment Test 2010
kkkk. ABEM ConCert Board Recertification Test 2009
llll. ABEM Lifelong Learning Self-Assessment Test 2008
mmmm. ABEM Lifelong Learning Self-Assessment Test 2007
nnnn. ABEM Lifelong Learning Self-Assessment Test 2006
oooo. ABEM Lifelong Learning Self-Assessment Test 2005
pppp. ABEM Lifelong Learning Self-Assessment Test 2004

2. Coursework

a. Ultrasonography in the emergency department
b. 19th Annual High-Risk Emergency Medicine
c. 13th Annual National Emergency Medicine Board Review

XIV. COMMUNITY SERVICE

1. Civic Organizations

a. Halfway Home Greyhound Adoption Service - Tulsa, Oklahoma (2007-2012)
b. Habitat for Humanity - Waco, Texas (1990-91)
Service Project of Alpha Epsilon Delta, Texas Beta Chapter

CV updated 03/15/23

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Ryan A. Stanton MD, FACEP

Question #1: **How will you mitigate the threat of losing members of the College when encountering divisive topics that may make large portions of the membership feel alienated or disenfranchised?**

I have always said "that if nobody disagrees, you didn't say anything". We have an ever-growing collection of wedge issues that are meant to divide rather than achieve progress. While I have always felt we should steer well clear of wedge issues, we must still be active advocates for our members, profession, and patients. The key is threading the needle regarding issues that are important, but also have significant political and belief system overtones. There are ways that we can plant a flag as a college without wading into the politics of the topic. The beauty and risk off our profession is that we are overall balanced along the spectrum of politics and beliefs. The diversity helps us move forward, but also means that any given topic has a similar spectrum of positions. As the VP of Communications, I have worked with our comms staff and leadership to respect the positions of our members and find the opportunities to forward our profession and our ability to care for our patients.

The reality is that no membership is guaranteed. We must continue to fight for each and every member. This includes the willingness to listen, dialogue, and find the common ground which will hopefully lead to the best positional direction of the college. Mitigating the threat of losing organizational members when encountering divisive topics requires proactive strategies that foster inclusion, respect, and open communication.

Firstly, creating a culture of respect and inclusivity is paramount. ACEP must maintain and enforce clear policies that promote respect for diverse opinions and backgrounds.

Secondly, leadership must exemplify open communication and active listening. As the board, staff, and leaders, we should encourage dialogue for members to express their views with the knowledge that it may lead to a compromise, position shift, or something in between.

Thirdly, focusing on common goals and shared values can unite members despite differences. Emphasizing ACEP's mission and the collective benefits of diverse perspectives can help reframe divisive topics as opportunities for growth and progress.
Finally, not being afraid to take a position if it is in the best interest of emergency physicians, our specialty, and patients. We don't have to swing at every pitch, but also don't need to be afraid to put our foot down. This also means that we must all be flexible, open minded, and looking at the bigger picture that is emergency medicine. If there is one thing I have learned throughout my life, I don't always get what I want…and sometimes, that's ok.

Question #2: **Given that the resources of ACEP are not infinite, how will you determine if ACEP should be involved in issues perceived to be not directly related to emergency medicine?**

At this point, anyone that has any engagement is aware that money doesn't grow on trees, and we don't own a forest. As part of the fiduciary responsibility to ACEP, I must help narrow our focus to the products and efforts that advance emergency physicians, our specialty, and the patients we care for. However, we have motivated and passionate members with projects and visions that are worth support. I believe ACEP can help facilitate these passions without "breaking the bank".

We should support members to voice their interests and provide pathways for discussion and dialogue. This helps promote the benefit of "group think", helping build out ideas with avenues of progress, and as a college, consideration of other opportunities through sections, interest groups, and even companion organizations. As ACEP, we may not be able to invest directly, but that doesn't extinguish the legitimacy or opportunities of ideas.

We must clearly define and communicate the core missions and vision of ACEP in order to ensure overall alignment within the organization. With that framework in mind, building tools and technology that promote the transparency of the work that has been done throughout the history of this organization and facilitating the advancement of the ideas and work of our members, finding the best avenue for the next steps and opportunities.

One of the growing areas of our members is the social EM space. This is a very active and important portion of our membership with many great ideas and passions. Many of these fall outside the traditional guardrails of emergency medicine. However, they are very important topics and beliefs, holding very close to the hearts of members. We must work to establish the pathways and opportunities that can advance these passions without pulling ACEP away from its primary mission and focus.

Question #3: **What steps would you take to distinguish ACEP membership as having tangible and essential benefits to practicing emergency physicians?**

The FACEP designation is one of the most obvious, as it is not a token title give upon membership, it is earned with dedication to ACEP, colleagues, and our specialty. Having this attached to our names is the indication of our commitment to the present and future of emergency medicine.

The key is that the ability for ACEP to move the needle only comes from the size of its membership. Thus, membership is key to the continued advocacy missions of the college. The reminder of the WWII recruitment poster that "We Need You" and though we are not at war, there are individuals, organizations, corporations, and others that want to tear down ACEP and emergency medicine. We truly do need each and every emergency physician to facilitate the change that needs to happen for our physicians and patients.

The first step is to communicate the value of membership. Some examples include the ACEP RUC team that has advocated CPT and reimbursement changes which well pay for your membership every single year through billing reimbursement and value. Despite the overall inflation impacts on salary, these drops would be vastly more if not for the efforts of ACEP. Others include the DC team that has facilitated discussions and meetings with the FTC, DOJ, policy makers, and countless others on your behalf while pulling together stakeholders to understand the EM environment, challenges, and opportunities. Putting together the largest and most successful conference on the building and maintenance of physician owned groups through the INDY Class, or the reinvention of satellite conferences into Accelerate, giving the opportunity efficiencies of scale and the cross pollination of meeting experience.

ACEP must leverage technology and resources to meet the needs of our members. As the world advances, so must our college. Each member should be able to tailor their ACEP experience to the needs of their practice, passions that drive them, and resources that support their world of EM. Helping each and every emergency physician "find their why" and build the most fulfilling career possible.

We need to evolve as our profession and membership changes. The 21st century ACEP is not that of our founders, that fought to establish our profession and a solid foundation for today. Change is tough, but it is necessary. Though our experiences across the country may be similar, the practice has changes, challenges have changed, and we find ourselves as the safety net of a dysfunctional system the puts banners over bedside care.

As ACEP, we are the united voice of nearly 40,000 emergency physicians and we must use that voice to advocate for our physicians, specialty, and patients. As individuals, we are vulnerable, but together, we can facilitate change. We will never alleviate all the challenges or fix all the problems, but that shouldn't stop us from fighting for the specialty that we love. The practice of medicine is tough, but it is essential and ACEP is here to give present and future generations of emergency physicians the best opportunity to succeed.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Ryan A. Stanton MD, FACEP

Contact Information
106 Stonewall Drive
Nicholasville KY, 40356
Phone: 859-948-2560
E-Mail: RStanton@acep.org

Current and Past Professional Position(s)
Central Emergency Physicians – 2003-Present
Medical Director – Lexington Fire/EMS – 2003-Present
Medical Director – GMR Motorsports/NASCAR/SRX/USF – 2017-Present
Founder/CEO – Everyday Medicine – 2012-Present
Chief Medical Contributor – Fox 56 News – 2022-Present
Medical Director- UK Good Samaritan EM – 2008-2013
Faculty- University of Kentucky Chandler Medical Center – 2008-2013
Chief Medical Contributor- WKYT TV 27 – 2019-2021
Chief Medical Contributor- WTVQ ABC-36 – 2008-2018
Clear Channel Radio- 2005
National Public Radio- WETS-FM 89.5 – 1996-2008

Education (include internships and residency information)
University of Kentucky Emergency Medicine – 2005-2008
East Tennessee State University – Surgery Internship – 2003-2004

East Tennessee State University – James H. Quillen College of Medicine – Class of 2003

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM – Emergency Medicine – 2009-2019, recert 2019-2029
ABEM – Emergency Medical Services – 2021-2031

Professional Societies
American College of Emergency Physicians – 2005-Present
Kentucky Chapter of the American College of Emergency Physicians – 2005-Present
Kentucky Medical Association/LMS – 2003-Present
American Academy of Emergency Medicine – 2019-2021

National ACEP Activities – List your most significant accomplishments
Vice-President of Communications(Inaugural) – 2023-Present
ACEP Frontline Podcast – Creator/Host – 2017-Present
Member – Communications/PR Committee – 2008-Present
ACEP/EDPMA Joint Task Force on Reimbursement – PR Chair – 2016-2017
Chair – Communications/PR Committee – 2014-2016
9-1-1 Network Advocacy Member of the Year – 2014
ACEP Spokesperson of the Year - 2012

ACEP Chapter Activities – List your most significant accomplishments
KACEP President – 2012-2014
KACEP PR Chair – 2008-Present
KACEP Education Chair – 2008-2013

Practice Profile

Total hours devoted to emergency medicine practice per year: **1000** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **100** % Research **0** % Teaching **0** % Administration **0** %

Other: **About another 2400 hrs per year of EMS and motorsports medicine.** ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am a partner in a two-hospital physician owned democratic group with 24 physicians serving community hospitals with a volume of 80k per year. My primary site is a comprehensive stroke and heart center.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Emergency Physician – Central Emergency 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. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 3 Cases Plaintiff Expert 0 Cases

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Ryan A. Stanton MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Global Medical Response

Address: 4400 Hwy 121, Suite 700
Lewisville, TX 75056

Position Held: GMR Motorsports Medical Director

Type of Organization: Emergency Medical Services

Employer: EMSConnect

Address: PO Box 8648
Spokane, WA 99203

Position Held: Educator

Type of Organization: EMS Education

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Opioid Response Network

Address: ORN@aaap.org

Type of Organization: Not for Profit

Leadership Position: Educator and Content Creator

Term of Service: 2019-Present

Organization: EMSConnect

Address: PO Box 8648
Spokane, WA 99203

Type of Organization: EMS Education

Leadership Position: Minority Owner

Term of Service: 2018-Present

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: Teleflex – Clinical Advisor

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

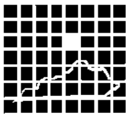
☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Ryan A. Stanton MD, FACEP Date 6/17/24



Kentucky Chapter of the American College of Emergency Physicians

KACEP
PO Box 2831
Louisville, KY 40201-2831

OFFICERS
President
Hugh Shoff, MD, FACEP

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Christopher Pergrem, MD, FACEP

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Executive Director
Ashlee Melendez, MSPH, BSN

August 1, 2024

ACEP Councillors;

It is with great pleasure the Kentucky Chapter of ACEP (KACEP) and the ACEP Pain Management and Addiction Medicine Section endorse Dr. Ryan A. Stanton as a candidate for President-Elect for the American College or Emergency Physicians. We have had the pleasure of serving with Ryan over many years. He has shown exemplary state and national involvement in ACEP. Ryan is currently serving on ACEP Board of Directors and has held many state leadership roles; Councilor, Public Relations Committee Chair, Vice President, and President of KACEP. He remains an integral member of the state Board of Directors and serves as the Board Liaison for Pain and Addiction Medicine.

Ryan is our "go-to" member for all things public relations. His background in television and radio makes him very comfortable in front of crowds and the camera. He has natural leadership ability and is very charismatic. He serves in leadership and medical directorships for many different entities; Lexington Fire/EMS, GMR Motorsports Safety Team, AirMed International, and throughout Kentucky and beyond for several opioid, pain, and addiction recovery efforts.

Ryan works clinically in the emergency department and yet he always finds time to advocate for emergency medicine with the legislators in Frankfort and Washington DC. No matter how busy, we know we can always count on Ryan to testify on behalf of emergency physicians throughout the state and nation. He takes every opportunity to promote strategies that manage acute and chronic pain in emergency medicine. He has provided many educational presentations on the treatment of patients with opiate addiction.

Ryan always hosts our KACEP EMRA grant awardees at the ACEP Leadership and Advocacy meetings in Washington, DC. He provides our residents a view of the Hill that most would not be able to offer. This has opened many young minds to emergency medicine advocacy, leadership, and action.

Ryan's curriculum vita illustrates his numerous achievements during his career. His medical work, Fire/EMS leadership, media roles, and his young physician mentorships have touched many lives. It is our pleasure to endorse Dr. Ryan Stanton.

Sincerely,

Hugh Shoff, MD, MS, FACEP
President
KY Chapter of ACEP

Reuben Strayer, MD, FACEP
Chair
Pain Management and Addiction

Ryan A. Stanton MD, FACEP

Friends and Colleagues,

We are in a time of significant change within our profession and College. We face immense challenges, but adversity invites opportunity. Our members and fellow physicians are seeking a strong presence and advocate for our profession. There are pressures from all sides trying to chip away at our environment, departments, and physicians. As the American College of Emergency Physicians (ACEP), we must be the unifying and resolute voice, ready to speak and fight for our physicians.

We have two major roles as ACEP:

1. *Advocacy for Emergency Medicine and OUR Specialty*: We serve as the collective voice of emergency medicine, fighting to advance our field and advocating for our physicians, patients, and profession.

2. *Facilitating Individual Growth and Fulfillment*: We support each physician's unique path. Every member has distinct interests and skills. We must leverage our size and resources to help every emergency physician achieve their best and most fulfilling career.

We aim to be large enough to advocate for emergency medicine, yet small enough to meet the needs of every unique physician.

I bring decades of media experience, but I am much more than just a “voice for the College.” Since graduating from residency in 2008, I have been a leader at local, state, and national levels. I have led the emergency medicine arm of the most comprehensive statewide opioid program in the country and have been appointed to the Kentucky Statewide Opioid Prescribing Council, guiding legislation and policy for the Commonwealth.

I have built relationships with legislators across the country to promote emergency physician interests, including participating in White House round tables and meeting with the Ways & Means Committee. As a leader within ACEP, I have fought for physician rights, transparency, due process, and changes to the status quo. As a content expert, I have supported many states with legislative, event, and communication needs. In these efforts, fighting for reimbursement, scope of practice guardrails, ED boarding/throughput reform, and the ongoing fight against the criminalization of emergency care. I have had the honor of serving as your first VP of Communications and have received the inaugural Spokesperson of the Year and the 9-1-1 Advocacy Member of the Year awards. If there is one promise, I have and will continue to FIGHT for YOU.

The College cannot do it alone. The president-elect and president represent the direction, will, and voice of the members, council, committees, and board. We must lean into our member expertise across the breadth of emergency medicine to advance our specialty into the future. I am fully prepared to be that leader and promote the greatness of our 37,000+ members. Whether medical students, residents, attendings, or legacy physicians, we are a community of individuals who can collectively change the healthcare landscape.

We are the American College of Emergency Physicians. We serve every man, woman, and child in this country. Together, we are the safety net of this nation’s healthcare system. You and I, as one, WE can create the future of emergency medicine.

VOTE

2024 PRESIDENT-ELECT

RYAN STANTON MD, FACEP

MORE THAN A VOICE...
A TIRELESS ADVOCATE AND FIGHTER

LEADING FROM THE FRONT FOR ALL EMERGENCY PHYSICIANS

- Husband
- Father
- Community Doc
- Tireless EM Advocate
- Double Boarded - EM and EMS
- Community EP - SDG
- EMS/Event Medical Director

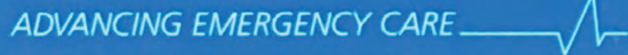
859-948-2560
RStanton@ACEP.org

@EverydayMed

State and National

LEADER

American College of Emergency Physicians®



Ryan A. Stanton MD, FACEP, FAAEM

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Nicholasville, KY 40356

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EMAIL
ryanastanton@gmail.com
youreverydaymedicine@gmail.com

WEB
www.StantonMD.com

Profile

Board certified emergency and EMS physician in Lexington, Kentucky with involvement in community, pre-hospital, and motorsports medicine. Interests in media and public education through internet, podcast, print, and television. Active in leadership with local and national organizations through work with Central Emergency Physicians, KACEP, ACEP, AMR, and NASCAR.

Experience

EMERGENCY PHYSICIAN, CENTRAL EMERGENCY PHYSICIANS, LEXINGTON, KY – 11/2013-PRESENT

Emergency Physician at Baptist Health Lexington

MEDICAL DIRECTOR, LEXINGTON FIRE/EMS LEXINGTON, KY - 3/2013-PRESENT

Medical Director for one of the premier fire departments and EMS services in Kentucky, overseeing the EMS operations for over 48,000 EMS runs annually.

MEDICAL DIRECTOR, GMR MOTORSPORTS – 4/2017-PRESENT

On-track response physician for NASCAR as part of the AMR/NASCAR Safety Team at tracks throughout the country. Named GMR Motorsports Medical Director as of 1/1/20.

KENTUCKY/FLORIDA STATE MEDICAL DIRECTOR, AIRMED INTERNATIONAL – 1/2014-PRESENT

Kentucky and Florida state medical director for AirMed International which provides air medical services throughout the world.

EVERYDAY MEDICINE AND ACEP FRONTLINE PODCASTS, 1/2010-PRESENT

Production of two emergency medicine based podcasts. Everyday Medicine in conjunction with Emergency Medicine News and ACEP Frontline with the American College of Emergency Physician

EMSConnect- 5/2019-Present

EMS part-owner and educator for EMSConnect. One of four physician educators for this nationwide company.

CHIEF MEDICAL CONTRIBUTOR, WDKY FOX-56 NEWS, LEXINGTON, KY – 1/2022-PRESENT

Chief Medical Contributor for Fox-56 News with weekly “Doc Is In” live segments and weekly taped segments that go out to 6 stations.

CHIEF MEDICAL CONTRIBUTOR, WKYT-27, LEXINGTON, KY – 1/2017-12/2021

Medical Services for Kentucky Speedway 2006-2014 and Talladega Super Speedway 2015-2017

INFIELD CARE CENTER FOR NASCAR SANCTIONED AND OTHER RACING EVENTS KENTUCKY SPEEDWAY AND TALLADEGA SUPER SPEEDWAY – 6/2006-4/2017

Medical Services for Kentucky Speedway 2006-2014 and Talladega Super Speedway 2015-2017

"DOCTOR ON CALL" FOR ABC-36, LEXINGTON, KY – 1/2009-12/2016

On-Air physician for weekly "ask the doc" segments, weekly "what's going around" segments, and as needed for health-related interviews.

EMERGENCY PHYSICIAN, MESA/TEAMHEALTH, LEXINGTON, KY -7/2008-7/2014

Emergency Physician and past Medical Director at UK Good Samaritan Hospital in Lexington, KY

ASSISTANT PROFESSOR OF EMERGENCY MEDICINE, UK HEALTHCARE, LEXINGTON, KY – 7/2008-6/2013

Emergency Physician and Assistant Professor for the UK Emergency Medicine Residency Program.

ABC NEWS MEDICAL UNIT INTERN, BOSTON, MA, FALL 2005

Worked with the ABC Medical Unit on story research, composition, interviews and writing for ABCNews.com and ABC News programs under the direction of Dr. Tim Johnson.

WETS-FM 89.5 NATIONAL PUBLIC RADIO PRODUCER, JOHNSON CITY, TN - 10/1996-12/2015

Produced "Everyday Medicine", a weekly segment pertaining to common medical topics focused towards patients and the lay public. Past roles as a board operator and announcer, as well as producer of several programs including "Reel Music" and "Ritmo Latino".

WJHL-TV CBS PRODUCTION ASSISTANT, JOHNSON CITY, TN – 4/1999-8/1999

Production assistant duties including camera operation, sound board, editing, story composition, and directing.

Board Certification

American Board of Emergency Medicine, Board Certified, 2009-Present

American Board of Emergency Medicine-, Emergency Medical Services, Board Certified, 2021-Present

American Board of Emergency Medicine, Board Eligible, 2008-2009

Medical Licensure

Kentucky, 6/26/2008-Active -License #41963

Resident License- 1/2007-6/2008

Alabama, 9/25/2014-Active- License #MD.33740

Tennessee, 4/7/2016-Active- License #54178

Florida, 2017-Active- License #ME.134262

New York, 2018-Active- License #293995-1

Delaware, 2018-Active- License #C1-0012583

Georgia, 2018-Active- License #079785

Pennsylvania, 2018-Active- License #MD465496

Virginia, 2018-Active- License #0101264445

North Carolina, 2018-Active- License #2018-00671

Nevada, 2020-Active- License #19571

Indiana, 12/9/2004-Active- License #01060023A

Residency Training

University of Kentucky, Emergency Medicine, 7/2005-6/2008

East Tennessee State University, General Surgery Preliminary, 7/2003-6/2004

Education

ETSU James H. Quillen College of Medicine, Medical Doctor, 8/1999-5/2003

East Tennessee State University, BS- Chemistry, 8/1995-5/1999

Leadership Positions

Founder/CEO, Everyday Medicine LLC, 7/2013-Present

Board of Directors, American College of Emergency Physicians, 2019-Present
Vice-President of Communications – 10/2023-Present

Medical Director, GMR Motorsports, 1/2020-Present

Medical Director, Lexington Fire/EMS, Lexington-Fayette Urban County Government, 3/2013-Present

President, KACEP(Kentucky Chapter of the American College of Emergency Physicians), 1/2013-12/2014

Chairman of Public Relations Committee, American College of Emergency Physicians, 10/2014-10/2016

Assistant Medical Director, AirMed International, 1/2014-Present

Director of PR, Media, and Education, Mesa Medical Group, Lexington, KY, 1/2013-7/2014

Medical Director, UK Good Samaritan Emergency Room, University of Kentucky Healthcare, 7/2008-7/2013

Assistant Medical Director, Kentucky Motor Speedway Emergency Medical Services, 2010-2013

President Elect, KACEP(Kentucky Chapter of the American College of Emergency Physicians), 1/2010-12/2012

Vice President, KACEP, 1/2010-12/2012

Public Relations Committee Chairman, KACEP, 7/2008-Present

Vice Chairman UK ED Executive Committee, UK Healthcare, 1/2010-6/2013

Counselor, American College of Emergency Physicians, 10/2011- Present

PR Committee, American College of Emergency Physicians, 10/2008-Present

National Spokesman, American College of Emergency Physicians, 10/2008-Present

Medical Operations Subcommittee Member, UK Good Samaritan Hospital, 2008-2013

Emergency Medical Advisory Board, Lexington/Fayette County, KY, 7/2008-Present

Chief Resident, UK Healthcare Emergency Medicine, 7/2007-6/2008

Awards/Honors

East Tennessee State University, James H. Quillen College of Medicine

Outstanding Alumni, Commencement Speaker, May 2023

East Tennessee State University, James H. Quillen College of Medicine Outstanding Alumni, 2022

ACEP 911 Network Member of the Year, American College of Emergency Physicians, 2014

Spokesman of the Year, American College of Emergency Physicians, 2011-2012

Preceptor of the Year, UK Physician Assistant Program, 2010-2011

UK Leadership Legacy Mentor, University of Kentucky, 2011-2012

Gatton School of Business Executive Leadership Program, University of Kentucky, 2009-2010

Publications/Presentations/Talks

Recurring Media Productions

ACEP Frontline Podcast- 10/2015-Present

StantonMD TV Show- 3/2016-9/2018

The Doc is In TV Segment- 2012-Present

Six television markets around the southeast United States

Chief Medical Contributor- WDKY Fox-56 News- 1/2022-Present

Chief Medical Contributor- WKYT-TV Lexington- 1/2017-12/2021

WVLK 97.3FM/590AM- Weekly Medical Contributor and Guest Host(Various Shows)- 2010-Present

American College of Emergency Physicians- Spokesperson- 2008-Present

Everyday Medicine for Physicians Podcast- 1/2010-12/2019

Everyday Medicine Podcast- 1/2006-12/2015

Presentations/Talks

Recurring

Kentucky Statewide Opioid Stewardship and KY Bridge- 2019-Present

Texas Opioid Response Network- 2019-Present

Emerald Coast Conference- 2021-Present

Emergencies in Medicine- 2019-Present

EMSConnect- 2018-Present

Individual Presentations

ACEP Accelerate 2024 – Tips and Sips: Media and Medicine – Arlington, TX 3/12/2024

Tennessee ACEP – Putting the Lines in Headlines – Chattanooga, TN 3/7/2024

Virginia ACEP – Putting the Lines in Headlines – Homestead, VA 2/25/2024

Virginia ACEP – Doc In Traffic: Motorsports Medicine – Homestead, VA 2/25/2024

Mass Gathering Medicine Summit – It's Getting Hot in Here – New York, NY 11/17/2023

ACEP23 – Closing Keynote Moderator – FTC Chair Khan – 10/10/2023

ACEP23 – Panel and Moderator – Medical Student Forum – Why EM – 10/8/2023

Michigan ACEP – It's Getting Hot in Here – Mackinaw, MI 8/1/2023

Emerald Coast Conference – It's Getting Hot in Here – Destin, FL 6/6/2023

East Tennessee State University – James H. Quillen College of Medicine – Commencement Keynote Address – Finding Your Why – Johnson City, TN 5/12/2023

Louisiana ACEP – Finding Your Why – Baton Rouge, LA 3/8/2023

Emergencies in Medicine – It's Getting Hot in Here – Park City, UT 2/26/2023

Emerald Coast Conference – Finding Your Why – Destin, FL 6/7/2022

Louisiana ACEP – Motorsports Medicine – New Orleans, LA 3/9/2022

Emergencies in Medicine – Motorsports Medicine – Park City, UT 2/26/2022

ACEP19- Moderator: SoMe in EM- Denver, CO 10/29/19

Emerald Coast Conference- Mythbusting: EM Medication Myths- Destin, FL 6/3-5/2019

Emerald Coast Conference- Law and Order: EM Medical Malpractice- Destin, FL 6/3-5/2019

Emerald Coast Conference- He Said, She Said: Vaccine Refusals- Destin, FL 6/3-5/2019

Kentucky Hospital Association- KY Statewide Opioid Stewardship- ALTO in EM and Beyond, Multiple Sites in KY 2019

Tennessee ACEP 2019- Opioids State of the Union- Chattanooga, TN 3/4/2019

ANC-AHE Annual Conference- State of the Union: Opioids in America- Savannah, GA, 2/20/19

NASCAR Summit 2019- What Can You Actually Do in a Racecar- Concord, NC 1/2019

Kentucky Hospital Association Leadership Academy- Moderator for Opioid Panel Discussion- Louisville, KY, November 2018

PHI Regional Outreach Critical Care Symposium- Sepsis in the EMS Setting- Morehead, KY, November 2018

ACEP18- Becoming Unjaded: The Opioid Epidemic- San Diego, CA, October 2018

ACEP18- Social Media: Collaboration or Litigation- San Diego, CA, October 2018

ACEP18- Mills Memorial Lecture- ACEP Past, Present, and Future- San Diego, CA, October 2018

SEC ACEP- Mythbusting in Emergency Medicine- Destin, FL, June 2018

SEC ACEP- Frontline Live: The Evolution of Medical Education- Destin, FL, June 2018

SEC ACEP- Opioid Epidemic: State of the Union- Destin, FL, June 2018

ACEP Leadership and Advocacy 2018- Advocacy Panel- Washington DC, May 2018

Tennessee ACEP- 2018 Annual Meeting- Opioid Epidemic: State of the Union- Chattanooga, TN, March 2018

NASCAR Summit 2018- AMR/NASCAR Year in Review- Concord, NC, January 2018

NASCAR Summit 2018- The Approach to the Car and Driver- Concord, NC, January 2018

KY ENA State Educational Conference- Surviving Dreamland: The Opioid Crisis, Lexington KY, August 2017

SEC ACEP- Opioids: Why That Didn’t Work, Destin FL, June 2017

SEC ACEP- The Physician Pilot: Keeping the Skies Friendly, Destin FL, June 2017

Ohio ACEP Emergency Medicine Forum- Faces of Physician Leadership, Columbus OH, May 2017

11th Annual Intermountain Brain Injury Conference- Approach to the Acutely Agitated Patient, Johnson City TN, March 2017

11th Annual Intermountain Brain Injury Conference- TBI 101, Johnson City TN, March 2017

ACEP Leadership and Advocacy 2017- Where the Rubber Meets the Road: Emergency Medicine and SoMe, Washington DC, March 2017

TN ACEP Annual Meeting- Narcotics to Narcan: State of the Opioid Union Address, Chattanooga TN, February 2017

KACEP Medical Director Conference- From IV to IO and In-Between, Louisville KY, November 2016

ACEP16- Rapid Fire: Narcotics to Narcan, Las Vegas NV, October 2016

ACEP16- Rapid Fire: Do Your Patients Know You Care?, Las Vegas NV, October 2016

ACEP16- Feel the Burn: Preventing Burnout in EM, Las Vegas NV, October 2016

CECentral- Opioid Symposium, Narcotics to Narcan: Tackling the Opioid Epidemic, Lexington KY, October 2016

SEC ACEP- Critical Findings for the Community Doc, Destin FL, June 2016

SEC ACEP- Malpractice Minefield, Destin FL, June 2016

TN ACEP- Narcotics to Narcan, Chattanooga TN, March 2016

Can't Miss Trauma for the Community Physician, SEC ACEP, Destin FL, June 2016

NASCAR Summit- I Will Take CO for an Answer, Concord NC, January 11, 2016

SEC ACEP- Implementing Narcan, Destin FL, June 2015

SEC ACEP- Building a Disaster Plan, Destin FL, June 2015

NASCAR Summit- Metropolis in a Cornfield, Charlotte NC, January 2015

CECentral- Heroin: Old Dog with New Tricks, Lexington KT, October 2014

FACOS Annual Clinical Assembly- Building the Framework for a Disaster, Boston MA, September 2014

TN ACEP- Heroin: Old Dog with New Tricks, Chattanooga TN, March 2014

SEC ACEP- Opioid Legislation: That Just Happened, Destin FL, June 2014

SEC ACEP- Frequent Flyers: Can We Cut the Sky Miles, Destin FL, June 2014

NASCAR Summit- That Just Happened, Charlotte NC, January 2014

CECentral- The Good, Bad, and Ugly of Substance Abuse, The Frontline of Addiction and Substance Abuse, Lexington KY, August 2013

SEC ACEP- Encephalitis and Meningitis Make My Head Hurt, Destin FL, June 2013

SEC ACEP- Street Drug Abuse, Destin FL, June 2013

SEC ACEP- Opioid Crisis in the US, Destin FL, June 2013

The Faces of Substance Abuse- "KASPER Update Panel", Lexington KY, January 23, 2013

NASCAR Summit- "They Could Be Drunk...Or They Could Be Dying", Concord NC, January 8, 2013

ACEP Spokesman Network- "Prescription Drug Abuse Prevention", Multiple Presentations, 2012

KMA Annual Meeting- "HB1 Update", Louisville KY, September 2012

SEC ACEP Back to Basics- "The Weakest Link", Destin Fl, June 12, 2012

SEC Hot Topics in Emergency Medicine- "Green Tobacco Sickness", Destin FL, June 2011

SEC Hot Topics in Emergency Medicine- “Scan Them Until They Glow: Risks of CT Radiation and Emergency Care”, Destin FL, June 2010

AAEM National Conference Photo Contest- “Purulent Pericardial Effusion”, February 2008

AAEM National Conference Open Mic Competition- “Anatomy of a Plane Crash”, February 2008

Research Publications

Ryan Stanton, Jeff Schoondyke, Rebecca Copeland, "Papillary Fibroelastoma in the Left Ventricular Wall", Cardiology Review, Volume: Fall 2003,

Ryan Stanton, Ted Parks, "Bilateral Anterior Compartment Syndrome and Creatine Monohydrate Usage", Journal of Emergency Medicine, 2003

Ryan Stanton, Floranne Wilson, and Kyle Colvett, "Metastatic Basal Cell Carcinoma", Southern Medical Journal, October 2003

References

Dr. Mark Spanier, Baptist Health Lexington ED Medical Director, Central Emergency Physicians, 859-260-6180, markspanier1@gmail.com

BC Chad Traylor, Battalion Chief- Lexington Fire/EMS, 859-231-5644, traylorc@lexingtonky.gov

Dr. Chris Doty, Residency Director UK Department of Emergency Medicine, 859-323-5908, chris.doty@uky.edu

Board of Directors Candidates

Scientific Assembly
LAS VEGAS 24

acep Scientific Assembly LAS VEGAS 24

2024 Board of Directors Candidates

Jennifer J. Casaletto, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Heidi C. Knowles, MS, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Steven B. Kailes, MD, MPH, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Diana B. Nordlund, DO, JD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

C. Ryan Keay, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Bing S. Pao, MD, FACEP

- Written Questions
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- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Jennifer J. Casaletto, MD, FACEP

***Question #1:* What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

I am honored and humbled by the opportunity to represent you on the ACEP BOD and, if elected, pledge to continue to demonstrate an unwavering commitment to our profession and our patients. By way of introduction, I'm grateful for emergency medicine residency training at Carolinas Medical Center and experience gained through a decade in academic emergency medicine serving as the education director and associate residency director at Maricopa Medical Center and later, as the founding residency director at Virginia Tech-Carilion. Now as a fully "recovered" residency director, my practice has been as a community emergency medicine nocturnist for the last decade with several shifts each month at the "big house" where the residents and I take turns keeping each other on our EM toes. Experience across academics and residency program leadership as well as community EM brings a unique viewpoint to our BOD.

I promise to bring communication skills and a passion for advocacy on behalf of our College, skills previously recognized with our College's Spokesperson of the Year and two Service to the College awards. Service as prior Chairwoman of ACEP's Academic Affairs Committee (tasked with developing and executing the College's educational initiatives), Chairwoman of ACEP's Educational Meetings Committees (tasked with planning and hosting our annual meeting) and ongoing service on the Education Steering Committee, honed leadership skills and expertise in shaping educational initiatives within the organization. In addition, experience serving as Chair of the Young Physicians Section (YPS) as well as on ACEP's Leadership Diversity Task Force highlights my commitment to fostering the development of the next generation of emergency physicians.

Participation on the Council Steering Committee, Tellers, Credentials, & Elections Committee, and the State Legislative & Regulatory Committee provided a broad understanding of ACEP's operations and governance. Current service on the Federal Government Affairs, National Chapter Relations, and Education Steering Committees, allows for continued involvement and contribution to ACEP's national initiatives. As a current member of the NEMPAC Board of Directors, I am an avid recruiter of fellow College members to join me as a Give-a-Shift member further contributing to our PAC's ability to support federal candidates who share a commitment to improving our ability to safely and effectively practice emergency medicine.

As former President for both Arizona ACEP and NCCEP, I am able to lead, collaborate, and communicate effectively.. Representing Arizona, YPS, and currently North Carolina has been a privilege, allowing me to meet and learn from many of you as a member of the Council over the last two decades. Regionally, serving as co-chair of NCCEP's fledgling Leadership and Advocacy fellowship (entering it's second year) and North Carolina Chair of the wildly successful annual tri-state Coastal Emergency Medicine Conference that brings nearly 300 emergency physicians and their families to Kiawah Island each June and substantiates innovative action to advance emergency medicine practice, wellness, and advocacy…and a need to improve my limbo skills for the famous CEMC oyster roast!

Most of all, in addition to extensive and diverse experience within ACEP coupled with proven leadership, I promise to bring you the work-ethic of an emergency physician, the energy of a boy mom, the dedication of a marathon runner, and the smile of a colleague who's so very honored be considered in this group of esteemed colleagues as a candidate for the ACEP Board of Directors.

***Question #2:* What strategic priorities should ACEP pursue to maintain itself as the home for all emergency physicians!**

To maintain its status as the home for over 44,000 board-certified emergency physicians and 9,300 resident physicians, ACEP must pursue a multi-faceted strategic approach to combat burnout, currently affecting two-thirds of emergency physicians. Prioritizing advocacy and workforce support to increase compensation, decrease administrative burdens, and protect emergency physicians from workplace violence will prevent us from "three-peating" the burnout championship.

1. Advocate for Fair Compensation
Serving as the leading voice for emergency physicians, ACEP is the only emergency medicine organization with the resources to effectively advocate for a fix to the flawed Medicare payment system. Since 2001, Medicare physician payment rates have
fallen 29% when adjusted for inflation. ACEP must lobby for reforms to ensure fair compensation that reflects the critical role of emergency care, secure financial stability, and increase career longevity. Additionally, ACEP must push for income and billing transparency amongst employers so that Emergency Physicians may better advocate for just compensation.

2. Reduce Administrative Burden
We have all felt our shifts becoming more challenging with sicker patients, nursing and ancillary staff shortages, increased patient boarding, and expanding interruptions and regulatory requirements. ACEP must address workforce burdens that drive burnout by aggressively solving challenges and supporting workplace wellness for all emergency physicians. ACEP must compel hospital leadership to deploy organizational resources to implement evidence-driven tactics to reduce boarding and advocate federally for alignment of financial incentives to further this mission. Our College should work towards reducing administrative burdens via elimination of requirements not shown to improve patient care, streamlined hospital processes to improve workflow efficiency, and improved EMR systems to help reduce Emergency Physician burnout.

3. Put an End to Workplace Violence
Emergency physicians are exposed to significant rates of physical and verbal abuse, with 9 in 10 reporting that violence in their department has adversely impacted their job environment and patient care. ACEP must continue to advocate for policy changes that require hospitals to protect Emergency Physicians and for the establishment of federal criminal penalties for violence against healthcare workers, similar to those in place for airline and airport workers.

Question #3: **What innovative strategies would you use to recruit and retain membership?**

Similar to most member organizations, ACEP experienced membership decline associated with the COVID pandemic. However, unlike 80% of US membership organizations, whose membership challenges were related to the cancellation of their annual meeting and a lack of organizational activity, ACEP brought our emergency physician community together with ACEP Unconventional and continued to support emergency physician practice through efforts such as, facilitating information-sharing via engagED, developing the Field Guide to COVID-19, advocating for our safety lobbying Congress for PPE, working with the TJC to support physicians wearing their own PPE, and partnering with Amazon to get institution-level access for ACEP members. While ACEP was doing what EPs do best, identifying and caring for the most emergent member needs, ACEP wasn't doing what the one-quarter of US member associations who saw membership growth during this time were doing…continuing membership recruitment efforts.

Recruitment requires providing a compelling value proposition and innovating to meet members' changing needs. In addition to offering practice support, advocacy, career development, and networking, ACEP must listen to needs of graduating residents and new attendings. With elimination of CME funding in many of our hospitals and groups, it is crucial to continue to add value and communicate that value to residents before graduation. Our state chapter members and leaders are uniquely positioned to follow EMRA's lead in partnering with local EM residency programs to improve communication of ACEP's value to EM bound medical students and EM residents by hosting residency visits or local events relevant to our shared mission. In addition to outreach, we must further develop chapter-level engagement opportunities for residents and newly graduated attendings, providing a sense of belonging to our new members and a leadership pipeline for the chapters' future.

Retaining members requires maintaining trust and demonstrating continued value. Effective, timely, and personally relevant communication is required to achieve these goals. Creation of an accurate database of emergency physicians living and working within a state as well as a network of each states' EM groups and ED medical directors would help chapter leaders disseminate relevant information, strengthen advocacy efforts, and plan regional solutions summits to focus on unique challenges. Opening lines of communication with chapter leaders allows member and non-member emergency physicians to reach out with questions and concerns.

By integrating these innovative recruitment and retention strategies, ACEP can effectively showcase the value of membership and foster a supportive and influential professional community dedicated to advancing emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Jennifer J. Casaletto, MD, FACEP

Contact Information
527 Stonewater Bay Lane
Mount Holly, NC 28120
Phone: (602) 319-3454 (mobile)
E-Mail: jennifercasaletto@hotmail.com

Current and Past Professional Position(s)

2020-present	Emergency Medicine Physician CirrusMD Denver, Colorado
2019-present	Emergency Medicine Physician Mid-Atlantic Emergency Medical Associates (MEMA) Salisbury, North Carolina
2015-2021	Emergency Medicine Physician Schumacher Clinical Partners University of North Carolina-Rockingham (2017-2021) Rutherford Regional Hospital (2015-2016)
2012-present	Adjunct Clinical Faculty Physician Atrium Health's Carolinas Medical Center Department of Emergency Medicine Charlotte, North Carolina
2012-2019	Emergency Medicine Physician Emergency Medicine Physicians, LLC/USACS Gaston (2012-2014) & Mecklenburg-Iredell (2014-2019) Charlotte, North Carolina
2009-2012	Residency Program Director Associate Professor (tenured), Virginia Tech Carilion SOM Virginia Tech-Carilion Clinic Department of Emergency Medicine Roanoke, Virginia
2003-2009	Associate Residency Director Assistant Professor of Clinical Emergency Medicine, University of Arizona Maricopa Medical Center Department of Emergency Medicine Phoenix, Arizona

Education (include internships and residency information)

Residency	Carolinas Medical Center Charlotte, North Carolina Emergency Medicine	7/00 – 6/03
Medical School	Vanderbilt University SOM Nashville, Tennessee Doctor of Medicine	8/96 - 5/00
Undergraduate	University of Notre Dame South Bend, Indiana Bachelor of Science, Biochemistry & Theology	8/92 – 5/96

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine
Initial certification 2004, recertification 2014
(tasks completed for 2024 recertification due 12.31.24)

Professional Societies

ACEP 2000-present (AzCEP 2003-2009, VaCEP 2009-2012, NCCEP 2012-present)
CORD 2005-2013
SAEM 2000-2013

National ACEP Activities – List your most significant accomplishments

Academic Affairs Committee	2004-2014
Committee Chair	2011-2013
Annals Editor in Chief Evaluation Task Force	2012
Council Steering Committee	2013-2015
Council Tellers, Credential, and Elections Committee	2009-2010/2012-2013
Education MOC/MOL Committee	2008-2020
Educational Meetings Committee	2016-present
ACEP22 Conference Director, San Francisco, CA	2021-2022
Leadership & Advocacy Conference Chair, Washington, DC	2019-2022
Education Steering Committee	2012-present
Federal Government Affairs Committee	2018-present
Growth of ACEP Council Task Force	2019
Leadership Diversity Task Force	2017-2018
National Emergency Medicine Political Action Committee (NEMPAC)	
Board of Directors	2023-present
State Legislative & Regulatory Committee	2013-2018
Trauma and Injury Prevention Section	2000-present
Young Physician Section	2008-2015
Section Chair	2012-2013
Chair-elect	2011-2012
Councillor	2010-2011
Alternate Councillor	2009-2010
Steering Committee	2008-2014

ACEP Chapter Activities – List your most significant accomplishments

Arizona College of Emergency Physicians

President-Elect/President	2008-2009
Councillor	2008
Education Committee Chair	2009
Secretary	2007
Board of Directors	2004-2009

North Carolina College of Emergency Physicians	2012-present
President	2021-2022
President-Elect	2020-2021
Secretary-Treasurer	2019-2020
Board of Directors	2015-present
Councillor	2012-present
Education Committee	2012-present
Coastal Emergency Medicine Conference -NC Chair	2018-present

Practice Profile

Total hours devoted to emergency medicine practice per year: **1350** total hours per year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **78%** Research **0%** Teaching **20%** Administration **2%**

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Community bedside EM practice — 60 hours/month
Academic EM practice/bedside & teaching —24 hours/month
EM telemedicine physician — 32 hours/month

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

N/A

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert X Cases 5 (five) **Plaintiff Expert Cases 0 (zero)**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Jennifer J. Casaletto, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*
2.

Employer:	THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a Carolinas Medical Center
Address:	1000 Blythe Blvd
	Charlotte, NC 28203
Position Held:	Adjunct Faculty, Department of Emergency Medicine
Type of Organization:	Non-profit healthcare system (W2)

Employer:	Jennifer Casaletto, MD
Address:	524 Stonewater Bay Lane
	Mount Holly, NC 28120
Position Held:	board-certified emergency physician
Type of Organization:	self-employed via 1099 contract work

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

American Board of Emergency Medicine

Item Writer	2018-present
Oral Examiner	2013-present
Standard Setting Task Force	2016

American College of Emergency Physicians

Academic Affairs Committee	2004-2014
Committee Chair	2011-2013
Annals Editor in Chief Evaluation Task Force	2012
Council Steering Committee	2013-2015
Council Tellers, Credential, and Elections Committee	2009-2010
	2012-2013
Education MOC/MOL Committee	2008-2020
Educational Meetings Committee	2016-present
ACEP22 Conference Director, San Francisco, CA	2021-2022
Leadership & Advocacy Conference Chair, Washington, DC	2019-2022
Education Steering Committee	2012-present
Federal Government Affairs Committee	2018-present

Growth of ACEP Council Task Force	2019
Leadership Diversity Task Force	2017-2018
National Emergency Medicine Political Action Committee (NEMPAC)	
Board of Directors	2023-present
State Legislative & Regulatory Committee	2013-2018
Trauma and Injury Prevention Section	2000-present
Young Physician Section	2008-2015
Section Chair	2012-2013
Chair-elect	2011-2012
Councillor	2010-2011
Alternate Councillor	2009-2010
Steering Committee	2008-2014

Arizona College of Emergency Physicians

President-Elect/President	2008-2009
Councillor	2008
Education Committee Chair	2009
Secretary	2007
Board of Directors	2004-2009

Carilion Clinic

Center for Experiential Learning Advisory Committee	2010-2012
Graduate Medical Education Committee	2009-2012
Program Directors Committee	2009-2012

Carolinas Medical Center

Domestic Violence Healthcare Project Advisory Committee	2002-2003
Emergency Medicine Alumni Association Co-director	2013-present

Center for Healthcare Against Family Violence, Co-Medical Director 2006-2009

Council of Emergency Medicine Residency Directors (CORD) 2006-2013

Nominations Committee	2010-2011

Maricopa Integrated Health System

Graduate Medical Education Committee	2006-2009
Injury Prevention Task Force	2006-2009
Continuing Medical Education Committee	2004-2005

Maricopa Medical Center, Department of Emergency Medicine

Associate Residency Program Director	5/06–3/09
Education Director (Assistant Program Director)	1/04-5/06
Promotions Committee	1/04-3/09
Residency Steering Committee	8/03-3/09
Curriculum Committee	8/03-3/09

North Carolina College of Emergency Physicians 2012-present

President	2021-2022
President-Elect	2020-2021
Secretary-Treasurer	2019-2020
Board of Directors	2015-2023
Councillor	2012-present

Education Committee 2012-present
Coastal Emergency Medicine Conference -NCCEP Chair 2018-present

North Carolina Medical Board 2019-present
Emergency Medicine Expert Reviewer

State of Arizona
Committee on the Impact of Domestic Violence and the Courts 2007-2009
Appointed by Supreme Court Justice Ruth A. McGregor
Health Cares About Family Violence Subcommittee of Arizona 2005-2007
Governor's Domestic Violence Council, Chairman
Maricopa Association of Governments Domestic Violence Council 2005-2009

Society of Academic Emergency Medicine
Regional Meetings Task Force 2008-2009
Graduate Medical Education Committee 2007-2011
Subcommittee Chair – Malpractice Effects
CPC Task Force 2006-2009
Faculty Development Committee 2005-2008
Subcommittee Chair – Junior Faculty Objectives
Domestic Violence Interest Group (disbanded) 2000-2004

Vanderbilt University School of Medicine
Secretary/Treasurer, Class of 2000
Practicing Caring Medicine for AIDs Patients, Course Co-director

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE
☒ If YES, Please Describe:

Northwest Anesthesia Seminars (CME Provider) - speaker honorariums and reimbursed travel expenses

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Jennifer Casaletto, MD, FACEP Date June 10, 2024

Officers

Jill Benson, MD, FACEP
President

Madji Namde, MD
President-Elect

Melanie Artho, MD
Secretary/Treasurer

Thomas Bernard III, MD, FACEP
Immediate Past President

Board of Directors

Richard Benson, MD
Smeet Bhimani, DO
Christopher Griggs, MD, MPH, FACEP
Matthew Heuton, MD
Joshua Loyd, MD, NRP
Swarup Misra, DO
Josh Sawyer, MD, FAAEM
Brandon Smallwood, MD, FACEP
Benjamin Wiles, DO

Resident Members
Mark Baumgarten, MD
Lauren Coaxum, MD
Caitlin Dakermanji, MD
Tess Munoz, MD
Matthew Yeager, MD (Voting Resident Member)

Councillors

Melanie Artho, MD
Jill Benson, MD, FACEP
Thomas Bernard III, MD
Scott Brown, MD, FACEP
Gregory J. Cannon, MD, FACEP
Jennifer Casaletto, MD, FACEP
Tommy Mason, MD, FACEP
Eric Maur, MD, FACEP
Abhi Mehrotra, MD, FACEP
Bret Nicks, MD, FACEP
Stephen Small, MD, FACEP

Executive Director

Colleen Kochanek
colleen@kochaneklawgroup.com
P.O. Box 1038
Wake Forest, NC 27588
(919) 809-5618
http://www.nccep.org

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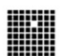

American College of
Emergency Physicians

February 2, 2024

Melissa Costello, MD, FACEP
℅ Ms. Sonja Montgomery
Nominating Committee
P.O. Box 619911
Dallas, TX 75261-9911
nominations@acep.org

Re: Endorsement for election of Jennifer J. Casaletto, MD, FACEP to the ACEP Board of Directors

Dear Dr. Costello and Esteemed Councillors:

On behalf of the North Carolina College of Emergency Physicians (NCCEP), I write to enthusiastically nominate and endorse Jennifer Casaletto MD, FACEP as a candidate for the ACEP Board of Directors. She has demonstrated an unwavering commitment to the field of emergency medicine and has consistently gone above and beyond in her service to ACEP, making her an ideal candidate for this prestigious role.

Dr. Casaletto's national service within ACEP has been exemplary, marked by numerous achievements and accolades. She was recognized as the College's Spokesperson of the Year in 2022, an attestation to her communication skills and commitment to advocacy on behalf of our College. She was twice acknowledged with Service to the College awards, a testament to her dedication and contributions. Dr. Casaletto has served as the Chairwoman of the Academic Affairs and the Educational Meetings Committees and continues to serve on the Education Steering Committee, showcasing her leadership skills and expertise in shaping educational initiatives within the organization. Her former role as the Chair of the Young Physicians Section further highlights her commitment to fostering the development of the next generation of emergency physicians.

Dr. Casaletto's prior participation on the Council Steering Committee, Tellers, Credentials, and Elections Committee, and the State Legislative & Regulatory Committee underscores her broad understanding of ACEP's operations and governance. Currently, she serves on the Federal Government Affairs, National Chapter Relations, and Education Steering Committees, and continues to actively contribute to ACEP's national initiatives.

As a current member of the NEMPAC Board of Directors, she is known as an avid recruiter of fellow College members to join her as a Give-a-Shift member.

On a regional level, Dr. Casaletto's dedication is equally impressive. Her role as the former President for both Arizona ACEP and NCCEP speaks volumes about her ability to lead and collaborate effectively at both state and regional levels. Representing Arizona, YPS, and now North Carolina, she has been an active member of the Council for more than fifteen years. In addition, she currently serves as the North Carolina Chair of the wildly successful annual tri-state Coastal Emergency Medicine Conference and co-chair of NCCEP's fledgling Leadership and Advocacy fellowship (currently entering its second year) further demonstrating her commitment to advancing emergency medicine across different regions.

In conclusion, Jennifer's extensive and diverse experience within ACEP, coupled with her proven leadership, makes her an outstanding candidate for the ACEP Board of Directors. Her passion for the field, combined with a track record of accomplishments, will undoubtedly contribute significantly to ACEP's mission. The North Carolina College of Emergency Physicians wholeheartedly nominates and endorses Jennifer for the ACEP Board of Directors and believes she will bring invaluable insights, dedication, and leadership to the role.

Respectfully,

Jill Benson, MD, FACEP
President, North Carolina College of Emergency Physicians

Jennifer J. Casaletto, MD, FACEP

I am honored and humbled by the opportunity to represent you on the ACEP Board of Directors (BOD) and, if elected, pledge to continue my unwavering commitment to our profession and our patients. As a fully "recovered" emergency medicine residency director, I've spent the last decade as a community emergency medicine nocturnist including several shifts each month at the "big house." My practice across the emergency medicine (EM) spectrum of academics, residency program leadership, and community EM practice brings a unique perspective to our BOD. This BOD must seize the opportunity and meet the challenge to serve, unite, and advocate for over 40,000 board-certified Emergency Physicians and 9,300 EM resident physicians. To *serve*, we must prioritize fair compensation that acknowledges emergency care's critical role and secures the financial stability and career longevity of our colleagues. We must push for revenue and billing transparency from employers to ensure fair and just compensation. To *unite*, we must address workplace burdens that drive burnout by aggressively addressing emergency department (ED) challenges while supporting workplace wellness for all Emergency Physicians. To *advocate*, we must drive policy changes to compel hospitals to protect the rights of Emergency Physicians and to establish federal criminal penalties for violence against healthcare workers.

As a Board member, I commit to bringing passionate advocacy and strong communication skills, skills recognized with the College's Spokesperson of the Year and two Service to the College awards. Service as prior Chair of ACEP's Academic Affairs Committee, Chair of ACEP's Educational Meetings Committees and current service on the Education Steering Committee, sharpened my leadership skills and enhanced my ability to shape vital educational initiatives. In addition, service as Chair of the Young Physicians Section (YPS) and on ACEP's Leadership Diversity Task Force highlights my commitment to fostering the development of the next generation of Emergency Physicians.

Participation on the Council Steering Committee, Tellers, Credentials, & Elections Committee, and the State Legislative & Regulatory Committee provided a broad insight into ACEP's operations and governance. Current service on the Federal Government Affairs, National Chapter Relations, and Education Steering Committees, allows for continued involvement and contribution to ACEP's national initiatives. As a current member of the NEMPAC Board of Directors, I recruit fellow College members to join me as a Give-a-Shift member, advancing our PAC's ability to support federal candidates who share a commitment to the safe and effective practice emergency medicine.

As former President for both Arizona ACEP and NCCEP, I was entrusted to lead, collaborate, and communicate effectively. Representing Arizona, YPS, and currently North Carolina has been a privilege, allowing me to meet and learn from many of you as a colleague on the Council for two decades. Regionally, service as co-chair of NCCEP's fledgling Leadership and Advocacy fellowship (entering its second year) and North Carolina Chair of the wildly successful annual tri-state Coastal Emergency Medicine Conference bringing nearly 300 emergency physicians and their families to Kiawah Island each June demonstrate my contributions to innovative advancements of emergency medicine practice, wellness, and advocacy…and a need to improve my limbo skills for the famous CEMC oyster roast!

Most of all, in addition to extensive and diverse experience within ACEP coupled with proven leadership, I promise to bring you the work-ethic of an emergency physician, the energy of a boy mom, the dedication of a marathon runner, and the smile of a colleague who's so very honored to be considered in this group of esteemed colleagues as a candidate for the ACEP Board of Directors. I humbly ask for your vote for the ACEP Board of Directors.

VOTE
Jennifer Casaletto, MD, FACEP
for ACEP Board of Directors

Past-President, North Carolina College of Emergency Physicians

Past-President, Arizona College of Emergency Physicians

NEMPAC Board of Directors

ACEP
Academic Affairs Committee Chair
ACEP22 Conference Director
Annals Editor-in-Chief Evaluation Task Force
Educational Meetings Committee Chair
Education Steering Committee
Federal Government Affairs Committee
Leadership & Advocacy Conference Director
State Legislative & Regulatory Committee
Young Physician Section Chair

ACEP Council
Council Steering Committee
Growth of ACEP Council Task Force
Leadership Diversity Task Force
Tellers, Credentials, and Elections Committee

ACEP Recognition
Service to the College Award
Spokesperson of the Year

Hospital & Academic Leadership
Former EM Residency Program Director
Center for Healthcare Against Family Violence, Medical Director

Civic & Community Leadership
Arizona Governor's Domestic Violence Council, Subcommittee Chair
NBC 12-KPNX Medical Expert

Endorsed by

Collaborative Leadership • Effective Communication • Advocacy

VOTE

Fair compensation
Reduction of administrative burdens
End workplace violence

Jennifer J. Casaletto, M.D., F.A.C.E.P.

PERSONAL

Birthdate	3/27/1974
Address	524 Stonewater Bay Lane Mount Holly, NC 28120
Phone	(602) 319-3454 (m)
E-mail	jennifercasaletto@hotmail.com

EMPLOYMENT

2020-present	Emergency Medicine Physician CirrusMD CirrusMD Provider Network 3513 Brighton Blvd., Suite 230 Denver, Colorado 80216
2019-present	Emergency Medicine Physician Mid-Atlantic Emergency Medical Associates (MEMA) Novant Health Rowan Medical Center 612 Mahaley Ave, Salisbury, NC 28144 (704) 210-5000
2015-2021	Emergency Medicine Physician Schumacher Clinical Partners 200 Corporate Blvd, Lafayette, LA 70508 (800) 893-9698 University of North Carolina-Rockingham (2017-2021) Rutherford Regional Hospital (2015-2016)
2012-present	Adjunct Clinical Faculty Physician Atrium Health's Carolinas Medical Center Department of Emergency Medicine 1100 Blythe Blvd, Charlotte, NC 28203 (704) 355-3658
2012-2019	Emergency Medicine Physician Emergency Medicine Physicians, LLC/USACS Gaston (2012-2014) & Mecklenburg-Iredell (2014-2019)

	101 East WT Harris Blvd. Suite 3109, Charlotte, NC 28262 (303) 445-4361 ext. 1102	
2009-2012	Residency Program Director Associate Professor (tenured), Virginia Tech Carilion SOM Virginia Tech-Carilion Clinic Department of Emergency Medicine 1906 Belleview Avenue, Admin 1-South Roanoke, VA 24014 (540) 853-0182	
2003-2009	Associate Residency Director Assistant Professor of Clinical Emergency Medicine, University of Arizona Maricopa Medical Center Department of Emergency Medicine 2601 East Roosevelt Street Phoenix, Arizona 85008 (602) 344-5808	

EDUCATION

Residency	Carolinas Medical Center Charlotte, North Carolina Emergency Medicine	7/00 – 6/03
Medical School	Vanderbilt University SOM Nashville, Tennessee Doctor of Medicine	8/96 - 5/00
Undergraduate	University of Notre Dame South Bend, Indiana Bachelor of Science, Biochemistry & Theology	8/92 – 5/96

CERTIFICATIONS

Fellow, American College of Emergency Physicians	10/2006
American Board of Emergency Medicine	6/2004
Georgia State Medical License	
North Carolina State Medical License	

Kenya Medical and Dental License
Tennessee State Medical License
Virginia State Medical License
Advanced Cardiovascular Life Support
Pediatric Advanced Life Support
Advanced Trauma Life Support-Instructor
Advanced Hazmat Life Support

AWARDS

American College of Emergency Physicians
Service to the College October 2014
Spokesperson of the Year October 2022
Service to the College October 2022

Maricopa Medical Center
Emergency Medicine Teaching Attending of the Year 2004-2005

Vanderbilt University School of Medicine
SAEM Excellence in Emergency Medicine 2000
Canby Robinson Research Fellowship 1997

University of Notre Dame
Magna Cum Laude Biochemistry & Theology 1996
Women's Rowing Varsity Letters 1993-1995

GRANTS

Maricopa Medical Foundation Housestaff Achievement Grant 2008-2009
Arizona Emergency Department Survey of Subspecialty On-Call Availability
Maricopa Medical Foundation ($650)

Maricopa Medical Foundation Housestaff Achievement Grant 2008-2009
Effect of Routine EMS Communications on Physician Efficiency in the ED
Maricopa Medical Foundation ($1040)

STOP Violence Against Women Formula Grant 2005-2008
State of Arizona, Co-Primary Investigator ($124,182)
Renewed through 12/2007 ($81,000)
Renewed through 12/2008 ($81,000)

CMC and UFS Domestic Violence Healthcare Project 2002-2005
Duke Endowment, resident involvement as secondary medical director to Dr. Maria Pelucio ($125,086)

SCHOLARLY ACTIVITIES

PUBLICATIONS

Peer-reviewed

Casaletto JJ. **Atrial fibrillation.** *Critical Decisions in Emergency Medicine.* 2014 Apr; 28(4).

Casaletto JJ, Wadman MC, Ankel FK, Bourne CL, Ghaemmaghami CA. **Emergency medicine rural rotations – a program director's guide.** *Ann Emerg Med.* 2013 May; 61(5):578-583.

Wadman M, Clark T, Casaletto J, Muelleman R, et al. **Rural clinical experiences for emergency medicine residents: a curriculum template.** *Acad Emerg Med.* 2012 Nov; 19(11):1287-1293.

Casaletto JJ. **Is salt, vitamin, or endocrinopathy causing this encephalopathy? A review of endocrine and metabolic etiologies of altered level of consciousness.** *Emerg Med Clin N Am.* 2010 Aug; 28(3):633-662.

Kendall J, Pelucio MT, Casaletto J, et al. **Impact of emergency department intimate partner violence intervention.** *J Interpers Violence.* 2009 Feb; 24(2):280-306.

Farley H, Casaletto J, Ankel F, Young KD, Hockberger R. **An assessment of the faculty development needs of junior clinical faculty in emergency medicine.** *Acad Emerg Med.* 2008 July; 15(7):664-8.

Perera NM, Casaletto JJ. **A painless rash of the hands and feet.** *Ann Emerg Med.* 2008 Feb; 51(4):354, 360.

Casaletto JJ, Barrow LA. **Tracheal transection.** *Emerg Med.* 2008 Feb; 40(2):38-41.

Casaletto JJ, Shriki J. **Aortic transection.** *Emerg Med.* 2007 Sept; 39(9):38-41.

Casaletto J, Berman P. **Evaluation and management of atrial fibrillation.** *Emerg Med Reports.* 2007 Sept; 28(20):237-48.

Casaletto JJ. **Book and media review: *First Aid for the Emergency Medicine Clerkship, 2nd edition.*** *Ann Emerg Med.* 2007 Jan; 49(1):121-122.

Casaletto JJ. **Differential diagnosis of metabolic acidosis.** *Emerg Med Clin N Am.* 2005 Aug; 23(3):771-787.

Casaletto JJ. **Book and media Review: *Emergency Medicine Orals, 3rd edition*.** *Ann Emerg Med.* 2004 Aug; 44(2):196-7.

Ernst AA, Weiss SJ, Nick TG, Casaletto J, Garza A. **Domestic violence in a university emergency department.** *South Med J.* 2000 Feb; 93(2):176-81.

Weiss S, Garza A, Casaletto J, Stratton M, Ernst A, Blanton D, Nick TG. **The out-of-hospital use of a domestic violence screen for assessing patient risk**. *Prehosp Emerg Care*. 2000 Jan-Mar; 4(1):24-7.

Ernst AA, Casaletto J, Nick TG, Weiss SJ. **Serum glucose levels in elderly trauma victims**. *Acad Emerg Med*. 1999 Nov; 6(11):1177-9.

Non-peer reviewed

Casaletto J. *Becoming a Walmart Greeter: Young Physicians Represent on Tellers, Credentials, and Elections Committee.* ACEP YPS Section Newsletter. 2009

Casaletto J, Schmitz G. *Medical Marriages.* ACEP YPS 3-5 Years Out Series. Epub.

Casaletto J. *EMF/ACEP Teaching Fellowship: It's Hot.* ACEP YPS Section Newsletter. 2007;12(2).

Book Chapters

Casaletto JJ, Lake AS. **Maxillofacial Injury.** In: Roppolo LR, Davis D, Kelly S, Rosen P. Emergency Medicine Handbook: Critical Concepts for Clinical Practice. Philadelphia: Elsevier; 2007. pp. 95-107.

Casaletto JJ, de Kort M, Garff A. **Head Injury.** In: Roppolo LR, Rosen P, Davis D, Kelly S, Rosen P. Emergency Medicine Handbook: Critical Concepts for Clinical Practice. Philadelphia: Elsevier; 2007. pp. 83-94.

Abstract Publications

Hopson LR, Wald DA, Casaletto J, et al. **Resident as teacher programs in mandatory emergency medicine clerkships.** *Ann of Emerg Med*. 2010 Sept; 56(3): S139.

Kendall J, Pelucio MT, Casaletto J, et al. **Impact of emergency department intimate partner violence intervention.** *J Interpers Violence.* 2008 Mar 31: EPub.

Casaletto JJ, MacLaughlin J, Pelucio MT. **Impact of Emergency Department-Based Intimate Partner Violence Intervention.** Abstracted in *Ann Emerg Med.* 2004 Oct; 44(4): S10.

Ernst AA, Casaletto J, Weiss SJ, et al. **Domestic violence in a university ED.** Abstracted in *Ann of Emerg Med*. 1998 Jan; 32: Parts 2 & 92. *South Med J*. 1998 Jan; 32; S44 & S33.

Garza A, Casaletto J, Weiss SJ, et al. **Domestic violence pre-hospital: development of a survey tool, the DVSAS.** Abstracted in *Ann of Emerg Med*. 1998 Jan; 32: Parts 2 & 92. South Med J. 1998 Jan; S9 & S32.

PRESENTATIONS

Oral Presentations

"On-call Specialist Shortage in Arizona Emergency Departments: Hospital Characteristics and Practices Associated with Greater On-call Physician Availability"
SAEM Western Regional Research Forum, Sonoma, California, March 2010.

"On-Call Specialist Shortage in Arizona: Effects on Higher Level of Care Transfers and Patient Care"
SAEM Western Regional Research Forum, Sonoma, California, March 2010.

"Serum Glucose Levels in Elderly Trauma Victims"
ACEP Scientific Assembly, Las Vegas, Nevada, October 1999.

"Domestic Violence in a University Emergency Department"
Southern Medical Association, New Orleans, Louisiana, November 1998.

"Domestic Violence Prehospital: development of a survey tool, the DVSAS"
ACEP Scientific Assembly, San Diego, California, October 1998.

"Combinatorial Mutagenesis on the *cro*-Repressor"
Howard Hughes Medical Institute Summer Research Forum, Notre Dame, Indiana, August 1994.

"Effect of Polyclonal Antibodies on Bacterial Adherence to Biomaterials"
Virginia Academy of Science, Richmond, Virginia, May 1992.

Poster Presentations

"Resident as Teacher Programs in Mandatory Emergency Medicine Clerkships"
ACEP Scientific Assembly, Las Vegas, Nevada, September 2010.

"An Assessment of the Faculty Development Needs of Junior Clinical Faculty in Emergency Medicine"
CORD Annual Assembly, New Orleans, Louisiana, March 2008.

"Impact of Emergency Department-Based Intimate Partner Violence Intervention"
ACEP Scientific Assembly, San Francisco, California, October 2004.

"Domestic Violence in a University Emergency Department"
ACEP Scientific Assembly, San Diego, California, October 1998.

TEACHING

Peer Lectures (invited)

Bump or Brain Injury: Pediatric Head Injury
Cardiac Fashion Wear: VADs, Vests, and Ventricular Devices
EM ENT and Dental Updates: We Can Handle the Tooth
High-Risk EKGs: The Good, the Bad and the Ugly
Management Update 2023: AFIB — March 2023
PE, PESI, and PERC
Trauma Update 2023
What Not to Miss: Intimate Partner Violence
Current Topics in Emergency Medicine, Banff, Alberta

Bump or Brain Injury: Pediatric Head Injury
EM ENT and Dental Updates: We Can Handle the Tooth
High-Risk EKGs: The Good, the Bad and the Ugly
No Fibbing: AFib Management Update 2023 — February 2023

Rad! Reading Head CTs in the ED
Trauma Update 2023
What Not to Miss: Intimate Partner Violence
Topics in Emergency Medicine, Snowmass, Colorado

Bump or Brain Injury: Pediatric Head Injury
CT in the ED: Is the Physical Exam Dead?
Cardiac Fashion Wear - VADs Vests & Ventricular Devices
Forgotten Ventricle: Finding and Fixing RV Failure
Management Update: Atrial Fibrillation 2023 February 2023
PE, PESI, PERC
What Not to Miss: Intimate Partner Violence
Topics in Emergency Medicine, Maui, Hawaii

Bump or Brain Injury: Pediatric Head Injury
CT in the ED: Is the Physical Exam Dead?
ENT and Dental Updates: We Can Handle the Tooth November 2022
Management Update 2022: AFIB
PE, PESI, PERC
Trauma Updates 2022
What Not to Miss: Intimate Partner Violence
Topics in Emergency Medicine, Orlando, Florida

Forgotten Ventricle: Finding & Fixing RV Failure
Hot Topics in Trauma 2022 November 2022
NCCEP Fall Conference, Asheville, NC, Kauai, HI

Management Updates 2022: Atrial Fibrillation
High Risk EKGs: The Good, The Bad, and The Ugly!
Cardiac Fashion Wear: VADs, Vests, & Ventricular Device
Hot Topics in Trauma 2022
Bump or Brain Injury: Pediatric Head Injury 2022 May 2022
EM ENT and Dental Updates: We Can Handle the Tooth
What Not to Miss: Intimate Partner Violence
Topics in Emergency Medicine, Kauai, HI

Atrial Fibrillation: Management Updates for 2022
High Risk EKGs: The Good, The Bad, and The Ugly!
Hot Topics in Trauma 2022
Bump or Brain Injury: Pediatric Head Injury April 2022
The physical exam is dead…or is it? CT Imaging in the new radiation world order…
ENT and Dental Updates: We Can Handle the Tooth
Topics in Emergency Medicine, Providenciales, Turks & Caicos Islands

Atrial Fibrillation: Management Update 2020
Cardiac Fashion Wear: VADs, Vests, & Ventricular Device
High Risk EKGs: The Good, The Bad, and The Ugly
Hot Topics in Trauma 2022
Bump or Brain Injury: Guide to Pediatric Head Injury

Top 10 Eye Emergencies: The Blind Leading the Blind January 2022
ENT and Dental Updates: We Can Handle the Tooth
Topics in Emergency Medicine, Lake Tahoe, California

The physical exam is dead…or is it? CT Imaging in the new radiation world order…
ENT and Dental Updates: We Can Handle the Tooth
Bump or Brain Injury: Guide to Pediatric Head Injury May 2021
Atrial Fibrillation: Management Update 2020 December 2020
High Risk EKGs: The Good, The Bad, and The Ugly
Hot Topics in Trauma 2020
NWAS Topics in Emergency Medicine, Live Webinar

Atrial Fibrillation: Management Update 2020
High Risk EKGs: The Good, The Bad, and The Ugly
Hot Topics in Trauma 2020
Bump or Brain Injury: Guide to Pediatric Head Injury
Top 10 Eye Emergencies: The Blind Leading the Blind August 2020
The physical exam is dead…or is it? CT Imaging in the new radiation world order…
ENT and Dental Updates: We Can Handle the Tooth
Topics in Emergency Medicine, Glacier National Park (Whitefish), MT

Bump or Brain Injury: Guide to Pediatric Head Injury
Hot Topics in Trauma 2020
High Risk EKGs: The Good, The Bad, and The Ugly
Atrial Fibrillation: Management Update 2020
Cardiac Fashion Wear: VADs, Vests, & Ventricular Devices
Triple Threat: Allergy, Anaphylaxis, and Angioedema February 2020
ENT and Dental Updates: We Can Handle the Tooth
Top 10 Eye Emergencies: The Blind Leading the Blind
Intimate Partner Violence: Role of the Emergency Physician
The physical exam is dead…or is it? CT Imaging in the new radiation world order…
Topics in Emergency Medicine, Eastern Caribbean Cruise

Bump or Brain Injury: Guide to Pediatric Head Injury
Hot Topics in Trauma 2019
High Risk EKGs: The Good, The Bad, and The Ugly
Atrial Fibrillation: Management Update 2019
Cardiac Fashion Wear: VADs, Vests, & Ventricular Devices July 2019
ENT and Dental Updates: We Can Handle the Tooth
Top 10 Eye Emergencies: The Blind Leading the Blind
Intimate Partner Violence: Role of the Emergency Physician
PE, PESI, PERC - Alliteration at its worst
The physical exam is dead…or is it? CT Imaging in the new radiation world order…
Topics in Emergency Medicine, Alaskan Cruise via Hubbard Glacier

Bump or Brain Injury: Guide to Pediatric Head Injury
Hot Topics in Trauma 2019

High Risk EKGs: The Good, The Bad, and The Ugly
Atrial Fibrillation: Management Update 2019 — March 2019
ENT and Dental Updates: We Can Handle the Tooth
Top 10 Eye Emergencies: The Blind Leading the Blind
Intimate Partner Violence: Role of the Emergency Physician
Topics in Emergency Medicine, Bonita Springs, Florida

Cardiac Fashion Wear: VADs, Vests, & Ventricular Devices
Triple Threat: Allergy, Angioedema, & Anaphylaxis — November 2018
NCCEP Fall Conference, Asheville, NC

Bump or Brain Injury: Guide to Pediatric Head Injury
Hot Topics in Trauma 2018
High Risk EKGs: The Good, The Bad, and The Ugly
Atrial Fibrillation: Management Update 2018 — April 2018
ENT and Dental Updates: We Can Handle the Tooth
Top 10 Eye Emergencies: The Blind Leading the Blind
Intimate Partner Violence: Role of the Emergency Physician
Topics in Emergency Medicine, Singer Island, Florida

Hot Topics in Trauma 2017
High Risk EKGs: The Good, The Bad, and The Ugly — October 2017
NCCEP Fall Conference, Asheville, NC

Bump or Brain Injury: Guide to Pediatric Head Injury
Hot Topics in Trauma 2017
High Risk EKGs: The Good, The Bad, and The Ugly — July 2017
Atrial Fibrillation: Management Update 2017
ENT and Dental Updates: We Can Handle the Tooth
Emergency Medicine Update, St. Petersburg, Florida

PE, PESI, PERC - Alliteration at its worst
The physical exam is dead…or is it? CT Imaging in the new radiation world order… — June 2017
Coastal Emergency Medicine Conference, Kiawah Island, SC

Bump or Brain Injury: Guide to Pediatric Head Injury
Hot Topics in Trauma 2017
High Risk EKGs: The Good, The Bad, and The Ugly — March 2017
Atrial Fibrillation: Management Update 2017
ENT and Dental Updates: We Can Handle the Tooth
Emergency Medicine Update, Kauai, Hawaii

Balance Billing Basics
ACEP Leadership and Advocacy Conference — March 2017
USACS Scholars Program, Washington, DC

Bump or Brain Injury: Guide to Pediatric Head Injury
Atrial Fibrillation: Management Update 2016 — November 2016
NCCEP Fall Conference, Asheville, NC

Tri-State Jeopardy Content Contributor: Trauma Emergencies June 2016
Coastal Emergency Medicine Conference, Kiawah Island, SC

Not quite ready for prime time: Pregnancy complications in the non-viable time period June 2016
Coastal Emergency Medicine Conference, Kiawah Island, SC

Bump or Brain Injury: Guide to Pediatric Head Injury
Trauma Update 2016: Bleeding and Backboards
High Risk EKGs: The Good, The Bad, and The Ugly May 2016
Atrial Fibrillation: Management Update 2016
ENT and Dental Updates: We Can Handle the Tooth
Emergency Medicine Update, Destin, Florida

Tri-State Jeopardy Content: Ophthalmological Emergencies June 2015
Coastal Emergency Medicine Conference, Kiawah Island, SC

Bump or Brain Injury: Guide to Pediatric Head Injury
Top 10 Eye Emergencies: The Blind Leading the Blind
High Risk EKGs: The Good, The Bad, and The Ugly Mar 2015
Atrial Fibrillation: Management Update 2015
ENT and Dental Updates: We Can Handle the Tooth
Emergency Medicine Update, Punta Cana, Dominican Republic

Top 10 Eye Emergencies: The Blind Leading the Blind
ENT and Dental Updates: We Can Handle the Tooth Nov 2014
NCCEP Fall Trauma Conference, Asheville, NC

Building and Growing a Hospital-Based Violence Intervention Program (moderator of panel discussion) Oct 2014
American College of Emergency Physicians 2014
Annual Meeting, Chicago, IL

Intimate Parter Violence: Role of the Emergency Physician
Top 10 Eye Emergencies Feb 2012
VaCEP Hot Topics at the Homestead, Hot Springs, VA

Atrial Fibrillation: Management Update 2011 Feb 2011
VaCEP Hot Topics at the Homestead, Hot Springs, VA

Resident as Teacher June 2010
SAEM Annual Meeting, Phoenix, AZ

Becoming a Strong EM Applicant April 2010
Mid-Atlantic SAEM Regional Meeting, Charlottesville, VA

Chief Resident Pitfalls: How to Avoid Them March 2010
CORD Academic Assembly, Orlando, FL

Resident as Teacher and Evaluator May 2009
SAEM Annual Meeting, New Orleans, LA

Atrial Fibrillation: Management Update 2009
Ultrasound Workshop: Endovaginal US for EM Physicians
When the HCG is Positive: OB Ultrasound in the ED Mar 2009
FAST
Mayo Emergency Medicine 2009: Moving Forward, Scottsdale, AZ

Becoming a Strong EM Applicant Jan 2009
Western SAEM Regional Research Forum, Park City, UT

Ultrasound for Emergency Medicine Physicians (2 day course) Jan 2009
LSU-Baton Rouge Department of Emergency Medicine
Baton Rouge, LA

Cardiac Update:Part I-Acute Management of Atrial Fibrillation July 2008
Audio-Digest Emergency Medicine
Volume 25, Issue 14

CPC: Pediatric Back Pain May 2008
CORD-SAEM CPC, Washington, DC

Atrial Fibrillation: Management Update 2008 April 2008
Mayo Emergency Medicine 2008: Moving Forward, Scottsdale, AZ

Ultrasound Workshop: Endovaginal US for EM Physicians April 2008
Mayo Emergency Medicine 2008: Moving Forward, Scottsdale, AZ

Becoming a Strong EM Applicant March 2008
Western SAEM Regional Research Forum, Costa Mesa, CA

Ultrasound for Pediatric Emergency Physicians and Trauma Surgeons (2 day course) January 2008
Phoenix Children's Hospital, Phoenix, AZ

Ultrasound for Emergency Physicians September 2007
Banner Good Samaritan Medical Center, Phoenix, AZ

Clinical Utility of Troponin, BNP, D-dimer in the ED April 2007
ACOEP Spring Conference, Litchfield Park, AZ

Management Update:Atrial Fibrillation March 2007
Mayo Emergency Medicine 2007: Moving Forward, Scottsdale, AZ

Top Articles in Emergency Medicine April 2006
ACOEP Spring Conference, Litchfield Park, AZ

IPV:ED Presentations, Universal Screening, and Intervention October 2005
Maricopa County Annual Domestic Violence Month Lecture Series
Phoenix, AZ

Role of Medical Providers in IPV Screening and Intervention September 2005
Pinal County Domestic Violence Coalition 10th Annual Conference

Casa Grande, AZ

Disaster Preparedness: Prehospital Planning, Scene Assessment, and Triage — March 2005
Scottsdale Healthcare Trauma Conference, Scottsdale, AZ

Intimate Partner Violence: A Multidisciplinary Approach to Detection and Intervention — November 2002
North Carolina Forensic Nursing Program, Charlotte, NC

Visiting Professorship Lectures (invited)

University of Notre Dame Department of Preprofessional Studies — April 2011
University of Notre Dame, South Bend, Indiana
The Role of Service in Professional Development

University of North Carolina Emergency Medicine Grand Rounds — September 2010
University of North Carolina, Chapel Hill, North Carolina
Intimate Partner Violence: Role of the Emergency Physician

University of Notre Dame Department of Preprofessional Studies — March 2010
University of Notre Dame, South Bend, Indiana
The Role of Service in Professional Development

Emory University Emergency Medicine Grand Rounds — August 2008
Grady Hospital, Atlanta, Georgia
Clinical Utility of Troponin, BNP, D-dimer in the ED

Consolata Hospital, Nyeri, Kenya — July 2007
Diagnosis and Management Update: Acute MI

Minneapolis Emergency Medicine Foundation — September 2006
Hennepin County Medical Center & Regions Hospital, Minneapolis, Minnesota
Intimate Partner Violence: Role of the Emergency Physician

Casa Grande Regional Medical Center, Casa Grande, Arizona — January 2006
Intimate Partner Violence: Five W's, Screening, Documentation, and Intervention

ACEP Teaching Fellowship Faculty Mentor — 2009-2018

Medical Student Advising

SAEM Virtual Advisor Program — 2003, 2004
Arizona College of Osteopathic Medicine Clinical Preceptor — 2003-2005

National Youth Leadership Forum on Medicine — June-July 2007

Training and Careers in Emergency Medicine — June-July 2008

OTHER SCHOLARLY ACTIVITY

Annals of Emergency Medicine Book, Media, and Article Reviewer — 2003-present

ADMINISTRATIVE and LEADERSHIP ACTIVITIES

American Board of Emergency Medicine

Item Writer	2018-present
Oral Examiner	2013-present
Standard Setting Task Force	2016

American College of Emergency Physicians

Academic Affairs Committee	2004-2014
Committee Chair	2011-2013
Annals Editor in Chief Evaluation Task Force	2012
Council Steering Committee	2013-2015
Council Tellers, Credential, and Elections Committee	2009-2010
	2012-2013
Education MOC/MOL Committee	2008-2020
Educational Meetings Committee	2016-present
ACEP22 Conference Director, San Francisco, CA	2021-2022
Leadership & Advocacy Conference Chair, Washington, DC	2019-2022
Education Steering Committee	2012-present
Federal Government Affairs Committee	2018-present
Growth of ACEP Council Task Force	2019
Leadership Diversity Task Force	2017-2018
National Emergency Medicine Political Action Committee (NEMPAC)	
Board of Directors	2023-present
State Legislative & Regulatory Committee	2013-2018
Trauma and Injury Prevention Section	2000-present
Young Physician Section	2008-2015
Section Chair	2012-2013
Chair-elect	2011-2012
Councillor	2010-2011
Alternate Councillor	2009-2010
Steering Committee	2008-2014

Arizona College of Emergency Physicians

President-Elect/President	2008-2009
Councillor	2008
Education Committee Chair	2009

Secretary	2007
Board of Directors	2004-2009

Carilion Clinic

Center for Experiential Learning Advisory Committee	1/10-2/12
Graduate Medical Education Committee	4/09-6/11
Program Directors Committee	4/09-6/11

Council of Emergency Medicine Residency Directors (CORD)	2006-2013
Nominations Committee	2010-2011

Maricopa Integrated Health System

Graduate Medical Education Committee	5/06-3/09
Injury Prevention Task Force	6/06-3/09
Continuing Medical Education Committee	1/04-7/05

Maricopa Medical Center, Department of Emergency Medicine

Associate Residency Program Director	5/06–3/09
Education Director (Assistant Program Director)	1/04-5/06
Promotions Committee	1/04-3/09
Residency Steering Committee	8/03-3/09
Curriculum Committee	8/03-3/09

North Carolina College of Emergency Physicians	2012-present
President	2021-2022
President-Elect	2020-2021
Secretary-Treasurer	2019-2020
Board of Directors	2015-present
Councillor	2012-present
Education Committee	2012-present
Coastal Emergency Medicine Conference -NC Chair	2018-present

North Carolina Medical Board	2019-present
Emergency Medicine Expert Reviewer	

Society of Academic Emergency Medicine

Regional Meetings Task Force	2008-2009
Graduate Medical Education Committee	2007-2011
Subcommittee Chair – Malpractice Effects	
CPC Task Force	2006-2009
Faculty Development Committee	2005-2008
Subcommittee Chair – Junior Faculty Objectives	

Domestic Violence Interest Group (disbanded) 2000-2004

Carolinas Medical Center
Domestic Violence Healthcare Project Advisory Committee 2002-2003
Emergency Medicine Alumni Association Co-director 2013-present
Vanderbilt University School of Medicine
Secretary/Treasurer, Class of 2000 1997-1998
Practicing Caring Medicine for AIDs Patients
Course Co-director 1997-1998

ACADEMIC DEVELOPMENT

AAMC/Medical Education Research Certification (MERC) March 2009-2010

EMF/ACEP Advanced Teaching Fellowship September 2007

CORD New Program Director's Workshop March 2006, 2007

ACEP Leadership and Advocacy Conference April 2005, 2007-15

SAEM-McMaster's Evidence Based Medicine Online Course February 2005

EMF/ACEP Teaching Fellowship 2003-2004

MEMBERSHIPS

American College of Emergency Physicians
North Carolina College of Emergency Physicians

COMMUNITY INVOLVEMENT

Room in the Inn/Roof Above 2019-present

Mountain Island Charter School Parent-Teacher Organization 2018-present

St. Mark Parent-Teacher Organization 2016-2019

Notre Dame Club of Charlotte 2012-present

Notre Dame Club of the Blue Ridge 2010-2020

Committee on the Impact of Domestic Violence and the Courts 2007-2009
Appointed by Supreme Court Justice Ruth A. McGregor

Center for Healthcare Against Family Violence, Co-Medical Director	2006-2009
Maricopa Association of Governments Domestic Violence Council	2005-2009
Health Cares About Family Violence Subcommittee of Arizona Governor's Domestic Violence Council, Chairman	2005-2007
NBC 12-KPNX Medical Expert	2004-2006
Notre Dame Club of Phoenix	2003-2009

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2024 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Steven B. Kailes, MD, MPH, FACEP

***Question #1:* What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

I'm a full time "pit doc" and I know the challenges faced by my peers and our patients. Throughout my career, I developed knowledge and skills in two areas that are important to every emergency physician: advocacy and reimbursement. In 2015-16, I led the Florida College of Emergency Physicians as their president against the commercial insurers in a battle over balance billing. We secured a good deal for physicians in Florida and subsequently had physician groups successfully challenge the limited payments insurers prefer. I also participate regularly in advocacy efforts in Tallahassee and Washington, DC.

In 2018, I was fortunate to be selected as one of five individuals for the inaugural ACEP Reimbursement Leadership and Development Program. The program was a deliberate education in medical reimbursement issues, coding and nomenclature, the AMA's Current Procedural Terminology (CPT) Advisory Committee and the AMA's RVS Update Committee (RUC). I serve on ACEP's Reimbursement Committee, chairing the committee from 2021 – 2023. Additionally, I am one of the editors for "Practice Essentials of Emergency Medicine," developed by EMRA and ACEP as an online course for the business of emergency medicine.

Healthcare in the U.S. is incredibly complex. Most people have no idea how much we collect per patient visit. They may have some idea of what we charge, but likely have little understanding of the under-compensated care we provide. As emergency physicians, we are committed to being available for our communities. We've been "rewarded" with reimbursement cuts by CMS and by the No Surprises Act (NSA). The NSA has been a private health insurance windfall and has dragged down our reimbursement even further.

Most physicians have little exposure to these important topics and committees. However, this knowledge is critical to ensuring we are paid fairly. As a specialty, we face negative financial pressures from government payers, large corporate groups, and the commercial insurers, as well as scope creep from NPs/PAs. These issues pose real and immediate risk to the future of emergency medicine practice. We need people on the Board who understand how we are paid, how reimbursement for our services is determined and how to advocate for what we deserve.

To preserve our practice and guide the future of emergency medicine, we need to advocate for many things, such as appropriate staffing, protection from workplace violence, and physician autonomy. Fair compensation for our time, skills, and expertise needs to be an advocacy priority, and we should never shy away from asking for what we are worth. As your representative, I will continue to fight for all of us to achieve the practice we yearn for and deserve. My background and skills will reinforce and enhance our college's efforts to handle the challenges ahead.

***Question #2:* What strategic priorities should ACEP pursue to maintain itself as the home for all emergency physicians!**

Emergency physicians are diverse, and their individual priorities differ. However, our reimbursement and compensation are universal concerns and must be advocacy priorities. The strategic plan on ACEP's website does not mention reimbursement as an advocacy priority. Few of us completed our training without incurring debt. All of us have made sacrifices, endured risks and experienced delayed gratification. We deserve fair and just compensation for the care we provide. We must make sure EM physicians are financially strong and EM groups honor physician autonomy, transparency and due process rights.

Additionally, our advocacy efforts need to be refreshed and reinvigorated. We serve many varied interests, and we need to create broader coalitions to help us fight our battles. We should develop advocacy allies, like patient groups, who will help us advance the many issues we and our patients face. Legislators must understand how our challenges impact staffing and patient care, instead of them thinking we are "just rich doctors complaining." Some have talked about unionization. This is certainly a sign of the frustrations many of us have with our practice environments and the lack of

physician control. We face staffing shortages, scope of practice creep, unrealistic "satisfaction" surveys, loss of due process rights, etc. We need to advocate for better reimbursement, physician autonomy and for the tools necessary to be successful.

We must understand the coming waves of change and be prepared to adjust and cope with these changes. Artificial intelligence (AI) has game-changing potential—both beneficial and threatening-- for the future of medicine. We need guardrails so the developing algorithms and AI technologies help us provide better care but recognize how every patient is unique. Amidst technological advancements, we must preserve the human connection and maintain the physician-patient relationship, while also being forward-thinking into advancing the field.

We are not being given enough resources, our patients struggle with access to care, and reimbursement for physicians has not kept up with inflation for over twenty years. We shouldn't have to wait for the system to collapse to get the changes we need to be made. We need to approach our problems differently to help us realize our goals and to overcome the challenges we face. ACEP must remain a home for all of emergency medicine and our specialty's existential threats must take priority for our advocacy and efforts.

***Question* #3: What innovative strategies would you use to recruit and retain membership?**

ACEP's value is not reaching all emergency physicians but, with early education, medical students and residents can better grasp "the why." This knowledge must start early and ACEP must do better explaining what ACEP provides for our careers. ACEP should seek greater partnerships with residency directors and programs to ensure practicing physicians see the many products of ACEP's efforts. While some issues are handled locally, many issues cannot be solved in our emergency department or hospital. We must have a community of like-minded individuals working towards shared goals.

As a community "pit-doctor," I believe I have a good understanding of the needs of emergency physicians. We need more practical education on how we get reimbursed to make independent groups stronger and to make every day doctors' lives easier. ACEP must collaborate with other organizations to unify and multiply our efforts in areas of common interest. We must educate everyone in emergency medicine about the important role ACEP and affiliated state chapters play in our professional lives, such as being the only emergency medicine representative at the AMA's RUC or Relative-Value Scale Update Committee. A recent success by the ACEP was averting a decrease of our reimbursement for our 99284 E&M codes, saving an estimated $200 million for emergency physicians in 2023.

If ACEP is already doing this, why be a member? ACEP has a voice for all, but its reach is limited by resources. More members translate to more resources. More resources allow better advocacy and influence. With greater resources, ACEP can satisfy the emergency medicine interests and education emergency physicians desire, as well as offering greater practice support and career guidance.

Our physician profession has lost sight of itself as a community. Too many feel like they just need to take care of themselves, and they cannot be a catalyst for change. We have difficult jobs that can be spiritually and emotionally draining, along with debt and responsibilities outside of the workplace. ACEP is a community of physicians working together to make changes. We sometimes disagree on issues but ultimately, we all share similar goals—good pay (with raises) and a safe working environment with the resources we need to care for our patients and ourselves. ACEP must start early to connect and resonate with the needs of emergency physicians.

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CANDIDATE DATA SHEET

Steven B. Kailes, MD, MPH, FACEP

Contact Information
3780 Waterside Drive
Orange Park, FL, 32073
Phone: 904-254-0613
E-Mail: skailes@gmail.com

Current and Past Professional Position(s)
Emergency medicine physician, Emergency Resources Group (ERG), Jacksonville, FL – 2013 - present
Director, Governmental Relations, ERG. 2023 - present
Director of Quality, ERG – 2017 - 2022
Medical Director, Camden Campus, ERG – 2017 - 2018
Emergency medicine physician, Titan Emergency Group, 2007 - 2013
Vice-Chair, Dept. of EM, Orange Park Medical Center, Titan Emergency Group, 2013
Emergency medicine physician, US Naval Hospital, Jacksonville, FL, 2004 - 2007
Battalion Surgeon, 2/4, 1st Marine Division, USMC, Camp Pendleton, CA, 1999 - 2001

Education (include internships and residency information)
Emergency Medicine residency, Naval Medical Center, San Diego, CA, 2001 - 2004
Basic Surgery internship, Naval Medical Center, San Diego, CA, 1998 - 1999

MD, Tufts University School of Medicine, 1998
MPH, Tufts University School of Medicine, 1998

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM. Certified 2005, Recertified 2015

Professional Societies
ACEP – American College of Emergency Physicians, 2006 - present
ACEP Council, 2008 - present
FCEP – Florida College of Emergency Physicians, 2006 - present
Past-President, Florida College of Emergency Physicians – 2015-2016
AAEM - American Academy of Emergency Physicians, 2005 - present
AMA – American Medical Association, 2012 - present
FMA – Florida Medical Association, 2008 - present
FMA House of Delegates, 2016 - present
DCMS – Duval County Medical Society, 2017 - present
Immediate-Past President, Duval County Medical Society - 2024

National ACEP Activities – List your most significant accomplishments
Fellow, Reimbursement and Leadership Development Program – 2019 - 2020
Member, State Legislative & Regulatory Committee, 2015 - present
Member, Reimbursement Committee, 2017 - present
Past-Chair, ACEP Reimbursement Committee – 2021 – 2023
Member, Clinical Resource Review Committee, 2021 - 2023
Member, Council Steering Committee, 2020 - 2022
Member, National Chapter Relations Committee, 2023 - present
Member, ACEP-EDPMA Joint Task Force on Balance Billing, 2016 – 2019
Leadership and Advocacy Conference attendee, 2010 – present
Presenter, "State strategies to deal with Out of Network/Balance Billing," 2016

Presenter, "How ACEP Can Be a Resource and Help Facilitate State Needs in Their Advocacy Efforts?" 2024
Councilor, FCEP, 2008 – present
Fellow, ACEP, 2007 - present

ACEP Chapter Activities – List your most significant accomplishments
FCEP Past-President, 2015 – 2016
FCEP Governmental Affairs Committee, 2006 – present
Past chair, 2011 – 2014
FCEP Medical Economics Committee, 2006 – present
FCEP Councilor to ACEP Council, 2008 - present

Practice Profile
Total hours devoted to emergency medicine practice per year: __**1600**__ Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care __**90**__% Research __**0**__% Teaching __**0**__% Administration __**10**__%
Other: ____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
Independent contractor (1099) for clinical/patient care. Employed (W-2) for administrative duties working for Emergency Resources Group (ERG), a multi-hospital group located primarily in the Jacksonville, FL, area.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Clinical emergency medicine physician
Director, Governmental Relations. Former Director of Quality and former medical director at our Camden Campus

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Steven B. Kailes, MD, MPH, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Emergency Resources Group

Address: 841 Prudential Dr., #1400

Jacksonville, FL 32207

Position Held: Staff physician, Director of Quality (former), Director of Government Relations

Type of Organization: Emergency medicine staffing group

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: ACEP

Address: 1125 Executive Circle

Irving, TX 75038

Type of Organization: National medical specialty organization

Leadership Position: Chair, reimbursement committee

Term of Service: 2021 - 2023

Organization: Florida College of Emergency Physicians

Address: 400 N. Wymore

Winter Park, Fl 32789

Type of Organization: State Medical specialty organization

Leadership Position: President

Term of Service: 2015 -2016

Organization: Duval County Medical Society

Address: 555 Bishopgate Lane

Jacksonville, FL 32204

Type of Organization: Local Medical specialty organization

Leadership Position: President

Term of Service: 2022 - 2023

Organization: St. Johns Board of Trustees

Address: 3100 Doctors Lake Drive

Orange Park, FL 32073

Type of Organization: Independent private day school, grades pre-K3 through 12

Leadership Position: President

Term of Service: 2013 - 2015

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☒ If YES, Please Describe: My spouse is a pediatric dentist and has a private practice

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ N/A
☒ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Steven B. Kailes, MD 6/15/2024

A CHAPTER OF THE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
3717 South Conway Road ● Orlando, FL 32812
(407) 281-7396 ● FAX (407) 281-4407
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The Florida College of Emergency Physicians (FCEP) is honored to endorse our colleague Steven Kailes, MD, MPH, FACEP, FAAEM as a candidate for the national ACEP Board of Directors. Dr. Kailes has been an active ACEP and FCEP member for 18 years. At the state chapter level, he has held every officer position and has also previously served as the Chairman of our Government Affairs committee. He is a passionate advocate for emergency medicine regularly attending our annual EM Days legislative conference, providing expert testimony in committee hearings, and developing strong relationships with legislators through years of dedication and involvement. Dr. Kailes has been a key activist on issues with major impact to emergency medicine including health insurance coverage balanced billing, fair payment/reimbursement of emergency care, statewide provider and health plan claim dispute resolution, and transparency in titles/proper patient-provider disclosure.

Nationally, Dr. Kailes has further proven his commitment to the college through active engagement with ACEP. Through his commitment to the preservation and growth of emergency medicine, Dr. Kailes earned the Fellow of the American College of Emergency Physicians (FACEP) distinction in 2007. He has represented our chapter on the ACEP council for sixteen years. He currently serves on multiple national ACEP committees including the National Chapter Relations Committee, Reimbursement Committee, and State Legislative/Regulatory Committee. Prior contributions to ACEP committees include membership on the Clinical Resources Review committee, Steering Committee, and ACEP/EDPMA Joint Task Force. In 2018, Dr. Kailes was selected to join the inaugural class of ACEP's Reimbursement Leadership Development Program (RLDP) where he gained a thorough understanding of the emergency medicine reimbursement process, developed a better understanding of the nuances of coding and reimbursement, presented himself as a strong, well-poised candidate for leadership roles in ACEP, and went on to serve as chair of ACEP's Reimbursement committee.

Dr. Kailes' distinguished professional career further demonstrates his passion for the specialty, specifically with regards to reimbursement, legislative advocacy, and the role of organized medicine. He possesses vast and distinctive professional knowledge and experience ranging from serving as a Director of Government Relations tasked with navigating through regulatory issues, reimbursement requirements, and legislative concerns; to military deployment in support of Operation Iraqi Freedom where he provided emergency medical and trauma support services for coalition forces, enemy combatants and civilians. Dr. Kailes maintains membership in multiple professional associations and specialty medical societies including serving in each officer role within the Duval County Medical Society; has authored articles in local, state, and national publications; has served on numerous Boards of Directors for both community and professional organizations; and has received many awards and military honors in recognition of his outstanding leadership and service – including being named the 2021 Baptist Medical Center Physician of the Year.

Dr. Kailes is a devoted father, husband, and a veteran of the United States Navy Reserves who is well-qualified, highly motivated to serve, and would be an invaluable member of the ACEP board. He is an emergency physician conscientiously providing care for patients; determined to offer compassionate, dignified and quality care to patients; and strives to improve the lives in his community through advocacy and engagement, while bringing substance to discussions and respect of differing opinions.

FCEP is pleased to support Steven Kailes, MD, MPH, FACEP, FAAEM as a candidate for the national ACEP Board of Directors.

Steven B. Kailes, MD, MPH, FACEP

I'm a full-time "pit doc," familiar with the challenges faced by my peers and our patients. I have developed knowledge and skills in two areas that are important to every emergency physician: advocacy and reimbursement.

In 2015-16, as president of the Florida College of Emergency Physicians, I led a successful battle against the commercial insurers over balance billing. This secured a favorable deal and legislation for Florida physicians. I continue to regularly advocate in Tallahassee and Washington, DC.

In 2018, I was one of five selected for the inaugural ACEP Reimbursement Leadership and Development Program. The program educated me on medical reimbursement issues, coding, and the AMA's CPT and RVS Update or RUC Committees. I continue to serve on ACEP's Reimbursement Committee, chairing the committee from 2021-23. Additionally, I am one of the editors for "Practice Essentials of Emergency Medicine," an online course for the business of emergency medicine developed by EMRA and ACEP.

Many physicians lack exposure to these critical topics. Understanding reimbursement is vital for fair compensation. We face financial pressures from payers, corporate greed, as well as scope creep from NPs/PAs. These issues threaten the future of emergency medicine practice. The Board needs members who understand these issues and will advocate for us.

I will strengthen the Board's knowledge and fight for you. We have many challenges, from the bedside to the impact of care on the community at large. We struggle with appropriate staffing, workplace violence and increasing demands without adequate resources needed to perform our tasks. Our emergency departments are centers for mental health crises, the homeless, and those without healthcare access. We face these challenges and other barriers to equality affecting patient care and health outcomes. Our College's efforts must focus on the critical issues to deliver patient care without interference. With the Board, and the College behind us, I will confront these issues and help tear down the barriers.

I believe we are undervalued. We deserve fair compensation for our time, skills, and expertise and should never shy away from asking for what we are worth. We must ensure our colleagues receive equal pay and benefits for equal work. Furthermore, we are not widgets or robots simply filling a labor pool. Our physician autonomy and due process rights must be safeguarded. Focusing on individual physician needs strengthens our groups and better serve the community. I will amplify our value and advocate for the resources and compensation we deserve and need.

As your Board representative, I will fight for the practice we deserve and desire. I bring a level-headed approach to problem solving and consensus-building. The College needs to evolve and provide tangible outcomes to the issues we face. My leadership experience and business acumen equip me to handle these challenges effectively.

I humbly ask for your vote to serve you and the College on the ACEP Board of Directors.

2024 Board of Directors Candidate

Who Am I?

- 20 years full-time clinical EM pit-doc in independent groups, working in both urban and community EDs
- Steadfast believer in a physician-led team, from bedside to practice management & leadership
- Dedicated servant to my community and profession
- US Navy veteran, operational duty with the USMC
- Husband and father of two young men

My Goals

- Be the voice for the everyday emergency physician
- Fight for an EM practice that is safe and reduces the struggles faced by physicians and our patients
- Utilize my strengths and expertise in reimbursement, medical economics & governmental affairs working with the Board

Leadership in Multiple Environments

- Duval County Medical Society, past-President, 2024
- Director, Governmental Relations, Emergency Resources Group (ERG), current leadership position
- Director of Quality, ERG, 5 years
- Medical Director & Chief of EM, ERG, Camden Campus, 2 years
- Partner & Board member, Titan Emergency Group - a multi-hospital, independent, democratic group
- EM Vice-chairman, Orange Park Medical Center, 1 yr.
- EM Physician, GME Committee and Medical Student Rotation Coordinator, Naval Hospital Jacksonville, FL
- Deployed to Iraq with Marine Expeditionary Force 2005-06
- Officer-in-charge and 2/4 Battalion Surgeon, 1st Marine Division, USMC, 1999 - 2001
- BLT Surgeon, 31st Marine Expeditionary Unit, Okinawa, Japan, 2000-01
- Board of Trustees, St. Johns Country Day School, member & past-President of the Board, 2008 - 2023

National and Chapter Commitment

ACEP

- Reimbursement Committee, past-Chair
- National Chapter Relations Committee
- State Legislative and Regulatory Committee
- Council Steering Committee
- Clinical Resource Review Committee
- Joint Task Force on balance billing w/EDPMA
- Reimbursement Leadership Development Program Fellow

FCEP, Florida Chapter of ACEP

- Past-President, 2015 - 2016
- ACEP Councillor for FCEP, 16 years
- Governmental Affairs Committee, past-Chair
- Medical Economics Committee

Steven Kailes, MD, MPH, FACEP, FAAEM

Steven B. Kailes

MD, MPH, FACEP, FAAEM

3780 Waterside Dr., Orange Park, FL, 32073
(904) 254-0613 skailes@gmail.com

I am an emergency physician conscientiously providing care for my patients. I am determined to offer compassionate, dignified and quality care to my patients. I strive to improve the lives in my community through advocacy and engagement, while bringing substance to discussions and respect of differing opinions. I am a devoted father, husband, and a veteran.

EDUCATION and TRAINING

2001 – 2004 **Naval Medical Center, San Diego, CA**
Residency in Emergency Medicine

1998 – 1999 **Naval Medical Center, San Diego, CA**
Internship in Basic Surgery

1994 – 1998 **Tufts University School of Medicine, Boston, MA**
Doctor of Medicine

1994 – 1998 **Tufts University School of Medicine, Boston, MA**
Masters in Public Health

1991 - 1993 **University of California, Los Angeles, CA**
Bachelor of Science, Physiological Science, cum laude

1988 – 1991 **Modesto Junior College, Modesto, CA**
Associate of Science, Physical Sciences and Mathematics, with honors

LICENSURE and SPECIALTY CERTIFICATION

2017 **State of Georgia**
Unrestricted Physician License #77284, Expires May 31, 2024

2013 **State of North Carolina**
Retired Volunteer License #2013-0220, Expires May 24, 2024

2005 **American Board of Emergency Medicine**
Diplomate of the American Board of Emergency Medicine. Recertification expires December 31, 2025. Certificate number 35497

2004 **State of Florida**
Unrestricted Medical Doctor License #ME 91282. Expires January 31, 2025

2000 **State of California**
Retired - Physicians and Surgeons License #A71665. Expires May 31, 2024

WORK HISTORY and MILITARY ASSIGNMENTS

2013 - now **Emergency Resources Group**, an independent practice with contracts at the Baptist Medical Center hospitals, Jacksonville, FL, area, Flagler Hospital in St. Augustine, FL, and Southeast Georgia Health System with campuses in Brunswick and St. Marys, GA, and Lakeland Regional Medical Center, Lakeland, FL

Emergency Department Medical Director and Chief of Emergency Medicine - Southeast Georgia Health System, Camden Campus,
February 2017 - September 2018

Director of Government Relations, in charge of helping steer us through CMS' MACRA and MIPS requirements, keeping abreast of legislative and regulatory issues and improving our evidenced-based clinical quality and documentation quality to maximize our revenue opportunities.
March 2017 - now

2014 **Independent Contractor** - CMP Staffing
- Services at Cape Fear Valley Medical Center. Fayetteville, NC

2007- 2013 **Staff Physician, Titan Emergency Group, Jacksonville, FL**

- Emergency Medicine Physician with medical staff appointments at multiple contracted medical facilities, including:
  - Memorial Hospital, Jacksonville, FL
  - Orange Park Medical Center, Orange Park, FL
    - Vice Chairman, *2013*
  - Capital Regional Medical Center, Tallahassee, FL
  - Putnam Community Medical Center, Palatka, FL
  - Gadsen County Medical Center, Quincy, FL
  - West Florida Hospital, Pensacola, FL

2004 - 2007 **Staff Physician, Emergency Department, Naval Hospital, Naval Air Station, Jacksonville, FL**

- Graduate Medical Education Committee and Medical Student Rotation Coordinator for the Emergency Department
- Deployment in support of Operation Iraqi Freedom 04-06.2, Assigned to Combat Logistics Battalion 2, 2nd MLG, II MEF, providing emergency medical and trauma support services for coalition forces, enemy combatants and civilians in Al Anbar Province, Iraq, *2005 - 2006*
- Resigned USN Commission with Honorable Discharge from Active Duty Service, September 2007

2004 **Lieutenant Commander, Medical Corps, US Navy Reserves**

2001 – 2004 **Resident, Emergency Medicine, Naval Medical Center, San Diego, CA**

1999 - 2001 **Battalion Surgeon, 2nd Battalion, 4th Marines, 5th Marine Regiment, 1st Marine Division, Camp Pendleton, CA**

- Officer-in-charge, Medical Section, Headquarters Company. Responsible for supervision and training of over thirty hospital corpsmen, and for providing the primary medical and emergency care services for over 1,000 US Navy and Marine Corps personnel

- Deployment with **Battalion Landing Team Surgeon, BLT 2/4, 31st Marine Expeditionary Unit**, Okinawa, Japan, July 2000 – January 2001

1999 **Field Medical School, Fleet Marine Force, Camp Pendleton, CA**

1998 – 1999 **Intern, Basic Surgery, Naval Medical Center, San Diego, CA**

1998 - 2004 **Lieutenant, Medical Corps, United States Navy Reserves**

1994 – 1998 **Ensign, Medical Corps, United States Navy Reserves, Armed Forces Health Professions Scholarship Program**

PROFESSIONAL ORGANIZATIONS

2016 - now **Duval County Medical Society**, Member
Board of Directors, *2017 - now*
- Immediate Past-President*, 2023 - 2024*
- President, *2022-2023*
- President-Elect, *2021 - 2022*
- Vice President, *2019 - 2021*

2014 - now **American Medical Association**, Member

2011 - now **Florida Medical Association**, Member
Delegate for Duval County Medical Society, *2017 - now*
Delegate for Florida College of Emergency Physicians, *2016*

2006 - now **Florida Chapter of the American College of Emergency Physicians (FCEP),** Member
Board of Directors, *2010 - 2017*
- Immediate Past-President, *2016 - 2017*
- President, *2015 - 2016*
- President-Elect, *2014 - 2015*
- Vice-President, *2013 - 2014*
- Secretary-Treasurer, *2012 - 2013*
- Chairman, Governmental Affairs Committee, *2011 - 2014*

2006 - now **American College of Emergency Physicians (ACEP)**, Member
- Fellow, *2007 - now*
- Member, National Chapter Relations Committee, *2023 - now*
- Member, Steering Committee, *2020 - 2022*
- Member, Reimbursement Committee, *2017 - now*
    - Chair, *2021 - 2023*
- Member, Clinical Resource Review Committee, *2021 - 2023*
- Reimbursement Leadership Development Program fellow, *2018 - 2020*
- Member, State Legislative & Regulatory Committee, *2015 - now*
- Member, ACEP/EDPMA Joint Task Force, *2016 - 2019*
- Councillor, representing FCEP, *2008 - now*

2008 - now **Board of Trustees, St. Johns Country Day School** – Pre-K3 through 12th grade college preparatory school located in Orange Park, FL
- Trustee Emeritus, *2016 - 2023*
- President, *2013 - 2015*
- Vice-President, *2011 - 2013*

2010 **Titan Emergency Group**
Board of Directors, *2010*
Member, Growth and Marketing Committee*, 2010 - 2011*

2010 - 2012 **Southeast Practice Management,** a billing and coding company
- Member, Board of Directors

2005 - now **American Academy of Emergency Medicine (AAEM)**
- Fellow, *2005 - now*

RESEARCH and PUBLICATIONS

2023 **Rahman N, Cain A, Premrajan G, Sharma V, Smiley A. Reimbursement Module, In: Stark N, Cozzi N, Pasichow S, ed. ACEP & EMRA Practice Essentials of Emergency Medicine. ACEP Online Learning Center;** Module Editors Kailes S, Maurer L, McKenzie D, Shoemaker J. October 2023. https://ecme.acep.org/.

2011 - 2016 ***EMpulse*****,** contributing author for the quarterly news magazine for members of the Florida College of Emergency Physicians (FCEP)

2015 Kailes SB, Gutierrez MA, **"Chapter 12: Hematologic and Immune System Disorders**." ***Emergency Medicine: A Focused Review of the Core Curriculum, 2nd Edition*****.** Editors Schofer JM, Mattu A, Kessler C, Lu LN, Parker T, Rogers R, Lex JR, Bottoni T, and farad A. Milwaukee: American Academy of Emergency Medicine Resident and Student Association, 2015. 377-412.

2008 Kailes SB, Costello T, Mossallam U, **"Chapter 11: Hematologic/ Oncologic and Immune System Disorders**." ***Emergency Medicine: A Focused Review of the Core Curriculum*****.** Ed. Schofer JM, Mattu A, Coletti JE, Gray EA, Rogers RL, and Shih RD. Milwaukee: American Academy of Emergency Medicine Resident and Student Association, 2008. 301-335.

2007 **"Pneumococcal bacteremia in febrile infants presenting to the Emergency Department before and after the introduction of the heptavalent pneumococcal vaccine."** Carstairs KL, Tanen DA, Johnson AS, Kailes SB, Riffenburgh RH. *Annals of Emergency Medicine*, Volume 49, Number 6, June 2007, pages 772-777

2004 **"Bacteremia in febrile infants presenting to the ED after the introduction of heptavalent pneumococcal vaccine."** Carstairs KL, Tanen DA, Kailes SB, Riffenburgh RH, Danish DC, Johnson AS. *Academic Emergency Medicine* Volume 11, Number 5, May 2004, page 596, abstract

- Society for Academic Emergency Medicine Annual Meeting, Orlando, FL, May 2004, poster presentation

2001 & 1998 **"Arthroscopic vs. Open Bankart Reconstruction: A Comparison using Expected Value Decision Analysis."** Kailes SB, Richmond JC. *Knee, Surgery, Sports, Traumatology, Arthroscopy* Volume 9, Issue 6, November 2001, pages 379-385

- Steven B. Kailes, B.S., and John C. Richmond, M.D., Arthroscopy Association of North America's 1998 Annual Meeting, Orlando, FL, April 29 – May 02, 1998, abstract

PRESENTATIONS

2023 **Healthcare Symposium 2023.** Brooks College of Health at the University of North Florida and Duval County Medical Society. Panel discussion: The role of organized medicine in population health. Panel Discussion: The next generation of leaders. Jacksonville, FL, October 2023.

2022 **Florida College of Emergency Physicians Symposium by the Sea, 2022.** General Session panel: Identifying, recruiting and retaining future leaders. Presented by Drs. N. Cozzi, S. Kailes, and J. Shoemaker. Bonita Springs, FL, August 2022.

2021 **Emergency Department Practice Management Association Solutions Summit, 2021. Beyond Resilence: Restoring Order In A Post-Pandemic World.** General Session panel: Identifying, recruiting and retaining next years' advocacy stars: Tips for building your bench at the State and National level. Presented by Drs. S. Good, B. Graham, S. Kailes, L. Mauer, and J. Shoemaker. Ft. Worth, TX, September 2021.

2021 **Emergency Medicine Reimbursement & Innovation Summit, 2021**. Panel discussion moderator for "Payer Shifts," virtual summit on February 25, 2021.

2020 **Insurance Summit 2020,** December 2020. Profits vs. Payments: Why physicians need a working venue to challenge underpayment by out-of-network insurers. Virtual summit presented on behalf of FCEP/EMLRC in cooperation with the Florida Orthopedic Society, Florida Society of Rheumatology, Duval County Medical Society, et al.

2020 **Emergency Medicine Reimbursement & Innovation Summit,** February 2020. Panel discussion moderator for Legs & Regs. Orlando, FL.

2017 **Emergency Medicine Payment Reform Summit: Action Plans for Federal and State Regulations**, February 2017. Panel discussion moderator for Telemedicine and EMS Innovations, Orlando, FL

2016 **Georgia College of Emergency Physicians Leadership and Medical Director's Forum**, December 2016, Presenter, "Fair Coverage: The Florida Experience, " Lake Oconee, Greensboro, GA

2016 **ACEP Leadership & Advocacy Conference,** May 2016. Presenter, "State Strategies to Deal with Out of Network/Balance Billing," Washington, DC

2015 **Florida College of Emergency Physicians Town Hall Forum: Florida and EM Healthcare -** Moderator, Symposium by the Sea 2015, Amelia Island, FL

2015 **Emergency Department Practice Management Association Solutions Summit XVIII -** Martin Gottlieb & Associates luncheon speaker presentation regarding Healthcare Issues in Florida. Amelia Island, FL.

2011 - now **Legislative updates -** Florida College of Emergency Physicians, *EM Pulse* quarterly magazine article contributions and Governmental Affairs Committee meetings

2007 **"Ultrasound Basics for the Emergency Department"** Southeast Emergency Consultants continuing education lecture series, May 2007

2004 **"Shock"** NMCSD Emergency Medicine Residency Program, February 2004

2003 **"Colchicine Toxicity – Case Presentation"** NMCSD Emergency Medicine Residency Program, July 01, 2003

2003 **Morbidity and Mortality Presentation**, including topics on Posterior Shoulder Dislocation, Conscious Sedation, and a literature review of the efficacy for non-contrast head CT scans in the minor head injury patient on Warfarin anticoagulation. NMCSD Emergency Medicine Residency Program, November 4, 2003

2003 **"Hypoglycemia"** NMCSD Emergency Medicine Residency Program, January 2003

2002 **"Sickle Cell Anemia"** NMCSD Emergency Medicine Residency Program, October 2002

2002 **"Genitourinary Trauma"** NMCSD Emergency Medicine Residency Program, June 2002

2002 **"Phlegmasia cerulea dolens- Photographic Case Presentation"** Society for Academic Emergency Medicine Annual Meeting, St. Louis, MO, May 2002

2002 **"Amphetamines – Case Presentation"** NMCSD Emergency Medicine Residency Program, January 2002

2002 **"Low Back Pain"** NMCSD Emergency Medicine Residency Program, January 2002

1998 & 1999 **"Arthroscopic versus Open Bankart Reconstruction: A Comparison Using Expected Value Decision Analysis"**

- A comparison of two treatment alternatives for model patients using literature and experience derived probabilities. Arthroscopy Association of North America's 1998 Annual Meeting, Orlando, FL, April 29 – May 02, 1998
- American Academy of Orthopaedic Surgeons Annual Meeting, February 04-08, 1999

1998 **"Peyronie's Disease"** NMCSD Urology Residency Program, December 1998.

1997 **"Osteochondromas"** Tufts University Orthopaedic Residency Program, October 1997

1997 **“Tufts-New England Medical Center Work-site Fitness Center”**
Feasibility study of a public health project for Health Promotion and Disease Prevention Course, TUSM MD/MPH Combined Degree Program

1996 **“An Update on Renal Transplantation”**
Surgical Grand Rounds, Newton-Wellesley Hospital, September 1996

1995 **“Asbestosis Awareness Program for Former Quincy Shipyard Workers”**
Created an awareness and screening program for Occupational and Environmental Health Course, TUSM MD/MPH Combined Degree Program

1994 **“Teenage Pregnancy Prevention Program for Mattapan, Massachusetts”**
Developed a public health program for a Boston community, Introduction to Public Health Course, TUSM MD/MPH Combined Degree Program

HONORS and AWARDS

2022 **Physician Quality Champion of the Month**, *May 2022,* Baptist Medical Center, South, Jacksonville, FL

2021 **Physician of the Year**, Baptist Medical Center, Clay Campus, Spirit of Magnet Awards

1995 - 2007 **Military Awards**
Fleet Marine Force (FMF) Warfare Officer Qualification, Navy and Marine Corps Commendation Medal, Iraq Campaign Medal with the FMF Combat Operations Insignia, Global War on Terrorism Service Medal (2nd award), Fleet Marine Force Ribbon, National Defense Medal (2nd award), Sea Service Deployment Ribbon (2nd award), Expert Pistol Marksman Medal

1998 **Commencement Committee Award**, **Tufts University School of Medicine (TUSM),** “Awarded to the student who has contributed the most to the medical school”

1994 - 1998 **President, TUSM Class of 1998**, Years I – IV
President, TUSM Student Council, Years III- IV
Executive Council Member, TUSM, Years III- IV
Medical School Representative, Trustees of Tufts College, Years I – III

1996 -1997 **Clinical Honors, TUSM** -- Emergency Medicine, Obstetrics/Gynecology, Adult Orthopaedics

1995 - 1997 **Preclinical Honors, TUSM -** Neuroscience, Surgical Anatomy

1993 **Cum Laude**, academic honors upon graduation from UCLA

1988 - 1991 **Dean's Honor List**, Modesto Junior College

HOBBIES

Spending time with my family

Golf, exercise, boating, and reading non-fiction

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

C. Ryan Keay, MD, FACEP

***Question #1:* What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

When I was 22-years old, I was sitting in the cabin of a small plane somewhere in the sky between Huslia and Fairbanks, Alaska. My patient was in his 80s, and his Athabaskan was better than his English. The sun had made a brief appearance in the winter sky, peeking above the horizon, as darkness set in again. As I struggled in the dark cold space to care for this dying patient, to get him to definitive care, I also realized I had wrenched him away from his village, with everyone and everything he knew. I wondered if what I was doing was the right thing. It is a question I ask myself repeatedly in life – are we doing the right thing? Who determines what is "right", and from whose perspective?

I represent the perspective of the independent, democratic medium-sized group of physicians who still maintain autonomy of practice. I came to medicine in a circuitous fashion, from anthropology studying human remains, to a flight medic, to medical school. I jumped from the Arctic to the tropics to study tropical medicine. I survived the suicide of my brother in medical school and had two children during a tough residency in Denver. I represent the perspective, knowledge and background of loss, motherhood, and challenge.

My leadership has spanned ED operations as a medical director, system-wide leadership in a large 7-state hospital system, and EMS medical direction. What I've seen and experienced through my professional career are the threads of connection through all the work we do. I have a vision of emergency medicine as not just the front-porch, or the safety net, but the web that connects all aspect of health care in our country. We are uniquely poised to understand the challenges of pre-hospital care. We see the bounce-backs and failures of access to care. I have worked in academics, privates, critical access, tertiary care, and urgent care. With my perspectives, I feel my one unique super-power is connection. Connecting with people, connecting systems, bridging gaps.

Right now, the College is starkly divided and these gaps drive rancor and animosity between colleagues. It's time to start coming together. The breadth of my experience and my ability to represent divergent viewpoints will help your Board to find consensus and better serve you.

***Question #2:* What strategic priorities should ACEP pursue to maintain itself as the home for all emergency physicians!**

I lived in a cabin in Alaska without running water and with an outhouse for 7+ years. A "home" can mean a lot of things to a lot of people. In order to be a home for all emergency physicians, we need to understand what our members and potential members, need. This question is really part and parcel of the question of recruiting and retaining membership. Our specialty has, essentially, a 45/55 split of academic and non-academic physicians. Practice in a large urban hospital is profoundly different from rural and critical access settings. Some regions struggle to attract board certified EM physicians, while others do not. Our challenge is to understand the needs of those disparate groups. We need to refocus on the loud voices who are shouting that this system is not working. We need to continue to systematically advocate and make ourselves the safe haven for the work that (1) eases the administrative burden on those practicing medicine, (2) protects the rights of physicians, and (3) works towards an economically sustainable model of emergency medicine.

To address the first point, the administrative burden of documentation, reporting requirements and oversight are drowning physicians in non-clinical work and are cited as a primary driver of burn-out. ACEP is doing amazing things around battling CMS requirements and checkbox medicine, and we can do more.

Protecting the rights of physicians is critical. We are in a disadvantaged position in negotiating with our employers, our contracted hospitals, and the insurers. EPs working for some large groups sometimes have their employment and due process rights abrogated. Contracted groups have onerous terms dictated to them by their hospital partners. And insurers impose "quality oversight" onto the practice of medicine, in the name of saving money. Having a toolbox to help physicians navigate

these power imbalances and being the resource for groups in distress is what a physician home looks like. It is the place you go for respite and help.

Finally, reimbursement is on the decline when adjusted for inflation, and insurers are increasingly resistant to timely payment. ACEP's reimbursement FAQs and work advocating for and supporting changes in the reimbursement models are priceless. The day-to-day struggles with the insurers and the NSA have left us hamstrung. ACEP will be a home for emergency physicians by ensuring that we are paid fairly for the care we provide to our patients.

Highlighting the practice of medicine, physician rights, and reimbursement will speak to ***every*** emergency physician and create a safe place for them to come, to vent and to find help. That is what a home is. The world has changed, and they don't need large conferences for CME. They need a real-time phone-a-friend.

***Question* #3: What innovative strategies would you use to recruit and retain membership?**

The answer to this question is simple – it is not an easy fix. It is a multi-phase process, and we have to listen to the voices of our membership. The themes that are evident today are not new or unexpected. Most organizations through history experience a disconnect between older, "seasoned" membership, and the younger, vigorous parts of our organizations. In ACEP, we have not yet ascertained what drives different demographics to join, and stay, a part of a larger organization. Unless you have information to inform strategy, then you are stabbing in the dark. The longest-serving members of the College are rightly proud of the institution that they were part of creating and shaping. The rising generation, however, may be interested in transformative disruption of the status quo, a longer-term vision of the future, and most importantly in having their voices heard. Those in mid-career may simply be trying to prevent drowning in the burden of compliance, decreasing reimbursement, and harmonizing a life with their careers.

So, with this potential paradigm, I would pose the following questions as the framework for three pillars of work. 1. What is essential to ACEP and cannot be changed? 2. What needs to be disrupted and remade? 3. And finally, what needs to be added to make us whole? When we understand those three pillars, then we can begin phase two of the process. Listening sessions with key stakeholders will help us to understand for ***each*** demographic within ACEP what falls into those three buckets. Phase three will be to then take the summary of that information to the other teams – to dialogue around the needs and fears, and truly understand the barriers to implementing change. Finally phase four is implementation – and we have to get this right.

This will be uncomfortable, and the conclusions could be radical. However, to stay static in today's world is to fade into irrelevance, and our country and our membership needs the voice and presence of emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

C. Ryan Keay, MD, FACEP

Contact Information
16110 East Shore Drive
Lynnwood, WA 98087
Phone: 206-604-3102
E-Mail: ryankeay@me.com, crkeay@northsoundem.com

Current and Past Professional Position(s)

2009-present Emergency Medicine physician, North Sound Emergency Physicians, Providence Regional Medical Center Everett
2021-present Emergency Medicine physician, Puget Sound Physicians, Snoqualmie Valley Hospital
2010-2014 Emergency Medicine physician, UW Physicians, Harborview Medical Center/UW

Education (include internships and residency information)

1992-1996 BA, Anthropology, University of Alaska Fairbanks, Fairbanks, AK
1999-2000 BA, Biology, University of Alaska Fairbanks, Fairbanks, AK
2004 Community Medicine Public Health Training, Chiang Mai Medical School, Chiang Mai, Thailand
2004 Certificate in Tropical Medicine, Mahidol University, Bangkok, Thailand

2005-2009 Emergency Medicine Residency, Denver Health Medical Center, University of Colorado, Denver, CO
2008-2009 Chief Resident, Emergency Medicine, Denver Health Medical Center, Denver, CO

2000-2005 MD, University of Washington School of Medicine, Seattle, WA

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

2010-present Board Certification in Emergency Medicine, American Board of Emergency Medicine (ABEM) Diplomate, expires 12/31/2029. Recertified 2019

Professional Societies

2005-present American College of Emergency Physicians (ACEP)
2005-2009 Colorado Chapter, ACEP (CO-ACEP)
2005-2012 American Academy of Emergency Medicine (AAEM)
2009-present Washington Chapter, ACEP (WA-ACEP)
2023-present National Associated of EMS Physicians (NAEMSP)

National ACEP Activities – List your most significant accomplishments

2007-present ACEP Leadership and Advocacy Conference in Washington D.C.
2015-2016 Alternate Delegate to ACEP Council meeting
2017-present Delegate to ACEP Council meeting
2017-2019 Chair-elect, Medical Director's Section
2019-2021 Chair, Medical Director's Section
2019-2022 Member, Tellers and Credentials Committee
2022-present Member, Steering Committee
2022-present Member, DEI Committee

ACEP Chapter Activities – List your most significant accomplishments

2007-2008 Resident liaison to CO ACEP
2014-2015 WA ACEP Board of Directors mentee
2014-2020 WA ACEP Liaison to WA Emergency Nurses Association
2015-present WA ACEP Education Committee
2015-2023 WA ACEP Board Member
2019-2020 WA ACEP Board of Directors Treasurer
2020-2021 WA ACEP Board of Directors President-elect
2021-2022 WA ACEP Board of Directors President

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 **30** % Research **0** % Teaching **5** % Administration **35** %
Other: EMS Medical Direction **30** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

North Sound Emergency Medicine is a small democratic, egalitarian shareholder group of approximately 50 shareholders and 20 employees. We are a single-site group for a large 600-bed Level II trauma regional hospital, and hold the contract for the hospital observation unit and stress test lab, for which we have employee staffing. I have been with the group 15 years, 14 as a partner and 7 years as ED Medical Director. I also currently serve on the group's Board of Directors.

Puget Sound Physicians is a small democratic partnership that staffs a medium-sized local hospital, critical access hospital and numerous urgent cares. I currently work part-time as an employee working several shifts a month at their small critical access hospital site in Snoqualmie, WA.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

2024-present Medical Director for the Providence Intervention Center for Assault and Abuse (PICAA)
2023-present Medical Director, Sno911 Dispatch
2023-present Medical Director, Northwest Ambulance
2023-present Medical Program Director, Snohomish County EMS (SCEMS)
2022-present Medical Program Director delegate, Tulalip Bay Fire Department (SCFD #15)
2021-present Division Chief of Outpatient and Community Medicine at Providence Regional Medical Center Everett (PRMCE) – including emergency medicine, radiology and all outpatient medical staff.
2021-present Medical Program Director delegate, Granite Falls Fire Department (SCFD #17)
2020-2023 Chair, Providence St. Joseph Health Emergency (PSJH) Medicine Steering Committee
2019-2021 Chair, ED & Upstream Improvements in Behavioral Health Care Focus Group, PSJH
2015-present Sepsis Clinical Lead, PSJH
2014-present North Sound Emergency Medicine (NSEM) Finance Committee member
2014-present Board Member, NSEM
2014-2021 Medical Director Emergency Department, PRMCE
2014-2020 Medical Program Director Delegate for Lake Stevens Fire and Snohomish Regional Fire & Rescue
2012-2019 PRMCE Engagement Team and Patient Satisfaction Committee
2012-2013 PRMCE Chest Pain Task Force Chair
2011-2012 PRMCE Task Force on Venous Thromboembolism
2009-present NSEM Human Resources Committee
2009-present NSEM Medical Quality Committee
2009-present NSEM ED Operations Committee

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases Plaintiff Expert 0 Cases

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

C. Ryan Keay, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: North Sound Emergency Medicine

Address: 15833 Mill Creek Blvd #12010

Mill Creek, WA 98012

Position Held: Physician, Board Member

Type of Organization: Democratic emergency medicine practice group

Employer: Puget Sound Physicians

Address: 18887 State Hwy 305, #600

Poulsbo, WA 98370

Position Held: Employed physician

Type of Organization: Emergency medicine practice group

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Providence Regional Medical Center Everett

Address: 1300 Colby Ave

Everett WA 98201

Type of Organization: Hospital

Leadership Position: Division Chief

Term of Service: No terms, served since 2021

Organization: Snohomish County EMS

Address: PO Box 214

Marysville, WA 98270

Type of Organization: Department of Health and County EMS

Leadership Position: Medical Program Director

Term of Service: No term, held position since 2023

Organization: WA ACEP Board of Directors

Address: 2001 6th Ave Suite 2700

Seattle WA 98121

Type of Organization: State Chapter of ACEP

Leadership Position: Treasurer, President-Elect, President, Past-President

Term of Service: 2015-2023 (currently honorary member of Board)

Organization: ACEP Steering Committee

Address: 4950 W Royal Lane

Irving TX 75063

Type of Organization: Committee of ACEP

Leadership Position: Member

Term of Service: 2 years (current) – 2023-present

Organization: ACEP DEI Committee

Address: 4950 W Royal Lane

Irving TX 75063

Type of Organization: Committee of ACEP

Leadership Position: member

Term of Service: Currently serving 3 years - 2022-present

Organization: ACEP Teller's and Credentials Committee

Address: 4950 W Royal Lane

Irving TX 75063

Type of Organization: Committee of ACEP

Leadership Position: Member

Term of Service: 4 years: 2019-2022

Organization: WA Poison Center

Address: 155 NE 100th St, #100

Seattle, WA 98125

Type of Organization: Non-profit poison center

Leadership Position: Board member, Secretary, President-elect, President, Past-president

Term of Service: 7 years

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☒ If YES, Please Describe: Husband is a Seattle Firefighter/EMT

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ N/A
☒ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Catharine Ryan Keay Date 14 June 2024

August 4, 2024

Dear Councillors,

On behalf of the Washington Chapter of the American College of Emergency Physicians, it is my honor to endorse Dr. Ryan Keay, MD, FACEP for a position on the ACEP Board of Directors. Dr. Keay is a leader and mentor, an advocate for emergency medicine, and a compassionate emergency physician. I have had the opportunity to work with Dr. Keay for more than a decade, both clinically and as a state chapter leader, and can speak highly of her qualifications and dedication to our specialty.

Dr. Keay received her undergraduate degrees in Biology and Anthropology at the University of Alaska. She went on to receive her Medical Degree from the University of Washington School of Medicine and completed her residency training in emergency medicine at Denver Health Medical Center in Denver, CO. Her leadership skills were evident during her training, as she was selected and served as chief resident.

After completing her residency, Dr. Keay moved back to Washington state to take a job with a small democratic group in Everett, WA at Providence Regional Medical Center, the busiest emergency department in the state. Her leadership skills quickly became evident to her group, and she assumed the role of ED Medical Director in 2014. Her passion and capacity for improving care is evident to those working in and outside of the ED, and her input is highly sought after. Dr. Keay went on to co-chair the hospital's Sepsis Quality Committee, serve as clinical lead for the Institute for Healthcare Improvement ED and Upstream (ED&UP) improvements in the Behavioral Health pilot site, and co-chair the ED Clinical Decision Team and ED&UP Performance Team. Simultaneously, she took on the unique and demanding role of Division Chief of Outpatient and Community Medicine at Providence Regional Medical Center.

ACEP has also benefited from Dr. Keay's dedication and leadership. Dr. Keay has been intimately involved in ACEP since her time as a resident, when she served as a delegate to ACEP's annual Leadership and Advocacy Conference. Dr. Keay has attended ACEP Council since 2017, has been an active member of the Medical Director's Section for nearly a decade, and served as the Section's Chair in 2019-2021, during the beginning of the COVID pandemic. She continues to be active at the national level, serving as a member of the Steering Committee from 2022 to 2024, and a member of the DEI Committee since its inception in 2022.

At the state level, Dr. Keay served on the WA ACEP Board of Directors from 2015 to 2023, and was elected chapter President, serving with distinction, in 2021-22. However, her other local work is often overlooked. She served as a board member for the Washington State Poison Control Center for six years, including two years as Board President. Additionally, she currently holds the position of Medical Program Director for two fire departments and Snohomish County EMS.

Beyond her clinical work, Dr. Keay strives to be a mentor and educator to future emergency physicians. She is currently a clinical faculty member at the Washington State University Elson S. Floyd School of Medicine, and previously held the title of Clinical Instructor at the University of Washington School of Medicine. She has mentored numerous residents and junior faculty, providing insights on leadership and management skills. She also continues to provide didactic education at WA ACEP's annual conference and bedside teaching for health sciences students at WSU.

I have had the pleasure of working with Dr. Keay at Harborview Medical Center and on the WA ACEP Board. She continues to be someone that I look to for counsel, providing thoughtful and pragmatic advice. Dr. Keay is also one of the most compassionate physicians I have worked with. Her desire to improve the lives of our patients and community is evident at the bedside and in the board room. ACEP would be fortunate to have someone of her caliber join the Board of Directors. The Chapter is elated that she has decided to run for the Board, and we look forward to providing our full support as she moves through the nominating process.

Sincerely,

Herbie Duber, MD, MPH, FACEP
President, WA ACEP
Professor, Dept of Emergency Medicine, University of Washington School of Medicine
Regional Medical Obicer, WA State Dept of Health

C. Ryan Keay, MD, FACEP

Connection, Community, and Innovation are the 3 pillars on which I want to build my work in the College and on the Board.

Connection is my superpower. Our current health care system is broken, disconnected and dysfunctional. I felt the power and meaning of connection in healthcare before I became a physician. When I was 22-years old, I was sitting in the cabin of a small plane somewhere in the sky between Huslia and Fairbanks, Alaska. My patient was in his 80s, and his Athabaskan was better than his English. The sun made a brief appearance in the winter sky, peaking above the horizon, as dark set in again. As I struggled in the cold, loud cabin to care for this patient, I realized that in his dying moments, he was 20,000 feet and thousands of miles away from everyone and everything he knew. Connecting with this man and showing him compassion in his final moments was now my sole mission and responsibility. Whether during a rural Alaskan medevac or in a busy emergency department, physicians are the threads that tie healthcare with our communities.

To make connections is to form communities. Our connections are framed in the paradigm of our experiences. Our college, our specialty, and our system of medicine is currently suffering from lack of connection and community.

I represent the community. I bring to the ACEP Board the perspective of the independent, democratic group of physicians who still maintain autonomy of practice. I came to medicine in a circuitous fashion, from anthropology studying human remains, to a flight medic, to medical school. I jumped from the Arctic to Thailand to study tropical medicine. I survived the suicide of my brother in medical school and had two children during a tough residency in Denver. I represent the perspective, knowledge and background of loss, motherhood, and challenge. What has grounded me in life and career is connection and community. What has propelled me forward is innovation.

My leadership has spanned ED operations as a medical director, system-wide leadership in a large 7-state hospital system, within ACEP and my chapter, and as an EMS Medical Program Director. What I've seen and experienced through my professional career are the threads of connection through all the work we do. I have a vision of emergency medicine as not just the front-porch, or the safety net, but the web that connects all aspect of health care in our country. We are uniquely poised to understand the challenges of pre-hospital care. We see the bounce-backs and failures of access to care. I have worked in academics, privates, critical access, tertiary care, and urgent care. The lessons I have learned are simple: learn from the past, own the present and innovate for the future. Without innovation we stagnate, and that is the death of our specialty.

With my background and perspective, I feel my one unique super-power is connection. Connecting with people, connecting systems, bridging gaps and building community. When we come together, and employ the power of innovation, then we will emerge stronger and sustainable. My favorite day is still when I get to sit and talk to and hold the hand of my patient. That is why we all came to emergency medicine.

CONNECTION, COMMUNITY AND INNOVATION

Ryan Keay, MD, FACEP

ACEP Board Candidate

RYAN KEAY, MD, FACEP
FOR
ACEP BOARD

Leadership:

Past President – WA-ACEP, Medical Director's Section, WA Poison Center
Past Medical Director – Providence Regional Medical Center Everett
Past Chair – EM Steering Committee, Providence St. Joesph Health
Division Chief – Providence Regional Medical Center Everett
Medical Program Director – Snohomish County EMS

Hailing from the Pacific Northwest, I am practiced at balancing a busy career in the rain with the rest of life's demands. I understand the business of medicine, the science of medicine, and the humility and humor it takes to survive in this field. I want to bring an innovative, connected community back to our college of Emergency Medicine.

Connection

Community

Innovation

October 1, 2023

Catharine Ryan Keay, MD
Curriculum Vitae

16110 E. Shore Drive Box A
Lynnwood, WA 98087
(206) 604-3102
crkeay@northsoundem.com
catharine.keay@providence.org

Personal Data
Place of Birth: Durham, NC
Date of Birth: March 21, 1974

Education

1992-1996	BA, Anthropology, University of Alaska Fairbanks, Fairbanks, AK
1999-2000	BA, Biology, University of Alaska Fairbanks, Fairbanks, AK
2000-2005	MD, University of Washington School of Medicine, Seattle, WA
2004	Community Medicine Public Health Training, Chiang Mai Medical School, Chiang Mai, Thailand
2004	Certificate in Tropical Medicine, Mahidol University, Bangkok, Thailand

Postgraduate Training

2005-2009	Emergency Medicine Residency, Denver Health Medical Center, University of Colorado, Denver, CO
2008-2009	Chief Resident, Emergency Medicine, Denver Health Medical Center, Denver, CO

Faculty Positions Held

2005-2009	Instructor, AIMS Community College Paramedic School, Greeley, CO
2010-2015	Clinical Instructor, Division of Emergency Medicine, University of Washington School of Medicine, Seattle, WA
2018-current	Clinical Faculty, Washington State University Elson S. Floyd School of Medicine

Hospital Positions Held

2008-2009	Attending Physician, Lone Tree Urgent Care, Littleton, CO
2009-present	Attending Physician, Providence Regional Medical Center, Everett, WA
2010-2015	Attending Physician, Emergency Medicine, Harborview Medical Center, Seattle, WA
2014-2021	Medical Director, Emergency Medicine, Providence Regional Medical Center, Everett, WA
2015-present	Co-chair Sepsis Quality Committee
2016-present	Sepsis Faculty for Providence St. Joseph Health Sepsis Collaborative, now the Sepsis Focus Group in the Acute Care Clinical Performance Group
2016-2019	Clinical core lead for Emergency Department Clinical Decision Team (ED CDT) for Providence St. Joseph Health

2018-2019	Institute for Healthcare Improvement ED and Upstream (ED&UP) Improvements in Behavioral Health care pilot site, clinical lead
2018-present	Co-chair of ED&UP Focus Group within the Providence St. Joseph Health Mental Health and Substance Use Clinical Performance Group (MHSU CPG)
2019-2021	Co-chair, Emergency Department Clinical Decision Team (ED CDT)
2020-2023	Co-chair, ED&UP Performance Team, Providence Regional Medical Center Everett
2021-2023	Chair, Emergency Medicine Steering Committee, Providence St. Joseph Health
2021-present	Division Chief, Outpatient and Community Medicine, Providence Regional Medical Center Everett

Honors

1996	Magna cum Laude, graduate, University of Alaska Fairbanks
2000	Cum Laude graduate, University of Alaska Fairbanks
2001	American Academy of Family Physicians, National Scholarship
2002-2003	National P.E.O. Scholar Award
2007	Gold Humanism and Teaching Award nominee
2009	Senior Resident of the Year (awarded by nurses/staff), Denver Health Medical Center
2009	Senior Resident of the Year (awarded by faculty), Denver Health Medical Center
2021	Providence Regional Medical Center Collaborator Award

Board Certification

2010-present	Board Certification in Emergency Medicine, American Board of Emergency Medicine (ABEM) Diplomate, expires 12/31/2029

Current Licenses to Practice

2009-present	Washington State Medical License, MD60082286, expires 3/21/2024

Professional Organizations

2005-present	American College of Emergency Physicians (ACEP)
2005-2009	Colorado Chapter, ACEP (CO-ACEP)
2007-present	ACEP, Committee of International Emergency Medicine
2005-2012	American Academy of Emergency Medicine (AAEM)
2009-present	Washington Chapter, ACEP (WA-ACEP)

Teaching Responsibilities

2005-2009	ACEP International Emergency Medicine interest group
2005-2009	Ski Patrol Instructor, National Ski Patrol Association and Denver Health
2005-2009	Volunteer Instructor, University of Colorado School of Medicine
2010-2014	Clinical Instructor, Harborview Medical Center
2014-present	Guest lecturer, Residency in Emergency Medicine, UW/Harborview
2015-present	Faculty Leavenworth Paramedic Lecture Series
2015-2021	Monthly run review for Lake Stevens Fire Department/Snohomish Regional Fire and Rescue, Medical Program Director delegate physician
2015-present	Speaker, WA-ACEP Annual Leadership Summit

2017 Faculty, Cardiology Updates 2017, Providence Regional Medical Center Everett
2018-2021 Conference co-chair, PRMCE Annual Trauma and Emergency Medicine Conference
2018-2022 Speaker, Addiction Medicine Conference, Providence Regional Medical Center Everett

Editorial Responsibilities
2006-2009 Emergency Medicine Resident Association International Emergency Medicine literature review committee

Special National/International Responsibilities
2000-2001 Delegate to the AMA-MSS
2001-2002 Alternate Delegate to the AMA-MSS
2001-2002 Committee for Programs and Activities for the AMA-MSS
2001-2003 Student Delegate to the American Medical Association -House of Delegates (HOD)
2007-present Delegate to American College of Emergency Physicians Leadership and Advocacy Conference in Washington D.C.
2013-present Expedition physician to Antarctica with Quark Expeditions
2015-2016 Alternate Delegate to American College of Emergency Physicians Council meeting
2017-present Delegate to American College of Emergency Physicians Council meeting
2017-2019 Chair-elect, Medical Director's Section, American College of Emergency Physicians
2019-2021 Chair, Medical Director's Section, American College of Emergency Physicians
2019-present Expedition physician, Lindblad Expeditions
2022-2024 Member, Steering Committee, American College of Emergency Physicians
2022-present Member, DEI Committee, American College of Emergency Physicians

Special Local Responsibilities
2009-present North Sound Emergency Medicine (NSEM) Human Resources Committee
2009-present NSEM Emergency Department Quality Review Committee
2009-present NSEM ED Operations Committee
2011-2012 Providence Regional Medical Center Everett (PRMCE) Task Force on Venous Thromboembolism
2012-present PRMCE Engagement Team and Patient Satisfaction Committee
2012-2013 PRMCE Chest Pain Task Force Chair
2014-present NSEM Finance Committee member
2014-present Board Member, North Sound Emergency Medicine (NSEM)
2014-2015 WA American College of Emergency Physicians Board of Directors mentee
2014-present WA American College of Emergency Physicians Liaison to WA Emergency Nurses Association
2015-2016 Choosing Wisely Task Force, Washington Health Alliance
2015-2020 Medical Program Director delegate, Lake Stevens Fire Department (later Snohomish Regional Fire and Rescue
2015-2023 WA American College of Emergency Physicians Board Member

2016-2022 WA Poison Center Board member
2018-2020 WA Poison Center President
2019-2020 WA American College of Emergency Physicians Board of Directors Treasurer
2020-2021 WA American College of Emergency Physicians Board of Directors President-elect
2021-2022 WA American College of Emergency Physicians Board of Directors President
2021-present Medical Program Director delegate, Granite Falls Fire Department (Snohomish County District 17)
2022-present Medical Program Director delegate, Tulalip Bay Fire Department (Snohomish County District 15)
2023-presesnt Medical Director, Sno911 Dispatch
2023-present Medical Director, Northwest Ambulance
2023-present Medical Program Director, Snohomish County EMS

Research

2015-2016 Clinical Transformation Committee Grant at Providence Regional Medical Center for evaluation of Emergency Department CT Utilization
2015-2018 Mercury-Janssen Study: Discharging Low-risk PE patients using the Hestia Criteria
2016-2018 CODA Trial: antibiotics versus appendectomy for acute appendicitis, in collaboration with the University of Washington.

Bibliography

Refereed Journals

1. Levine AC, Gool A, ***Keay CR***, Lay C, Melnick ER, Nielson JA, Becker J, Kbaleghi M, Chicharoon N, Johar S, Lippert S, Tebb ZD, Rosborough S, Arnold K (2007, December). International Emergency Medicine: A review of the literature from 2006. *Acad Emerg Med, 14(12),* 1190-3.

2. Levine AC, Becker J, Lippert S, Rosborough S, Arnold K. on behalf of the Emergency Medicine Resident Association International Emergency Medicine Literature Review Group, writing committee. (2008, September) International Emergency Medicine: A review of the literature from 2007. *Acad Emerg Med, 15(9),* 860-865.

3. Klug CD, ***Keay CR***, Ginde, AA. (2009). Fatal toxic shock syndrome from an intrauterine device. *Ann Emer Med, 54(5),* 701-703.

4. Peacock WF, Coleman CI, Diercks DB, Francis S, Kabrhel C, ***Keay CR***, Kline JA et al. (2018, September). Emergency Department Discharge of Pulmonary Embolus Patients. *Acad Emer Med, 25(9), 995-1003*

5. Miller GA, Buck CR, Kang CS, Aviles JM, Younggren BN, Osborn S, ***Keay CR.*** (2020, March). COVID-19 in Seattle – Early Lessons Learned. *JACEPOpen.*

Book Chapters

1. Keay CR (2011). Diabetes mellitus. In: Markovchick, V.J., Pons, P.T., Bakes K.M. (Eds.), *Emergency Medicine Secrets,* 5th ed (pp 312-316). St. Louis, MO: Elsevier Mosby.
2. Keay CR (2016). Diabetes mellitus. In: Markovchick VJ, Pons PT, Bakes KM, Buchanan JA (Eds.), *Emergency Medicine Secrets*, 6th ed. (pp 302-306). St. Louis, MO: Elsevier Mosby.
3. Keay CR (2020). Diabetes mellitus. In: Markovchick VJ, Pons PT, Bakes KM, Buchanan JA (Eds.), *Emergency Medicine Secrets*, 7th ed. ***In press.*** Elsevier Mosby.

Other Publications

1. Scott GR, Street SR, Steen S, Legge S, Lane R, Colby CR. (1996). Report on the human remains from Univak Island, Alaska. Report prepared for the Repatriation Office, Smithsonian Institution, Washington, DC.
2. Keay CR. (2008, October). Colorado a refuge. *Colorado American College of Emergency Physicians EPIC Newsletter,* 3.
3. Keay CR. (2008, March). Rural emergency medicine in crisis. *Colorado American College of Emergency Physicians EPIC Newsletter,* 9.

References and ongoing education

Available upon request

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Heidi C. Knowles, MS, MD, FACEP

***Question #1:* What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

As an incumbent on the Board of Directors, running for re-election, I bring a wealth of experience and a proven track record of effective leadership. My role as Medical Director and Chief of Operations for a high volume (>125,000 patients/year) emergency department has equipped me with invaluable leadership and operational expertise in managing complex and high pressure environments. Additionally, a background in state and national level leadership has equipped me with unique insights into the challenges and opportunities facing our organization at both local and national levels. I also have a deep understanding of our members' needs and a commitment to addressing those needs through innovative strategies and solutions.

My vision for the future of ACEP includes continued innovation, transparency, and a strong sense of community. I am committed to fostering an inclusive environment where every member feels valued and heard. My unique combination of skills, experience, and forward-thinking approaches will help drive ACEP's mission and ensure our organization's growth and success.

I am eternally grateful for the opportunity to serve over the past three years and look forward to continuing my service on the Board to advance our shared goals.

***Question #2:* What strategic priorities should ACEP pursue to maintain itself as the home for all emergency physicians!**

As a dedicated advocate for emergency medicine, I am committed to ensuring that ACEP remains the premier professional home for ALL emergency physicians. Given the rapid evolution of our field and the healthcare landscape, I propose focusing on these strategic priorities:

Enhancing membership engagement and value is paramount. We must offer personalized resources for all members, from those starting their careers to those nearing retirement. This should include expanding mentorship opportunities for seasoned physicians to share their knowledge as well as providing state-of-the-art continuing education tailored to both current clinical practices and relevant topics for those transitioning out of active practice.

Advocacy is a cornerstone of ACEP membership. We should strengthen our efforts at both state and national levels, fostering stronger collaborations with state chapters to enhance local advocacy. Our focus should remain on fair reimbursement practices, safe work environments, physician wellness, and legislation that protects emergency physicians from litigation and ensures adequate compensation for their high-risk work.

Additionally, I believe in the importance of transparency and communication. We must ensure that ACEP operates with openness, regularly updating members on key initiatives, decisions, and financial matters. Encouraging active feedback and dialogue with our members will help us better understand and address their needs, fostering a sense of trust and community within the organization.

My vision is for ACEP to not only adapt to the changing healthcare environment but also to lead the way in setting standards for excellence in emergency medicine. By concentrating on these priorities, we will safeguard our profession and enhance the quality of care our members provide.

***Question* #3: What innovative strategies would you use to recruit and retain membership?**

Recruitment and retention strategies are crucial for any membership organization. To do this, we must assess and address the needs and desires of both our current and potential members. These needs could include the following:

Education: Enhancing ACEP's educational offerings, including the Scientific Assembly, is essential for providing cutting-edge education. Developing unique opportunities like the Indy Master Class, which caters to EM physicians interested in the business and management aspects of the field, and offering ample networking opportunities for physicians to connect are key.

Community: Creating public awareness campaigns that highlight our work and the stories of individual emergency physicians can foster a sense of community and pride within the profession.

Leadership development: Developing future leaders should involve AI-driven personalized development plans, gamified learning experiences, and a digital mentorship platform with ACEP leaders to provide real-time advice and role modeling.

Recognition: Enhancing the recognition of emergency physicians through digital badges/certificates, an interactive recognition platform, and a peer-nomination system can bolster morale and professional pride.

Career longevity: Addressing moral injury and burnout in medicine requires advanced strategies and technologies, including digital wellness platforms with guided meditation and virtual counseling, AI-driven personalized wellness plans and telehealth peer support networks. Interactive webinars, advocacy campaigns, and innovative recognition programs further promote well-being.

Communication: Effective communication is *essential* for sharing the abundance of work that ACEP is doing daily. Leveraging the latest technologies and platforms, including data analytics and virtual reality, can personalize and enhance our messaging. Clear and consistent communication ensures everyone knows the available resources and ACEP's ongoing efforts to support professional growth and well-being.

By focusing on these areas, we can strengthen our organization, recruit new members, and retain current ones.

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CANDIDATE DATA SHEET

Heidi C. Knowles, MS, MD, FACEP

Contact Information
11901 Ridge Road
Forney, TX 75126
Phone: (903) 681-3762
E-Mail: hknowles@acep.org

Current and Past Professional Position(s)
Integrative Emergency Services
John Peter Smith Hospital System: 2/11 to current
Level 1 Trauma Center, EM Residency Program, approx. 125,000 patients/year
Medical Director, Chief of Operations, Vice Chair 1/23 to current
Associate Medical Director 8/20 to 12/22, Assistant Medical Director, 7/19 to 7/20
Director-Leadership and Advocacy, 7/15 - 6/19
TCU and UNTHSC School of Medicine
Assistant Professor, Department of Emergency Medicine 7/19-current
Southlake Emergicare
Texas Health Resources Southlake ED: 12/16 to current
Trinity Valley Community College
EMS Program Medical Director: 4/2011 to current
EmCare - Emergency Department Physician
Palestine Regional Medical Center 01/02/12 to 10/2017
Rural ED, 32,000 volume, Level 3 Trauma Center
University of Texas Health Science Center - Houston
Memorial Hermann Hospital: 10/11 to 8/15
Level 1 Trauma Center, EM Residency Staff Physician
Pegasus
Metroplex Hospital-Killeen: 08/12 to 12/12
Staff physician (temporary position for new contract start-up)
Emergency Service Partners - Emergency Department Physician
Palestine Regional Medical Center: 07/01/06 to 01/01/2012

Education (include internships and residency information)
University of Texas Health Science Center at Houston, Memorial Hermann Hospital 07/2003-06/2006
Emergency Medicine Residency
University of Texas Health Science Center at Houston, 08/1999-06/2003
Doctor of Medicine
Southwest Texas State University, San Marcos, Texas
Master of Science-Microbiology 01/1996-08/1998
Bachelor of Science-Biology/Chemistry minor 08/1990-05/1994

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM initial certification 12/2007-12/2017; recertification 12/2017-12/2027

Professional Societies

American College of Emergency Physicians (ACEP) 2002-current - Board of Directors 2021-current
Texas College of Emergency Physicians (TCEP) - Past President
Emergency Medicine Political Action Committee of Texas (EMPACT)- Executive Board 2018 to current
Texas Medical Association Inter-Specialty Society Committee TCEP Representative 2013 to current

National ACEP Activities – List your most significant accomplishments

American College of Emergency Physicians (ACEP) 2002-current

Board of Directors – 2021-current

Board liaison to the following committees/sections

- Medical-Legal Committee (2021-24)
- National Chapter Relations Committee (2021-22)
- Academic Affairs Committee (2021-24)
- Sports Medicine Section (2021-22)
- Locum Tenens Section (2021-22)
- Ultrasound Section (2023-24)
- Forensics Section (2023-24)
- Freestanding Emergency Centers (2022-24)
- CUAP Board of Governors (2023-24)
- AAWEP (2023-24)

Reference Committee 2010, 2016

Tellers and Credentials Committee 2011-2012, 2012-2013

Steering Committee 2014, 2015

Ethics Committee 2015-2019

ACEP Liaison to the Federation of State Medical Boards

ACEP Representative on the Society of Critical Care Medicine Committee to create Guidelines to Identify Critical Patients Outside the Emergency Department 2020-2023 (published Feb 2024)

ACEP Chapter Activities – List your most significant accomplishments

Texas College of Emergency Physicians (TCEP) Board of Directors, President 2017-2018

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 **1** % Teaching **9** % Administration **50** %

Other: __________ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Full-time employee for IES, a physician owned multi-hospital staffing organization. I am the Medical Director at John Peter Smith (JPS) Hospital, a large volume (125,000+/year), level 1 trauma center, county hospital ED.

PRN Independent Contractor with Southlake Emergicare, a physician owned, single hospital group that staffs the Texas Health Resources Southlake Surgical Center Emergency Department (very low volume ED)

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

At JPS, I am the Medical Director, Chief of Operations and Vice Chair for the Department of EM.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Heidi C. Knowles, MS, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Integrative Emergency Services

Address: Heritage Square One 4835 LBJ Freeway, Suite 900
Dallas, Texas 75244

Position Held: Medical Director, Chief of Operations and Vice Chair, Department of EM at John Peter Smith Health Network

Type of Organization: Mid-sized regional, physician owned staffing group; Level 1 trauma center, county hospital 125,000+ patients/year

Employer: Southlake Emergicare

Address: 1545 E Southlake Blvd
Southlake, Texas

Position Held: PRN staff physician

Type of Organization: Physician owned staffing group for Surgery Center ED

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Trinity Valley Community College

Address: 100 Cardinal Dr
Athens, Tx 75751

Type of Organization: Community College

Leadership Position: Medical Director for EMS program

Term of Service: 2011- current

Organization: Texas Chapter of American College of Emergency Physicians

Address: 401 W. 15th Street, Suite 695
Austin, Tx 78701

Type of Organization: State chapter of ACEP

Leadership Position: Past President, President, President-elect, Secretary-Treasurer, Board member, multiple committee roles

Term of Service: 2010-2019

Organization: Emergency Medicine Political Action Committee of Texas (EMPACT)

Address: 401 W. 15th Street, Suite 695

Austin, Tx 78701

Type of Organization: Emergency Medicine Political Action Committee

Leadership Position: Executive Board / Controlling Member

Term of Service: 2018-current

Organization: American College of Emergency Physicians

Address: 4950 W. Royal Lane

Irving, Tx 75063

Type of Organization: The leading EM advocacy organization

Leadership Position: Board of Directors –current member; multiple committee / section roles

Term of Service: 2021-current (Board of Directors); other roles 2010-current

Organization: Texas Medical Association

Address: 401 West 15th Street

Austin, Tx 78701

Type of Organization: Medical Advocacy Organization

Leadership Position: TCEP Representative Inter-specialty Society Committee (Alternate Delegate and Delegate); Young physician delegate; Young physician Steering Committee

Term of Service: 2012-current

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☒ If YES, Please Describe: Husband is chiropractor with solo private practice clinic

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ N/A
☒ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Heidi Knowles, MD, FACEP Date 6/14/2024

2024-2025
Board of Directors

Doug Jeffrey, MD, FACEP
President

A.J. Kirk, MD, FACEP
President Elect

Bryan Dunn, MD, FACEP
Treasurer

Marcus Sims, II, DO, FACEP
Secretary

Sandra Williams, DO, MPH, FACEP
Immediate Past President

Directors
Sara Andrabi, MD, FACEP

Jessica Best, MD, FACEP

Angela Cornelius, MD, FACEP, FAEMS

Brook Danboise, MD (Young Physician Director)

Cassidy Lane, DO (Candidate/Resident Director)

Ben Leeson, MD, FACEP

Julien Mahler, MD

Michael Parsa, MD, FACEP

Catherine Pivalizza (Medical Student Representative)

Theresa Tran, MD, MBA, FACEP

Mission Statement:
The Texas College of Emergency Physicians exists to promote quality emergency care for all patients and to represent the professional interests of our members.

July 31, 2024

Dear ACEP Councillors,

On behalf of the Texas College of Emergency Physicians (TCEP), it is my distinct pleasure to endorse Heidi Knowles, MD, FACEP, as a candidate for the ACEP Board of Directors.

Dr. Knowles has been an ACEP member since 2002 and brings a wealth of experience from her clinical practice in both rural and community settings, as well as her involvement at the national ACEP level and within our Chapter. Her background and accomplishments are particularly valuable in these challenging times for our profession, and she is well-equipped to advance emergency care. Dr. Knowles has served ACEP with distinction as a Board Member, Councilor, and has been an active member of several committees, including Ethics and the 911 Network.

Her contributions to TCEP truly highlight the skills she will bring to the ACEP Board of Directors. Her CV showcases her extensive committee involvement and her participation in our yearlong Fellows (TLAF) program. Dr. Knowles continues to serve on the Finance Committee, EMPACT Board, and Membership Committee. Notably, she co-directed and then directed our highly successful Residency Visit Program, which now includes 14 medical residencies in Texas.

Dr. Knowles has held every leadership position within the TCEP Board, culminating in her presidency in 2018. Her tenure as President was marked by exceptional dedication during a period of significant turmoil when we were without staff for over a year. The Board decided to relocate the office to Irving temporarily, and Dr. Knowles stepped up by going to the TCEP office 4-5 days a week, after her shifts, to manage association business. Her tireless efforts ensured the association's stability during that challenging transition. This experience has given her a unique understanding of the intricate workings of a state chapter. Dr. Knowles remains actively involved with TCEP and represents us on several Texas Medical Association committees and in their House of Delegates.

The Texas Chapter is proud to offer Dr. Knowles our highest endorsement.

Thank you for your consideration. Please feel free to reach out to me or our Executive Director, Jill Sutton, at jill@texacep.org, with any questions.

Sincerely,

Doug Jeffrey, MD, FACEP
President
Texas College of Emergency Physicians

Heidi C. Knowles, MD, FACEP

Councillors and Colleagues,

I am truly honored by your trust in me as a member of the Board of Directors over the past three years. Your confidence and support have been instrumental in our collective achievements. Serving you has been a privilege, and I am excited to announce my candidacy for re-election to continue our vital work.

As the Medical Director and Chief of Operations for one of the busiest emergency departments in the country, with extensive leadership roles at state and national levels, I bring proven leadership and a wealth of experience. My clinical hands-on experience "in the pit" gives me a firsthand understanding of our members' challenges, allowing me to advocate effectively on their behalf.

My vision for ACEP focuses on innovation, transparency, and fostering a vibrant community. I am committed to creating an inclusive environment where every member feels valued and plays a crucial role. With your support, my skills and forward-thinking strategies will drive ACEP's mission forward, ensuring our growth and success.

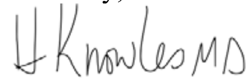
Key priorities include enhancing membership engagement through personalized resources, expanding mentorship opportunities, and delivering cutting-edge education. Strengthening advocacy at both state and national levels is crucial, focusing on fair reimbursement, safe work environments, physician wellness, and protective legislation. Transparency and regular updates on key initiatives will build trust and unity within ACEP.

Our members, including practicing and retired physicians, residents, and students, are the backbone of ACEP. To attract and retain members, we must continually enhance membership value, improve educational offerings, cultivate future leaders, and recognize the vital contributions of emergency physicians. Addressing moral injury and burnout is also critical, and I support advanced strategies such as digital wellness platforms and telehealth peer support networks.

Effective communication leveraging the latest technologies will keep our members informed and engaged with ACEP's efforts and resources. By focusing on these areas, we can strengthen our organization, recruit new members, and retain our current ones, ensuring ACEP remains the ***premier professional home*** for all emergency physicians.

I am immensely grateful for the opportunity to serve and for your unwavering support over the years. I look forward to using my knowledge and experience to advance our shared goals. Together, we can build a stronger, more inclusive ACEP that meets the evolving needs of our members. I humbly ask for your vote to continue this vital work and lead ACEP into a future of excellence and innovation. Vote for me, Heidi Knowles, for the ACEP Board of Directors.

Sincerely,



★★★ Re-elect ★★★

HEIDI KNOWLES MS,MD,FACEP

for

BOARD OF DIRECTORS

American College of Emergency Physicians

STATE AND NATIONAL INVOLVEMENT

State:

Texas Chapter Past President, Leadership and Advocacy Fellow, Residency Visit Coordinator, Multiple Committees; EMPACT (TCEP PAC) Executive Board member
Texas Medical Association - Interspecialty Society TCEP Representative

National:

ACEP Board of Directors (current)
ACEP Representative for Federation of State Medical Boards and Society of Critical Care Medicine (project for early identification of critical illness)
Board Liaison for multiple committees and sections

•COMMITTED •PROVEN SERVICE •DEDICATED

Active involvement is crucial in defining and protecting emergency physicians' roles. As your incumbent candidate for re-election, I am committed to being a dedicated advocate for our profession. My vision for ACEP includes innovation, transparency, and a strong sense of community. I am dedicated to fostering an inclusive environment where every member feels valued. My skills, experience, and forward-thinking approaches will drive ACEP's mission and ensure our growth and success. Additionally, my extensive experience in EMS education, rural and community emergency medicine, academic trauma centers, and as the medical director of one of the busiest EDs in the country provides me with the comprehensive perspective needed to effectively represent both physicians and patients.

Heidi Christine Knowles, MS, MD, FACEP

cell: (903)681-3762
email: hknowles@ies.healthcare

EDUCATION:

Emergency Medicine Residency
University of Texas Health Science Center at Houston
Memorial Hermann Hospital, Houston, Texas — 07/03 – 06/06

University of Texas at Houston, Medical School
Houston, Texas
Doctor of Medicine — 08/99 – 06/03

Southwest Texas State University
San Marcos, Texas
Master of Science-Microbiology — 01/96 – 08/98
Bachelor of Science-Biology/Chemistry minor — 08/90 – 05/94

Licensure: Texas Medical License #M3818

Certifications:
Board Certified American Board of Emergency Medicine — 12/17 – 12/27
Advanced Cardiac Life Support (ACLS) — 10/15– 10/17
Advance Trauma Life Support (ATLS) — 10/14 – 10/18

WORK EXPERIENCE:

Integrative Emergency Services
John Peter Smith Hospital System: 2/11 to current
Level 1 Trauma Center, EM Residency Program
Approx. 125,000 patients/year
Medical Director, Chief of Operations, Vice Chair 1/23 to current
Associate Medical Director 8/20 to 12/22
Assistant Medical Director, 7/19 to 7/20
Director-Leadership and Advocacy, 7/15 - 6/19
Core Faculty, 7/15 - current

TCU and UNTHSC School of Medicine
Assistant Professor, Department of Emergency Medicine 7/19-current

Southlake Emergicare
Texas Health Southlake ED: 12/16 to current
Multi-specialty surgical hospital, prn staff physician

Trinity Valley Community College
EMS Program Medical Director: 4/2011 to current

EmCare - Emergency Department Physician
Palestine Regional Medical Center 01/02/12 to 10/2017
Rural ED, 32,000 volume, Level 3 Trauma Center
(change of contract holder from ESP to EmCare, 01/02/12)

University of Texas Health Science Center - Houston
Memorial Hermann Hospital: 10/11 to 8/15
Level 1 Trauma Center, EM Residency Staff Physician
Pegasus
Metroplex Hospital-Killeen: 08/12 to 12/12
Staff physician (temporary position for new contract start-up)
Emergency Service Partners - Emergency Department Physician
Palestine Regional Medical Center: 07/01/06 to 01/01/2012

PUBLICATIONS:

Freeman, L, Carvajal, M, Knowles, H. Treating Hypertension in the Emergency Department, Part 1. *Emergency Medicine Reports*. Vol 26, No. 7. March 21, 2005.

Freeman, L, Carvajal, M, Knowles, H. Treating Hypertension in the Emergency Department, Part 2. *Emergency Medicine Reports*. Vol 26, No. 7, April 4, 2005.

Morgan, D., Wainscott, M., Knowles, H. Emergency Medical Services Liability Litigation in the United States: 1987 to 1992, *Prehospital and Disaster Medicine* (vol. 9, No. 4) October – December 1994.

Allen, N., Jesus, J., Knowles, H., Larkin, G., Schears, R. Extracorporeal Membrane Oxygenation in the ED: Exciting Medicine, Ethical Challenges. *ACEP Now*, July 19, 2016

Holmes, M., Stanzer, M., Schrader, C., Knowles, H. Chapter 27, Getting Involved in the House of Medicine, *Emergency Medicine Advocacy Handbook*, 4th edition, 2016.

Marco CA, Venkat A, Baker EF, Jesus JE, Geiderman JM, et al. Prescription Drug Monitoring Programs: Ethical Issues in the Emergency Department. *Annals of Emergency* Medicine. Nov 2016. 68(5):589-598, November 2016. Epub May 2016.

Huggins, C., Knowles, H., Wang, H. Large Observation Study on Risks Predicting Emergency Department Return Visits and Associated Disposition Deviations. *Clinical and Experimental Emergency Medicine*. May 7, 2019. Doi:10.15441/ceem.18.023. PMID: 31036785..

Knowles, H., Huggins, C., Robinson, R., et al. Status of Emergency Department Seventy-Two-Hour Return Visits Among Homeless Patients. *Journal of Clinical Medical Research*. 2019 Mar;11(3):157-164. DOI: 10.14740/jocmr3747. Epub 2019 Feb 13. PMID: 30834037

Mazur, B., Jennings, A., Knowles, H. Chapter 195, Globe Luxation Reduction, Reichman's Emergency Medicine Procedures, 3rd edition, 2018.

Wolfshohl JA, Bradley K, Bell C, Bell S, Hodges C, Knowles H, Chaudhari BR, Kirby R, Kline JA, Wang H. Association Between Empathy and Burnout Among Emergency Medicine Physicians. *J Clin Med Res*. 2019 Jul;11(7):532-538. DOI: 10.14740/jocmr3878. Epub 2019 Jun 11. PMID: 31236173; PMCID: PMC6575121.

Jyothindran R, d'Etienne JP, Marcum K, Tijerina A, Graca C, Knowles H, Chaudhari BR, Zenarosa NR, Wang H. Fulfillment, burnout and resilience in emergency medicine-Correlations and effects on patient and provider outcomes. PLoS One. 2020 Oct 19;15(10):e0240934. DOI: 10.1371/journal.pone.0240934. PMID: 33075090

Jyothindran R, d'Etienne JP, Marcum K, Ho A F , Robinson RD, Tijerina A, Graca C, Knowles HC, Zenarosa NR, Wang H. . Association between burnout and wellness culture among emergency medicine providers. *Clin Exp Emerg Med*. 2021;8(1):55-64. doi:10.15441/ceem.20.074. PMID:33845524

Byrd J, Knowles H, Moore S, Acker V, Bell S, Alanis N, Zhou Y, d'Etienne JP, Kline JA, Wang H. Synergistic effects of emergency physician empathy and burnout on patient satisfaction: a prospective observational study. *Emerg Med J.* 2021 Apr;38(4):290-296. DOI: 10.1136/emermed-2019-209393. Epub 2020 Nov 25. PMID: 33239313.

Kirby R, Knowles HC, Patel A, Alanis N, Rice C, d'Etienne JP, Schrader CD, Zenarosa NR, Wang H. The influence of patient perception of physician empathy on patient satisfaction among attending physicians working with residents in an emergent care setting. *Health Sci Rep*. 2021 Aug 17;4(3):e337. DOI: 10.1002/hsr2.337. PMID: 34430711; PMCID: PMC8369944.

Holmes CT, Huggins C, Knowles H, Swoboda TK, Kirby R, Alanis N, Bulga A, Schrader CD, Dunn C, Wang H. The association of name recognition, empathy perception, and satisfaction with resident physicians' care among patients in an academic Emergency Department. J Clin Med Res. 2023; 15(4): 225-232. Doi: 10.10740/jocmr4901. PMID: 37187709. PMCID: PMC10181348

Knowles, H., Swoboda, T.K., Sandlin, D. *et al.* The association between electronic health information usage and patient-centered communication: a cross sectional analysis from the Health Information National Trends Survey (HINTS). *BMC Health Serv Res* **23**, 1398 (2023). https://doi.org/10.1186/s12913-023-10426-6. PMID: 38087311

Grants and Research Support:

Clinical Trial sponsored by BrainBox Inc.
Role: Principle Investigator at JPS Health Network
Project: HEAD injury Serum markers and Multi-modalities for Assessing Response to Trauma (HeadSMART2).
IRB No. (WCG) 1293236

Clinical Trial sponsored by Calcimedica
Role: Principle Investigator at JPS Health Network
Project: A Randomized, Double-Blind, Placebo-Controlled Dose-Ranging Study of Auxora in Patients with Acute Pancreatitis and Accompanying Systemic Inflammatory Response Syndrome (CARPO).
IRB No. (WCG) 1304835

Clinical Trial sponsored by Comprehensive Research Associates
Role: Principle Investigator at JPS Health Network
Project: A Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group Phase 4 Study of the Efficacy and Safety of Patiromer for Oral Suspension in Combination with Standard of Care Treatment in Emergency Departments with Hyperkalemia (PLATINUM).
IRB No. (WCG) 1310268

TEACHING ACTIVITIES / PRESENTATIONS:

ACEP Leadership and Advocacy Conference
- Contract Management Groups- Historical Perspectives 5/2022
- AAWEP Why Lead Now Discussion Panel 5/2023

ABCD (Airway, Breathing, Circulation & Difficult Delivery) Simulation Course
- Course Director, 11/2017 and 2/2019

Texas College of Emergency Physicians Annual Meeting 4/2019, 3/2020, 4/2022, 4/2023
- LLSA Review state presentation

American College of Emergency Physicians Leadership and Advocacy Meeting
- Succession Planning - national presentation 2/2018

JPS Department of Pharmacy Lecture: Burnout Identification and Prevention 6/2019

JPS Emergency Medicine Residency Lectures
- Difficult Airway Course
- Acute Coronary Syndrome Update
- HEENT Tricks of the Trade
- Orthopedic Emergencies
- Emotional Intelligence
- Leadership and Advocacy – How to Get Involved
- OB Emergencies Simulation Day Coordinator
- Vaginal Bleeding in Pregnancy

Trinity Valley Community College EMS Medical Director
- Classroom lectures / clinical teaching for paramedic and EMT students (ongoing)

Texas College of Emergency Physicians Residency Visit Coordinator

Lecture to residents on topics including Leadership / Advocacy / Life After Residency / Myths of EM / Hot Topics of EM / Importance of Getting Involved / Maximizing Efficiency in the ED / Motivation

UTHSC San Antonio Residency Grand Rounds - Emerging Infectious Diseases 4/15

ACLS Course Instructor 2003-2006

EMS Continuing Education Instructor, Intermedix, 2005-2006

PROFESSIONAL MEMBERSHIPS:

Texas College of Emergency Physicians (TCEP)

Board of Directors, President 2017-2018
Board of Directors, President-elect 2016-2017
Board of Directors, Immediate Past President 2018-2019
Board of Directors, Treasurer 2015-2016
Board of Directors, Regular Member 2013-2016
Board of Directors, Young Physician Representative 2012-2013
Residency Visit Lecture Program
- Co-coordinator 2011-2013
- Coordinator 2014-2018

Board Liaison to Resident Committee 2014-2016
Fellow of TCEP Leadership and Advocacy Program 2010
Education Committee 2009-2013
Bylaws Review Committee 2010-2011
Membership Committee 2010 - 2018
Elections Committee 2010
Finance Committee 2017-current

Emergency Medicine Political Action Committee of Texas (EMPACT)

Executive Board / Controlling Member – 2018 to current

American College of Emergency Physicians (ACEP) 2002-current

Board of Directors – 2021-current

Board liaison to the following committees/sections

- Medical-Legal Committee (2021-24)
- National Chapter Relations Committee (2021-22)
- Academic Affairs Committee (2021-24)
- Sports Medicine Section (2021-22)
- Locum Tenens Section (2021-22)
- Ultrasound Section (2023-24)
- Forensics Section (2023-24)
- Freestanding Emergency Centers (2022-24)
- CUAP Board of Governors (2023-24)
- AAWEP (2023-24)

Fellowship Status - 2011
Reference Committee 2010, 2016
Membership Committee 2010-2016
Tellers and Credentials Committee 2011-2012, 2012-2013
Steering Committee 2014, 2015
Ethics Committee 2015-2019
ACEP Liaison to the Federation of State Medical Boards
ACEP Representative on the Society of Critical Care Medicine Committee to create Guidelines to Identify Critical Patients Outside the Emergency Department 2020-2023

Texas Medical Association

Young Physician Section Delegate 2012-2014
Young Physician Section Steering Committee 2012-2014
TexPAC Vice Chair, Region 2012
Inter-specialty Society Committee
Texas College of Emergency Physicians Representative
Alternate Delegate 2013-2014; Delegate 2014-2024
Member Anderson-Leon County Medical Society 2006-2019
Member Tarrant County Medical Society 2019 – Current

Society of Academic Emergency Medicine

Faculty Development Committee 2016-2018
Speed Mentoring Faculty 2017-2018

AWARDS

John Peter Smith Hospital **Physician of the Year** - 2021
Texas Health Resources Southlake **Physician of the Quarter –** 6/2017
James E. Hayes Award for Outstanding Contributions to TX Emergency Medicine 2019
Outstanding Emergency Medicine Resident- UT Houston 2006

VOLUNTEER ACTIVITIES:

Henderson County United Way Board of Directors, 2009-2013
Hurricane Katrina Disaster Relief, Astrodome Physician Services, 09/05
Kiwanis Club of Athens, Sponsored Youth Director 2009-2013
Trinity Habitat for Humanity Cowtown Brushup 2017, 2018 Team Coordinator
North Texas Alliance for Clinical Resilience 2018-2019

PERSONAL:

Born in McKinney, Texas
Married to Michael Ely, DC
Hobbies/interests include travel, scuba diving, gardening and beekeeping

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Diana B. Nordlund, DO, JD, FACEP

***Question #1:* What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

I will bring legal training and practice experience to the Board. With these skills, I can tackle College issues in a way that only a practicing physician-attorney can, with working knowledge of the day-to-day practicalities of both medicine and the law. I know how to approach a problem, vet arguments from both sides, and draw pragmatic conclusions with workable solutions. With legal training and practice experience that includes medical malpractice defense, health system risk management, and physician contracting, I will bring unique skills to the Board; I am versed in weighing and representing the interests of an individual physician, the challenges of running a small business, the at-times conflicting interests of a health system and the physicians providing medical care within it, and how state and national legislative priorities directly affect the practice of emergency medicine.

***Question #2:* What strategic priorities should ACEP pursue to maintain itself as the home for all emergency physicians?**

In his book *Languishing*, sociologist Corey Keyes quotes a study asserting that the key to flourishing in highly demanding medical professions (EM, General Surgery, and OB) is a supportive work environment: one that includes colleagues who are there for you when you need them as well as genuine collegiality with warm, open, and trusting relationships. ACEP should be the go-to when an EP needs someone in their court, whether it is for information, resources, key connections, advocacy, response to emerging issues, or implementation of effective solutions to practice challenges. ACEP must understand what EPs want and need from their organization and how to deliver it through effective channels, cultivate a transparent and accessible Board, and nurture a community that supports and empowers EPs.

***Question #3:* What innovative strategies would you use to recruit and retain membership?**

Building trust, strengthening community, and communicating value.

Building trust requires transparency, communication, and responsiveness. This requires direct-line interactions to understand the needs of members in a variety of practice environments to best serve the membership's needs. Communicating with chapters prior to impactful decisions whenever possible to gauge priorities, needs, and foresee potential problems is essential. A membership that feels heard, trusts and sees value in its organization, and freely shares that truth with others is an effective vehicle to retain and recruit.

Strengthening community requires connection. EPs face a variety of challenges that require real-time answers. Increasing the accessibility of College expertise and the ease with which members with similar interests and needs can connect with each other builds value and community. Facilitating follow up to these connection at in-person meetings further develops community. When ACEP is the go-to for speedy answers to tough problems, whether learning from others who have already been through similar situations or solving problems together, we build strength, efficiency, and purpose and demonstrate unique and indispensable value. We are stronger together—with our wealth of diverse opinions and experiences—working effectively toward common goals, benefitting from lessons learned, and recognizing the excellent work being done in all corners of the profession.

Communicating requires the right channels. ACEP needs to clearly communicate its values and value to members. Personally, I'm grateful to find a service or product that improves my quality of life in a manner consistent with my values while providing value proportional to the investment. Great gains have been achieved by our leadership, members, and staff that are not always known to general and potential membership, in part because our inboxes and notification queues are already overflowing. For EPs to determine for themselves if ACEP's values are consistent with their own and if ACEP provides value commensurate with the investment, the relevant information must be provided via channels that are already part of their routine or easily become part of their routine. Clarity of our organizational values so that they are easily identified and used as

a consistent lens through which to view organizational decisions is of utmost importance. In-person connection, such as between colleagues working side by side in the ED, at the state level in leadership and advocacy, and professional community building at all levels may be key to communicating a richer dimension of value.

CANDIDATE DATA SHEET

Diana B. Nordlund, DO, JD, FACEP

Contact Information

7707 Austinridge Dr SE, Caledonia, MI 49316
Phone: 616.291.4283
E-Mail: diana.nordlund@gmail.com

Current and Past Professional Position(s)

Corporate Compliance Officer, Partner, Attending Physician, Emergency Care Specialists
Corporate Compliance Officer, Partner, Attending Physician, Emergency Medical Associates
Attending Physician, Emergency Physicians Medical Group

Education (include internships and residency information)

Emergency Medicine Residency, Metro Health, Grand Rapids, MI, 2010
Traditional Internship, Metro Health, Grand Rapids, MI
Cooley Law School, Juris Doctor, Grand Rapids, MI, 2012
Kirksville College of Osteopathic Medicine/Andrew Taylor Still University, Kirksville, MO, 2006
University of Illinois at Urbana Champaign, Master of Music, Urbana, IL, 1999
Western Michigan University, Bachelor of Music, Kalamazoo, MI, 1998

Doctor of Osteopathy, 2006

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

AOBEM, 2013, 2023

Professional Societies

American College of Emergency Physicians
Michigan College of Emergency Physicians
State Bar of Michigan

National ACEP Activities – List your most significant accomplishments

Chair, Medical Legal Committee
Chair, Reference Committee B
Co-Chair, Reproductive Health and Patient Safety Task Force
Member, Council Steering Committee

ACEP Chapter Activities – List your most significant accomplishments

President, Board of Directors
Chair, State Legislative Committee
Chair, Leadership Development Task Force
Chair, Michigan Emergency Medicine Foundation, Board of Trustees
Chair, Executive Director Search Committee

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 **70** % Research **0** % Teaching **10** % Administration **10** %

Other: **Advocacy** **10** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Partner, Emergency Care Specialists. Multi-hospital: tertiary/urban, community, and rural. Residency affiliated.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Corporate Compliance Officer, Emergency Care Specialists

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 1 Cases **Plaintiff Expert 1 Cases**

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Diana B. Nordlund, DO, JD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Emergency Care Specialists

Address: 4100 Embassy Dr SE #400

Grand Rapids, MI 49546

Position Held: Corporate Compliance Officer, Partner, Attending Physician

Type of Organization: Independent Physician Group

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: American College of Emergency Physicians

Address: 4950 W Royal Lane

Irving, TX 75063-2524

Type of Organization: Professional Organization

Leadership Position: Committee Chair, Task Force Co-Chair, Committee Member, Councillor

Term of Service: 2-10 years, approximately

Organization: Michigan College of Emergency Physicians

Address: 6647 W St Joseph Hwy

Lansing, MI 48917

Type of Organization: Professional Organization

Leadership Position: President, IPP, Board Officer, Committee Chair, Task Force Chair, Councillor

Term of Service: 2-10 years, approximately

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Diana B Nordlund Date 6/15/24

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

6647 West St. Joseph Highway ♦ Lansing, Michigan 48917 ♦ 517-327-5700 ♦ FAX 517-327-7530 ♦ mcep@mcep.org

A Chapter of the American College of Emergency Physicians

OFFICERS

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Therese Mead, DO, FACEP

PRESIDENT-ELECT
Michael Gratson, MD, MHSA, FACEP

TREASURER
Luke Saski, MD, FACEP

SECRETARY
Andrew Taylor, DO, FACEP

IMMEDIATE PAST PRESIDENT
Michael Fill, DO, FACEP

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Jeffrey McGowan, DO, FACEP
Diane Paratore, DO, FACEP
Ryan Reece, MD, NRP, FACEP
Brittany Garza, DO (candidate member)

EXECUTIVE DIRECTOR
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www.mcep.org

52nd Michigan EM Assembly
July 27-30, 2025
Grand Hotel

Dear Councillors:

It is with great pleasure that the Michigan College of Emergency Physicians (MCEP) and the ACEP American Association of Women Emergency Physicians (AAWEP) Section endorse Diana Nordlund, DO, JD, FACEP for the office of ACEP Board of Directors.

Dr. Nordlund has served with distinction as a member of MCEP's Board of Directors for the last six years. During her term as MCEP President, she worked tirelessly to shepherd the Chapter through changes in executive staff, taking on additional leadership duties during this turbulent time for our Chapter, such as leading the Executive Director Search Committee.

She has played an integral role in our advocacy efforts and legislative wins, serving as our Legislative Committee Chair since 2019. As current chair of our Leadership Development Task Force, she works tirelessly to cultivate the next generation of College leaders. Having graduated from the program herself (2015) she understands how important the leadership pipeline is to the future of the College and the specialty. Dr. Nordlund also regularly delivers content at MCEP educational events and is a highly sought-after speaker.

On the National Level, Dr. Nordlund currently chairs the Medical Legal Committee, is a member of the Steering, State Legislative and Regulatory, and National Chapter Relations Committees. She is a past chair of Council Reference Committee B and past co-chair of the Reproductive Health and Patient Safety Task Force. She also consistently delivers educational content at multiple national events, including Scientific Assembly, ED Director's Academy, and the Leadership and Advocacy Conference.

Dr. Nordlund, an AAWEP section member, actively engages and supports female members to serve on MCEP and ACEP committees and in other leadership roles. She remains a staunch advocate for women physicians and the empowerment of women.

In addition to her activities on the state and national level, Diana is an active clinician and knows the issues facing the working physicians. She is a tireless worker and excellent thinker. One of her many strengths rests in her ability to define the critical core of complex issues and build consensus from disparate groups. She is well-spoken, astute in the area of media relations and will represent the College extremely well.

Dr. Nordlund's legal background would also be an asset to the ACEP Board of Directors. Dr. Nordlund possesses all the skills necessary to lead the College at the national level.

I respectfully ask that you join our Chapter and the American Association of Women Emergency Physicians Section in supporting the nomination of Diana Nordlund, DO, JD, FACEP for the office of Board of Directors of the American College of Emergency Physicians.

Regards,

Therese Mead, DO, FACEP
President, MCEP

Alecia Gende, DO, CAQSM, FACEP
Chair, ACEP AAWEP Section

Diana B. Nordlund, DO, JD, FACEP

Vision Statement – ACEP Board of Directors Candidate

I believe that Emergency Physicians will change the face of medicine – again. Decades ago, we united to be recognized as a specialty. Now, our grit, determination, and innovation are essential to evolving today's model of emergency care. Emergency Physicians must remain autonomous, preserving the primacy of physician-led medical decision-making and the patient-physician relationship. Interference by corporate practices and other influences which would compromise these essential priorities must be eliminated. Efficiencies that protect physician cognitive bandwidth, engagement, resilience, and vision must be incorporated. In this way, EPs will once again lead healthcare to a model that is sustainable, rewarding, and effective.

I stand for empowering EPs. This includes:

- Legal protections such as
  Equitable due process and contracting practices;
  Appropriate independent contractor classification;
  Eliminating criminal liability for delivering the standard of care;
  Protecting physician decision-making from interference; and
  Codifying physician-led care;
- Ensuring EP's voices are heard and priorities valued in the corporate setting;
- Reimbursement and practice environments that attract high-quality clinicians; and
- A strong and vital ACEP.

To these priorities, I bring medical, legal, management, leadership, and advocacy expertise. With 14 years of EM practice in settings that include urban, rural, and academic environments in both independent and large managed-group practices, I have first-hand experience with how different the resources and challenges can be in these varied environments. I understand that one size does not fit all and that ACEP serves physicians who practice and lead in all of these settings.

As a licensed attorney with practice experience in physician contracts and medical malpractice defense, I understand how physician quality of life is affected by these legal principles. I can interpret and apply legal language and deftly advocate for effective protections. As a Corporate Compliance Officer for two different independent physician groups over the course of my career, I continue to manage the impact of regulations on the practice of medicine, educate physicians, and balance risk.

My years of experience in MCEP and ACEP include MCEP Past President and State Legislative Committee Chair, ACEP Medical Legal Committee Chair, Council Reference Committee B Chair, and EM Reproductive Health and Patient Safety Task Force Co-Chair; national committees served include the Council Steering Committee, State Legislative/Regulatory Committee, and National/Chapter Relations Committee, With this experience, I know how our College works and understand the utmost importance of communication and relationships. Synergy of our membership's incredible depth of expertise, talent, and determination, both at the national and state level, is integral to our success as an organization.

As physicians, we have a unique privilege to directly impact our patients' quality of life. To empower ACEP members, we must protect the quality of the practice environment and physician autonomy. Drawing on my time in the trenches – both medical and legal – I believe that robust debate broadens our understanding of critical issues. Through collaborative discussion, we become better positioned to develop and implement solutions. When we prioritize communication and collegiality, we make the most of our resources and can focus them on key issues that have the most meaningful impact.

As a member of your Board of Directors, I will listen. I will consider how each issue affects you and the frontline delivery of emergency medicine. I will actively incorporate new knowledge and viewpoints and will not back down from the challenges that we face together.

I stand to protect the interests of Emergency Physicians and ACEP members.

I stand for a strong and vital ACEP that facilitates the best possible practice environment for you.

YOUR VOTE
FOR BOARD OF DIRECTORS

Diana Nordlund, DO, JD, FACEP

Immediate Past President, MCEP
Chair, Medical Legal Committee, ACEP
Chair, State Legislative Committee, MCEP
Compliance Officer, Emergency Care Specialists, PC

Contact Information & CV:

What I Bring to the Board:

Legal Expertise

Licensed Attorney
Practice in
Malpractice Defense
Physician Contracts

Leader's Vision

Listen
See the Whole Picture
Build Consensus
Act Decisively

Clinical Experience

Full-time Clinician at ECS
Physician-Owned/Independent
Tertiary
Suburban
Rural

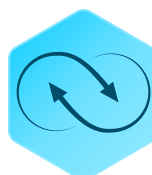
Fierce Belief

Physician Autonomy
Direct Advocacy
Strength in Community

What I Stand For:

Trust

Shared Values
Communication
Collaboration



Synergy

Chapter Innovation
National Resources
Strategic Relationships

Results

Better Laws
Better Working Conditions
Better Medicine

Proudly Endorsed By:

DIANA B NORDLUND, DO, JD, FACEP

7707 Austinridge Dr SE • Caledonia, MI 49316 • 616.291.4283 • diana.nordlund@gmail.com

EDUCATION & TRAINING

Juris Doctor, May 2012; GPA 3.89, Class Rank 7/519
Thomas M. Cooley Law School, Grand Rapids, MI, January 2008-May 2012

- Certificates of Merit (First in Class):
  - Contracts I and II, Torts I, Property I, Criminal Procedure, Scholarly Writing, Pretrial Skills, Medical Malpractice, Advanced Writing
- Teaching Assistant, Medical Malpractice, Fall 2011
- Legal Extern, Medical Malpractice, Smith Haughey Rice & Roegge, Fall 2011
- Legal Extern, Spectrum Health System, Grand Rapids, MI, Summer 2011
- Grand Rapids Higher Education Network (GRAHEN)
  - Outstanding Adult Learner Award, 2011
- Thomas M. Cooley Law School Negotiation Competition Finalist, 2010
- Thomas M. Cooley Law Review, Senior Associate Editor, 2010
- Women Lawyers Association of Michigan Foundation Scholar, 2009
- Sol Siegel Memorial Award Recipient, 2008
- Shane Joseph Johnson Memorial Scholarship Recipient, 2008
- Thomas M. Cooley Law School Honors Scholarship Recipient, 2008-2012

Emergency Medicine Residency with Osteopathic Internship, June 2010
Metro Health Hospital, Grand Rapids, MI, July 2006-June 2010

- Casselman Award for Best Scientific Paper:
  - *Medical Futility: Ethics, the End of Life, and the Elephant in the Room*
- Graduate Medical Education Committee Member
- Institutional Review Board Member

Doctor of Osteopathic Medicine, May 2006; GPA 87.89/100
Kirksville College of Osteopathic Medicine, Kirksville, MO, August 2002-May 2006

- Vice-President, American Undergraduate Academy of Osteopathy, 2003-2004
- Sigma Sigma Phi Honor and Service Society Member, 2002-2004
- Still-Bright Award Recipient, 2002
- Leadership & Service Award Recipient, 2002
- Student Ambassador, 2002-2004
- Liaison to Gross Anatomy Faculty, 2002

Master of Music, January 2000; GPA 3.83
University of Illinois at Urbana-Champaign, Urbana, IL

- Graduate Teaching Assistant and Scholarship Recipient, 1998-1999

Bachelor of Music, August 1998; GPA 3.88
Western Michigan University, Kalamazoo, MI

- International Scholar, *American Institute of Musical Studies*, Austria, 1998
- Study Abroad Scholar, *L'Université Catholique de Lyon*, France, 1997
- Presidential Scholarship Recipient, 1994-1998
- National Merit Scholar, 1994-1998

DIANA B NORDLUND, DO, JD, FACEP

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PROFESSIONAL PRACTICE

Emergency Department Attending Physician

- Emergency Care Specialists, PC, Grand Rapids, MI, August 2017-present
- Emergency Medical Associates, PLLC
  Sparrow Health System, Lansing, MI, April 2013-August 2017
- Emergency Physicians Medical Group, PC
  Lakeland Health Care, Saint Joseph, MI, July 2010-April 2013

Attorney/Partner, Nordlund | Hulverson, PLLC, Grand Rapids, MI, Jan 2018-Mar 2023
Associate Attorney, Henn Lesperance, PLC, Grand Rapids, MI, January 2014-Sept 2016
Emergency Department Physician, Hayes Green Beach Hospital, Charlotte, MI, 2010
Urgent Care Physician, Spectrum Health System, Grand Rapids, MI, 2008-2009

ACADEMIC APPOINTMENTS

Assistant Clinical Professor, September 2016-present

- Michigan State University College of Human Medicine – Grand Rapids, MI
- Central Michigan University College of Medicine – Mount Pleasant, MI (2018)

Assistant Clinical Professor, Core Faculty, March 2015-June 2017

- Michigan State University – Lansing, Emergency Medicine Residency

Assistant Professor, Campbell University, August 2014-July 2015

- Jerry M. Wallace School of Osteopathic Medicine, Lillington, NC

Adjunct Faculty, Michigan State University, East Lansing, MI, 2007-2015

SPECIAL RECOGNITION

Outstanding Contributions to Emergency Medicine Education Award Recipient
University of Maryland Emergency Medicine Residency Program, March 2020
(Deferred due to COVID-19; awarded in March 2023)

PROFESSIONAL ACTIVITIES

Leadership Roles and Activities

Chair, Reference Committee B, ACEP, 2023 Council Meeting
President, MCEP Executive Leadership, July 2022-Aug 2023
Chair, Medical Legal Committee, ACEP, October 2022-present
Co-chair, EM Reproductive Health and Patient Safety Task Force, July 2022-2023
Chair, Leadership Development Task Force, MCEP, September 2021-present
President-Elect, MCEP Executive Leadership, July 2021-July 2022
Teller, ACEP Council Tellers Committee, 2021
Treasurer, MCEP Executive Leadership, July 2020-2021
Secretary, MCEP Executive Leadership, July 2019-2020
Chair, State Legislative Committee, MCEP, July 2019-present
Corporate Compliance Officer, Emergency Care Specialists, Mar 2019-present
Deputy Compliance Officer, Emergency Care Specialists, Sept 2017-Feb 2018
Vice Chair, State Legislative Committee, MCEP, September 2016-July 2019
Board Member, Michigan College of Emergency Physicians, August 2016-present
Councillor, American College of Emergency Physicians, October 2018-present
Alternate Councillor, American College of Emergency Physicians**,** October 2015, 2017
Fellow, American Academy of Emergency Medicine, November 2017-present
Fellow, American College of Emergency Physicians, January 2015-present
Corporate Compliance Officer, Emergency Medical Associates, Jan 2014-Aug 2017

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PROFESSIONAL ACTIVITIES (continued)

Invited Faculty

- ACEP, Scientific Assembly, Philadelphia, PA, October 2023
- MCEP, Scientific Assembly, Mackinac Island, MI, July 2023
- MCEP, Winter Symposium, Boyne Mountain, MI, February 2023
- ACEP, ED Director's Academy, Dallas, TX, November 2022
- ACEP, Scientific Assembly, San Francisco, CA, September 2022
- MCEP, Scientific Assembly. Mackinac Island, MI, July 2022
- ACEP, ED Director's Academy, Virtual, May 2022
- MCEP, Winter Symposium, Boyne Mountain, MI, February 2022
- ACEP, Scientific Assembly, Boston, MA, Oct 2021
- MCEP, Scientific Assembly, Traverse City, MI, Jul 2021
- Statewide Campus System, Lansing, MI, Jun 2021
- CMU, Medical Student Wellness Grand Rounds, Virtual, Feb 2021
- Risk Mgmt Conference, Emerg Resources Grp, Jacksonville, FL, Feb 2020
- Symposia Medicus, Hot Topics in Urgent & Emergent Care, NYC, Dec 2019
- Grand Rounds, FL Atlantic Univ, Schmidt College of Medicine, Nov 2019
- ACEP, Scientific Assembly, Denver, CO, Oct 2019
- MCEP, Scientific Assembly, Mackinac Island, July 2019
- ACEP, BalancED, Ojai, CA, February 2019
- MCEP, Winter Symposium, Boyne Mountain, MI, Jan 2019
- MI Primary Care Consortium Advanced Care Planning Conference, Oct 2018
- ACEP, Scientific Assembly, San Diego, CA, Sept 2018
- MCEP, Scientific Assembly, Mackinac Island, MI, Jul 2018
- Statewide Campus System, Grand Rapids, MI, Jun 2018
- AAEM, Scientific Assembly, San Diego, CA, April 2018
- MCEP, Winter Symposium, Boyne Mountain, MI, Jan 2018
- ACEP, Scientific Assembly, Washington DC, Oct 2017
- MI Primary Care Consortium Advanced Care Planning Conference, Oct 2017
- Michigan Academy of Physician Assistants, Fall Conference, MI, Oct 2017
- MCEP, Scientific Assembly, Mackinac Island, MI, Aug 2017
- MD ACEP, Annual Conference, Baltimore, MD, Mar 2017
- MCEP, Winter Symposium, Boyne Mountain, MI, Jan 2017
- MCEP, ED Director's Course, Howell, MI, August 2016
- MCEP, Scientific Assembly, Mackinac Island, MI, Jul 2016
- Henry Ford Health Systems APP Spring Dinner, May 2016
- Michigan Dermatology Physician Assistants, Annual Conference, Apr 2016
- Michigan Society of Healthcare Risk Management, Spring Program, Mar 2016
- South Haven Health System, Medical Staff In-service, Feb 2016
- MCEP, Winter Symposium, Boyne Mountain, MI, Jan 2016
- Spectrum Health Pennock, Medical Staff Keynote, Hastings, MI, Jan 2016
- MCEP, Business Development of Expert Witnessing, Nov 2015
- Cooley Law School, Medical Malpractice Panel Moderator, MI, Nov 2015
- ACEP, Scientific Assembly, Boston, MA, Oct 2015
- Michigan Academy of Physician Assistants, Fall Conference, MI, Oct 2015
- Cooley Law School, Medical Malpractice Course, Sept and Oct 2015

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PROFESSIONAL ACTIVITIES (continued)

- Western Michigan University School of Medicine, Grand Rounds, MI, Aug 2015
- MCEP, Scientific Assembly, Mackinac Island, MI, Jul 2015
- Spectrum Health Pennock, Grand Rounds, Hastings, MI, Jun 2015
- MAPA, Spring Conference, Troy, MI, Mar 2015
- Munson Medical Center, Grand Rounds, Traverse City, MI, Feb 2015
- MCEP, Winter Symposium, Boyne Mountain, MI, Feb 2015
- MCEP, Business Development of Expert Witnessing, Lansing, MI, Nov 2014
- ACEP, Scientific Assembly, Chicago, IL, Oct 2014
- MCEP, Scientific Assembly, Mackinac Island, MI, Jul 2014
- Campbell University, Wallace School of Medicine, Lillington, NC, Aug 2014
- Michigan State University, East Lansing, MI, Apr 2014 and Nov 2013
- Delta Township Fire Department, Lansing, MI, Apr and May 2014
- Central Michigan University, Grand Rounds, Saginaw, MI, Nov 2013
- Spectrum Health System, Informed Consent In-service/Panel, Jul 2011

Leadership Training

Physician Leadership Academy, Sparrow Health System, Lansing, MI, 2016
Emergency Department Director's Academy, Phase I, ACEP, Dallas, TX, Feb 2016
Leadership Development Program, Michigan College of Emergency Physicians, 2015

DIANA B NORDLUND, DO, JD, FACEP

7707 Austinridge Dr SE • Caledonia, MI 49316 • 616.291.4283 • diana.nordlund@gmail.com

COMMITTEE, WORKGROUP & TASK FORCE APPOINTMENTS

Reference Committee B, ACEP Council, 2022-23
- Chair, 2023
- Member, 2022

EM Reproductive Health and Patient Safety Task Force, ACEP, 2022
- Co-Chair

Leadership Development Task Force, Michigan College of Emergency Physicians
- Chair, September 2021-present

Governor's COVID-19 Re-Opening Advisory Workgrp, Behavioral Health, May 2020
Governor's COVID-19 Physician Task Force (with MSMS), May 2020
Tellers Committee, American College of Emergency Physicians (ACEP), 2020-2022
State Legislative and Regulatory Committee, ACEP, 2020-present
- Subcommittee Chair, 2021

State Legislative Committee, Michigan College of Emergency Physicians, 2015-present
- Chair, July 2019-present
- Vice Chair, September 2016-July 2019

Medical-Legal Committee, ACEP, 2011-present
- Chair, 2022-present
- Subcommittee Chair, 2015, 2021

Quality Committee, Michigan College of Emergency Physicians, 2016
Ethics Committee, Sparrow Health System, 2015-2016
Payor & Finance Committee, Sparrow Health System, 2014-July 2017

PUBLICATIONS

Fear Not: Utilizing Simulation for Medical Malpractice Education [abst 473].
- Hughes KE, Cahir TM, Nordlund D, Hughes PG.
  Academic Emergency Medicine. 2021;28(Suppl. 1):S230.

The Fourth Amendment: Coming to an ED Near You
- 29 ED LEGAL LETTER 3, March 2018

The Opioid Minefield
- 29 ED LEGAL LETTER 1, January 2018

On the Radar: MI-POST Legislation
- 37 MCEP NEWS & VIEWS 5, Sept/Oct 2017

"Emergency Department Documentation"
- Chapter 95, STRAUSS & MAYER'S EMERGENCY DEPARTMENT MANAGEMENT, McGraw-Hill Education, with Charles Grassie, MD, JD, FACEP

Beyond the Form: Talking Points on Informed Consent
- 32 ACEP NEWS 12, March 2013, with Andrew Koslow, MD, JD

Know your Medical Liability Policy
- 31 ACEP NEWS 26, December 2012, with Andrew Koslow, MD, JD

With the Chart as My Witness
- 31 ACEP NEWS 25, June 2012, with Andrew Koslow, MD, JD

Form Reform: Documenting Emergency Department Informed Consent
- 12 T. M. COOLEY J. PRAC. & CLIN. L. 415, Trinity Term 2010

DIANA B NORDLUND, DO, JD, FACEP
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PRESENTATIONS INCLUDE:

National and State-level:

American Academy of Emergency Medicine (AAEM):

Medicine and the Law: Case Illustrations
AAEM Scientific Assembly, April 2018

American College of Emergency Physicians (ACEP):

Uncharted Waters: Navigating Post-Roe Practice
Colin C. Rorrie, Jr. Lecture
Co-presented with Alison Haddock, MD, FACEP
EMTALA from the Trenches
ACEP Scientific Assembly, October 2022
Liability Concerns and Controversies: Working with Non-Physician Providers
ACEP Scientific Assembly, October 2022
Tort Hot, Tort Cold: Would Goldilocks Practice EM in Your State?
ACEP Scientific Assembly, October 2020, 2021, 2022
Opening Pandora's Box: The National Practitioner Databank
ACEP Scientific Assembly, October 2021, 2022
Litigation Stress
ED Director's Academy, 2021, 2022, 2023
Surviving a Lawsuit
ACEP Scientific Assembly, October 2019, 2020
The Subtle Art of Falling Apart
ACEP BalancED, February 2019
Rejecting Perfection: Finding Self Awareness and Peace
ACEP BalancED, February 2019
How Did I Get Here? Recognizing and Overcoming Hidden Abuse
ACEP BalancED, February 2019
Chart Beyond the Note: The Cost of Cutting, Pasting, and Addending
ACEP Scientific Assembly, September 2018, October 2019
Divorce, Depression, and Loss: How to Keep Going When It All Falls Apart
ACEP Scientific Assembly, September 2018
Black-Box Drugs We Still Use: What's the Risk?
ACEP Scientific Assembly, October 2017
Double Jeopardy: Risk in Cardiology
Co-presented with William J. Brady, MD, FACEP
ACEP Scientific Assembly, October 2017
GOTCHA! The Medical Chart: Anticipating the Lawyer's Review
ACEP Scientific Assembly, October 2014, 2015, 2017, 2018, 2019, 2020, 2021

Michigan College of Emergency Physicians (MCEP):

Law + Medicine: When the Numbers Don't Add Up
Michigan Emergency Medicine Scientific Assembly, July 2023
Stairway to Heaven: The Med-Legal 411
Michigan Emergency Medicine Winter Symposium, January 2022
Trial By Fire: A Medical Legal Discussion
Michigan Emergency Medicine Scientific Assembly, July 2022
Medical Legal Update
Michigan Emergency Medicine Scientific Assembly, July 2021
Medical Legal Update
Co-presented with Greg Henry, MD, FACEP
Michigan Emergency Medicine Scientific Assembly, July 2019
Physician, Heal Thyself: The Law, Your Health, and Your License
Michigan Emergency Medicine Winter Symposium, January 2019
Medical Legal Update
Co-presented with Greg Henry, MD, FACEP
Michigan Emergency Medicine Scientific Assembly, August 2018
Legal Landmines
Michigan Emergency Medicine Winter Symposium, January 2018
Medical Legal Update
Co-presented with Greg Henry, MD, FACEP
Michigan Emergency Medicine Scientific Assembly, August 2017
Legal Landmines
Michigan Emergency Medicine Winter Symposium, January 2017
Legal Landmines
ED Leadership and Management Course, MCEP, August 2016
Legal Update: Navigating High-Risk Waters
Co-presented with Greg Henry, MD, FACEP
Michigan Emergency Medicine Scientific Assembly, August 2016
Subpoenas and You: What can they make you do?
Michigan Emergency Medicine Scientific Assembly, August 2016
Collision Course: Law vs Real Life
Michigan Emergency Medicine Winter Symposium, January 2016
Medical-Legal Workshop: Charting in High-Risk Waters
Co-presented with Greg Henry, MD, FACEP
Michigan Emergency Medicine Scientific Assembly, July 2014, 2015
EMTALA Survival Guide
Michigan Emergency Medicine Winter Symposium, February 2015
How to Review a Case
Business Development of Expert Witnessing Course, November, 2014, 2015
Expert Panel Session
Co-panelists: Kathleen Cowling, DO, FACEP; Bradford Walters, MD, FACEP
Michigan Emergency Medicine Scientific Assembly, July 2014

Maryland College of Emergency Physicians (MD ACEP):

Legal Landmines!
MD ACEP Annual Conference, March 2017

Statewide Campus System (Michigan State University College of Osteopathic Medicine):

Surviving the Medico-Legal Jungle: What you don't know might eat you
Full session, June 2018

Michigan Society of Healthcare Risk Management (MSHRM):

Who's on First? Multiple Providers in a New Age
Spring Program, March 2016
ED Gone Wild: Reducing Risk When Working with Psychiatric Patients
Spring Program, March 2016

Michigan Primary Care Consortium:

Grey Areas of ACP: When Medicine and the Law Collide
Advance Care Planning Conference, October 2018
It Doesn't Need to Be an Emergency: How ACP Can Augment Care in the ED
Co-presented with Ken Johnson, MD, FACEP, and Greg Mervenne, MD
Advance Care Planning Conference, October 2017

Regional and Local-level:

EMTALA for Experts: The Good, the Bad, and the Onerous, January 2023
Ronald L Krome Lecture Series, Wayne State University School of Medicine
EMTALA for Regional Sites: What You Need To Know
Compliance Highlights
Medical Negligence: A Real-World Perspective (Panel Moderator)
Informed Consent: The Good, The Bad, and the Evidence
EMTALA Survival Guide
EMTALA for Experts
Senior Boot Camp: How to Beat a Lawyer 411
Chart Smart: How to Document Like a Pro
Effective Documentation: Create the chart that you deserve.
Documentation: Why you should care and what to do about it
Medical Jurisprudence 101: What you don't know can hurt you.
The Devil is in the Details: How documentation can make or break you
Murder by Numbers: Med Legal 101
Informed Consent: What it is and why we need it

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OTHER SERVICE

Clinic Manager, Christian Community Clinic, Kirksville, MO, 2003-2004

- Managed a volunteer clinic providing medical care for an underserved population

Founder, *Cozy Kitchen Cabaret*, Lansing, MI 2000-2002

- Produced and performed two original musical reviews to benefit local charities

BOARD CERTIFICATION

American Osteopathic Board of Emergency Medicine, January 2013 and 2023

ASSOCIATIONS

American Bar Association (ABA)
American College of Emergency Physicians (ACEP)
Grand Rapids Bar Association (GRBA)
Michigan College of Emergency Physicians (MCEP)
Michigan State Medical Society (MSMS)
Michigan Society of Healthcare Risk Management (MSHRM)
State Bar of Michigan (SBA): Admitted to practice law in the state of Michigan in 2012

References available upon request

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Bing S. Pao, MD, FACEP

***Question #1:* What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

The ACEP Board of Directors is more successful when there is a diverse Board with unique backgrounds, skills, and abilities. I have several skills that can complement the current ACEP Board. For example, I have expertise in emergency physician practice management, emergency medicine financing and reimbursement. I also have a track record of leadership within emergency medicine and beyond. Additionally, I have demonstrated the ability to successfully advocate for emergency physicians.

My first unique quality is a deep understanding of emergency medicine financing and practice management. As a senior director for a multi-site physician owned partnership, I understand how emergency physician practices and individual emergency physicians are reimbursed. I also understand the costs and challenges associated with running a physician practice. I negotiate contracts with health insurance companies and when there are problems with payment, I am experienced with disputing payments and advocating to regulators. I have a good understanding of what is required for successful litigation against health insurance companies. As emergency physicians continue to face payment denials and unfair payment practices by health insurers, my expertise in reimbursement will help ACEP fight for fair reimbursement throughout the country.

Second, I offer a diverse leadership experience. My participation in multiple local, state, and national medical organizations has resulted in opportunities to serve on several boards including the San Diego County Medical Society, California Chapter of the American College of Emergency Physicians (CAL/ACEP), Emergency Department Practice Management Association (EDPMA), and Physicians for Fair Coverage (PFC) a non-profit physician advocacy coalition. I have chaired multiple committees such as the California Medical Association (CMA) Hospital Based Practice Forum, CAL/ACEP Reimbursement Committee, and the EDPMA State Regulatory and Insurance Committee. I have led organizations as the president of the California Emergency Medicine Residency Association and as Chair of the Board for the Emergency Department Practice Management Association, the national trade association for emergency medicine. I believe my leadership skills can help guide the direction of ACEP and represent the interests of ACEP members.

Third, through my participation in various medical societies, I have accumulated the necessary skills for effective advocacy. I have served on numerous reference committees for state and national medical societies such as ACEP, CMA, and the American Medical Association (AMA). I have also served on multiple committees and task forces for specialty, state, and national medical societies. My experiences have resulted in an expansive knowledge of health care policy that can be used to develop strategic goals and tactics for advocacy. By aligning organizational health policies, I have helped coalitions advocate more effectively. I have experience building relationships with stakeholders, including policymakers, healthcare organizations, and business leaders for successful advocacy. Examples of my successful advocacy efforts include implementing a payment standard in Oregon's balance billing legislation, allowing batching of out-of-network claims in the Illinois dispute process, eliminating Veteran Affairs emergency professional claim denials, reversing Medicaid policy in Kansas to reduce payment, introducing legislation to hold health plans responsible for the patient cost share and many others. Additionally, I chair a political action committee to support physician champions elected to public office. These are just a few examples of how I can promote the interests of emergency physicians and advance the mission of ACEP.

***Question #2:* What strategic priorities should ACEP pursue to maintain itself as the home for all emergency physicians!**

There are three strategic priorities that ACEP should focus on in the interest of all emergency physicians. The first priority is producing a better work environment for emergency physicians and preventing moral injury. Emergency physicians face high workload and stress, long and irregular hours, lack of autonomy, interpersonal conflict, limited resources, and work-life imbalance. Inefficient emergency department care is compromising patient safety and quality of care resulting in moral injury for emergency physicians. As a practicing emergency physician, I have personally experienced how working in an understaffed, overcrowded and under-resourced emergency department can lead to moral injury. Emergency physicians need to take control of our working conditions while maintaining job security. An increasing number of ACEP members are becoming interested in unionization. The interest in unionization is directly related to emergency physicians losing autonomy and feeling

helpless trying to change their work environment. Promoting democratic physician owned practices can also help ACEP members improve job satisfaction. Improving work conditions may require ACEP to evaluate regulatory or legislative solutions to institute systemic changes to emergency department health care delivery.

The second priority is to ensure that emergency physicians receive fair payment. Without fair payment, emergency departments will not be able to adequately staff emergency departments and provide timely access to high-quality emergency care. The formula for the Medicare physician fee schedule must adjust for inflation and cover the cost of providing emergency professional services. There must be a mechanism for emergency physicians to negotiate fair rates with commercial insurers. Emergency physicians must be able to retain the ability to pursue a private right of action if a commercial insurer is not paying fairly. Commercial insurers must not be allowed to underpay emergency physicians because of EMTALA. Commercial insurers continue to deny, delay or reduce payment and ACEP should continue to advocate for fair payment and, if necessary, support litigation. ACEP can assist emergency physicians with litigation by consolidating plaintiffs/claims and help with raising funds for litigation. Professional societies have successfully litigated on behalf of members, but it takes time and resources. ACEP should continue to advocate for states to increase Medicaid rates for all providers or selectively for emergency care. ACEP should continue to differentiate emergency physicians from other specialties and provide the resources for state chapters to effectively advocate for fair reimbursement.

The third strategic priority is to increase ACEP membership. ACEP needs to make a greater investment in marketing the value of ACEP membership. ACEP can demonstrate the value of membership with targeted marketing and outreach to potential members. ACEP should continue to solicit feedback from younger members to understand their needs, preferences, and challenges. ACEP can use this feedback to continuously improve membership offerings, communication strategies, and member engagement initiatives.

***Question #3:* What innovative strategies would you use to recruit and retain membership?**

Increasing membership involves a strategic approach that focuses on attracting new members while also retaining current ones. Here are several strategies the College could consider:

1. **Targeted Outreach:** Tailor outreach efforts to residents, young emergency physicians, and recent graduates. Additionally, ACEP should perform a gap analysis by soliciting feedback from current and prospective members to understand their needs, preferences, and challenges. Use this feedback to continuously improve membership offerings, communication strategies, and member engagement initiatives. ACEP needs to effectively communicate with **non-members** on how ACEP membership can benefit individual emergency physicians. Highlight the value of membership, such as access to educational resources like board preparation material, networking opportunities, advocacy successes and professional development. Illustrate how ACEP membership can (1) improve reimbursement (2) protect emergency physicians' rights, for example, banning non-competes and preserving due process (3) help advocacy efforts to reduce overcrowding (4) provide advocacy and leadership training (5) teach practice management skills (6) allow members to participate in research, and (7) assist with career development. Consider direct outreach through phone calls, texts, e-mails or social media. Offer new members incentives, including credit or free subscriptions to educational material like ACEP Anywhere and/or registration to ACEP sponsored conferences. As a condition of the incentive offer, prospective members could be required to meet with Officers, Board Members and/or ACEP staff at ACEP sponsored meeting to talk about the benefits of membership. In-person marketing is a proven method for convincing prospective members to join.
2. **Referral Program:** Allow current members to receive discounts or benefits when referring prospective members or emergency physician groups that eventually join ACEP. The referral program could allow a member to bring a friend for free or at a discount to an ACEP sponsored event. By attending networking events, conferences, and regional meetings, prospective members will have the opportunity to connect with other emergency physicians, share best practices, and collaborate on research or quality improvement projects. Emergency physicians that seek a network of colleagues may be inclined to join ACEP.
3. **Member Benefits and Discounts:** Offer a range of member benefits, such as discounts on conferences, publications, and educational resources to new members. Group discounts could also include packages that include advertisement or registration at ACEP sponsored events. ACEP should also consider offering new members more free benefits or discounts for multi-year memberships.

By implementing a combination of these strategies, the College could effectively increase membership and strengthen its community of emergency medicine professionals.

American College of Emergency Physicians®
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CANDIDATE DATA SHEET

Bing S. Pao, MD, FACEP

Contact Information

P.O. Box 5000 PMB 205
Rancho Santa Fe, CA 92067
Phone: 858-922-9165
E-Mail: bingshihpao@gmail.com

Current and Past Professional Position(s)
Pinnacle Emergency Physicians - employee
Acute Care Specialists – independent contractor
Vituity – General Partner and Senior Director of Provider Relations
Assistant Clinical Professor, University of California at San Diego
Clinical Faculty, University of California at Riverside

Education (include internships and residency information)

Bachelor of Science in Biology, University of North Carolina at Chapel Hill, Graduated December 31st, 1987
Doctor of Medicine, Duke University, Graduated May 17, 1992
Internal Medicine Internship, University of Colorado Health Science Center, Completed June 2, 1993
Emergency Medicine Residency, University of California San Diego, Completed June 1, 1996

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM Certified November 20, 1998, Recertified January 1, 2009 & January 1, 2019

Professional Societies
American College of Emergency Physicians
California Chapter of the American College of Emergency Physicians
California Medical Association
San Diego County Medical Society
American Medical Association
Emergency Department Practice Management Association

National ACEP Activities – List your most significant accomplishments
ACEP Alternative Payment Model Task Force
ACEP Group Ownership Task Force
ACEP Accreditation Task Force
ACEP Balance Billing Task Force
ACEP Council Delegate & Reference Committee Member
ACEP Reimbursement Committee
ACEP Steering Committee

ACEP Chapter Activities – List your most significant accomplishments
California Chapter of the American College of Emergency Physicians, Chair Reimbursement Committee
California Chapter of the American College of Emergency Physicians, Government Affairs Committee
California Chapter of the American College of Emergency Physicians, Board of Directors

California Chapter American College of Emergency Physicians Distinguished Service Award
California Chapter American College of Emergency Physicians House of Medicine Award
California Chapter American College of Emergency Physicians Special Recognition Award

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 **0** % Teaching **5** % Administration **55** %

Other: ____________________ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I currently work for Vituity, a national multi-specialty/hospital physician partnership. Clinically, I work in the emergency department at Moreno Valley Hospital in California.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Senior Director of Provider Relations, Vituity

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert N/A Cases **Plaintiff Expert N/A Cases**

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Bing S. Pao, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Vituity

Address: 2100 Powell Street Suite 400

Emeryville, CA 94608

Position Held: Senior Director of Provider Relations

Type of Organization: Physician Partnership

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Emergency Department Practice Management Association

Address: 1660 International Drive Suite 600

McLean, VA 22102

Type of Organization: Trade Association

Leadership Position: Past Chairman of the Board, Board Member and Chair of the State Regulatory and Insurance Committee.

Term of Service: 2015-Current

Organization: California Medical Association

Address: 1201 K Street, suite #800

Sacramento, CA 95814

Type of Organization: Professional Medical Society

Leadership Position: Past Chair - Hospital Based Practice Forum, Delegate, Member of Committee on Medical Services

Term of Service: 2009-Present

Organization: San Diego County Medical Society

Address: 8690 Aero Drive, Suite 115-220

San Diego, CA 92123

Type of Organization: Professional Medical Society

Leadership Position: Board of Directors & Finance Committee

Term of Service: 2021-Present

Organization: American Medical Association

Address: 330 N. Wabash Ave., Suite 39300

Chicago, IL 60611-5885

Type of Organization: Professional Medical Association

Leadership Position: Alternate Delegate

Term of Service: 2021-Present

Organization: California Chapter of the American College of Emergency Physicians

Address: 1121 L Steet, Suite 401

Sacramento, CA 95814

Type of Organization: Professional Medical Society

Leadership Position: Past Board Member and Chair of the Reimbursement Committee

Term of Service: 2009-2012

Organization: California Emergency Medicine Residency Association

Address: 1121 L Steet, Suite 401

Sacramento, CA 95814

Type of Organization: Professional Medical Association

Leadership Position: Past President, Secretary/Treasurer

Term of Service: 1994-1996

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Bing Pao Date May 27, 2024

Dear Colleagues:

We are pleased to give our enthusiastic endorsement to Bing Pao, MD, FACEP for ACEP Board of Directors and strongly urges your support of his candidacy.

Dr. Pao's career demonstrates his steadfast commitment to improve the practice of emergency medicine.

Dr. Pao is a past board member of the California Chapter and has served the Chapter with incredible enthusiasm and dedication in a variety of leadership roles since he served as CalEMRA President in 1995-96. Through his numerous accomplishments, many years of service, and diversity of clinical experience, Dr. Pao will bring a broad and knowledgeable perspective to the ACEP Board. Dr. Pao's expertise and ability to combat exploitative behavior by insurance companies are needed on the ACEP Board of Directors.

Dr. Pao is a tireless advocate for emergency physicians, with several decades of commitment at every level of organized medicine. In addition to being a past board member of the California Chapter and past Co-Chair of the Chapter's Reimbursement Committee, Dr. Pao is a past board member of his local medical society, a delegate to the California Medical Association (CMA) House of Delegates, and the Chair of the CMA Hospital Based Practice Forum.

At the Chapter, group, and national level, Dr. Pao has been a passionate advocate for emergency physicians receiving fair compensation. His advocacy on behalf of our members has led him to testify before legislators in support of fair payment. He is a sought-after billing and reimbursement expert, serving on the CMA MACRA Task Force, and the College's Alternative Payment Model Task Force and Group Ownership Task Force. He has served as Chair of the Emergency Department Practice Management Association (EDPMA), Chair of the EDPMA Political Action Committee, and Senior Director of Provider Relations for Vituity.

We have witnessed Dr. Pao's ability to digest the complicated minutia of reimbursement and billing and relentlessly advocate on behalf of the average emergency physician.

Dr. Pao's dedication to emergency medicine and unique reimbursement skill set is exactly what we need on the ACEP Board of Directors as insurance companies continue to exploit front line emergency physicians. The California Chapter is extremely proud to endorse and respectfully requests your support of Dr. Bing Pao for the ACEP Board of Directors.

Respectfully,

MIKE GERTZ, MD, FACEP
California Chapter President (2023-24)

SERGIO HERNANDEZ, MD, FACEP
Democratic Group Practice Section Chair

Bing S. Pao, MD, FACEP

Emergency physicians face high workloads and stress, long and irregular hours, lack of autonomy, interpersonal conflict, limited resources, and work-life imbalance. Inefficient emergency department operations compromise patient safety and quality of care resulting in moral injury for emergency physicians. As a practicing emergency physician, I have personally experienced how working in an understaffed, overcrowded, and under-resourced emergency department can lead to moral injury. To protect our patients and ensure sustainable rewarding careers, emergency physicians need to take control of our working conditions. ACEP can support emergency physicians by promoting physician autonomy and instituting regulatory/legislative solutions for systemic changes that will improve working conditions.

Emergency physicians deserve fair payment. Without fair payment, emergency departments will not be able to staff emergency departments with board certified emergency physicians. The formula for the Medicare physician fee schedule must be inflation adjusted. ACEP should continue to advocate for states to increase Medicaid rates for emergency care. ACEP must support a mechanism for emergency physicians to negotiate fair rates with commercial insurers. ACEP needs emergency physicians who are experienced at fighting unfair health insurer payment polices. A stronger ACEP can assist state chapters to effectively advocate for fair reimbursement.

ACEP needs to make a greater investment marketing the value of ACEP membership. ACEP can demonstrate the value of membership with targeted marketing and outreach to potential members. ACEP should continue to solicit feedback from younger members to understand their needs, preferences, and challenges. ACEP should use this feedback to continuously improve membership offerings, communication strategies, and member engagement initiatives.

What do I offer the ACEP Board?

As a senior director for a national multi-site, equitably, owned physician partnership, I have a deep understanding of emergency medicine financing and practice management. I understand how reimbursement impacts emergency physician compensation. I negotiate contracts with health insurance companies, and I am effective at disputing unfair payments by health insurers. I also understand what is required for successful litigation against health insurance companies. My expertise in reimbursement will help ACEP fight for fair reimbursement throughout the country.

Second, I bring a diverse leadership experience. I have served on multiple boards and chaired numerous committees for county, state, and national medical societies. I served on the California ACEP Board and chaired the Reimbursement Committee. I was appointed to the ACEP Alternative Payment Model, Ownership, and the Accreditation Task Forces. I currently sit on the ACEP Reimbursement Committee and recently termed off the Steering Committee. I served as the the Hospital-Based Practice Forum Chair for the California Medical Association (CMA). I have led organizations as the president of the California Emergency Medicine Residency Association and as Chair of the Board for the Emergency Department Management Assocation (EDPMA), the national trade association of emergency medicine. I believe my leadership skills will help guide the direction of ACEP and represent the interests of ACEP members.

I possess an expansive knowledge of health care policy that I will use to develop strategic goals and tactics for advocacy. I am effective at forming coalitions with different stakeholders to amplify ACEP's advocacy efforts. For example, I formed a coalition to successfully rescind Kansas Medicaid policy to reduce payment for emergency services. Another example is successfully advocating for provider relief funds during the covid-19 pandemic. As chair of a political action committee, I also understand how to bridge the gap between physicians and legislators for more effective advocacy. These are just a few ways of how I can promote the interests of emergency physicians and advance the mission of ACEP. Please vote for Bing Pao, M.D., FACEP for the ACEP Board of Directors!

VOTE FOR Bing Pao, MD, FACEP for ACEP Board of Directors

Seasoned Healthcare Leader

Expertise in Emergency Medicine Financing and Practice Management

- Senior Director for Vituity, a democratic physician-owned partnership with no private equity investment or debt.
- Extensive knowledge of physician reimbursement.
- Understands the challenges of running a physician practice.

Proven Leadership Experience

- Service on various boards, including the San Diego County Medical Society, California Chapter of ACEP, Emergency Department Practice Management Association (EDPMA), and Physicians for Fair Coverage.
- Leadership roles include President of the California Emergency Medicine Residency Association and Chair of the Board for EDPMA.
- Extensive experience in guiding local, state, and national organizations to represent the interests of emergency physicians.

Effective Advocacy Skills

- Advancing the agenda of emergency physicians through ACEP, California Medical Association, and the American Medical Association committees/task forces.
- Experience in developing strategic goals and tactics for advocacy.
- Successful advocacy efforts, including legislative changes and policy reversals benefiting emergency physicians.
- Forming coalitions to successfully advocate against health insurers.
- Creating a bridge to legislators as chair of a Political Action Committee.

Vision for ACEP

Improving the Emergency Physician Work Environment & Preventing Moral Injury

- Address high workload, long hours, inadequate staffing, and lack of autonomy for emergency physicians by developing standards.
- Promote democratic physician-owned practices to improve job satisfaction.
- Evaluate regulatory or legislative solutions to improve working conditions for emergency physicians.

Ensuring Fair Payment

- Advocate for a Medicare physician fee schedule that adjusts to inflation.
- Establish mechanisms for negotiating fair rates with commercial insurers.
- Support litigation to address unfair payment practices by commercial insurers.

Increasing ACEP Membership

- Invest in targeted marketing and outreach to demonstrate the value of ACEP to potential members.
- Solicit feedback from younger members to improve membership offerings and engagement.
- Demonstrate the value of ACEP membership through continuous improvement in value and effective communication strategies.

Vote for Bing Pao for ACEP Board of Directors for experienced leadership in emergency medicine!

Endorsed by the California Chapter of the American College of Emergency Physicians

LinkedIn Page

Bing S. Pao

858-922-9165 | bingshihpao@gmail.com | LinkedIn

Profile

Dedicated and seasoned Emergency Physician offering experience in collaborating with others to solve problems. Ability to build effective working relationships with internal and external members to accomplish organizational goals. Track record of success delivering desired results in fast-paced, dynamic environments. Achieved success functioning as liaison between administrators, staff members, external agencies, and other key stakeholders. Excellent political, analytical, and communication skills with high attention to detail. Proven history of strengthening compliance, improving processes, elevating performance, negotiating, resolving disputes and providing excellent customer service. A skilled communicator with the vision and insight necessary to be able to create and provide strategic decisions.

Professional Experience

Pinnacle Emergency Physicians • Forest Park, GA • 1996 – 1999

Vituity • Emeryville, CA • 1999 – Present

Acute Care Specialists • Encinitas, CA • 2000 – 2001

Flight Physician, Life Flight San Diego

Reviewer, Journal of Emergency Medicine

Reviewer, Western Journal of Emergency Medicine

Appointments

- Scientific Advisory Board, Stemedica Cell Technologies, Inc.
- Assistant Clinical Professor, Department of Emergency Medicine, University of California, San Diego
- Clinical Faculty, University of California Riverside
- Residency Coordinator, Palomar Hospital
- Billing and Reimbursement Director, Vituity, Palomar-Pomerado Hospital
- Assistant Medical Director, Palomar Hospital Emergency Department
- Medical Staff Executive Committee, Palomar Hospital
- Senior Director of Provider Relations, Vituity

Organizations & Societies

- ACEP Councilor & Fellow
- ACEP Reimbursement Committee
- ACEP Steering Committee
- ACEP Accreditation, Alternative Payment Model & Group Ownership Task Force
- AMA Alternate Delegate, 2021-present

- CAL/ACEP Board of Directors, 2009-2012
- CAL/ACEP Membership Committee
- CAL/ACEP Reimbursement Committee Co-Chair
- CAL/EMRA President, 1995-1996
- CAL/EMRA Secretary/Treasurer, 1994-1995
- California Medical Association, Chair Hospital Based Practice Forum
- California Medical Association, Delegate Hospital Based Physicians Forum
- California Medical Association Organized Medical Staff Section
- California Medical Association MACRA and Medicare Task Force
- Disaster Medical Assistance Team
- Emergency Department Practice Management Association (EDPMA) Board of Directors & Chair
- Emergency Department Practice Management Association State Regulatory and Insurance Committee Chair
- Physicians for Fair Coverage, Treasurer & Board of Directors
- Public Health Service Externship Program
- San Diego County Medical Society Board of Directors

Education & Certifications

EMERGENCY MEDICINE RESIDENCY, UNIVERSITY OF CALIFORNIA, SAN DIEGO
INTERNAL MEDICINE INTERNSHIP, UNIVERSITY OF COLORADO HEALTH SCIENCE CENTER, BOULDER, CO
MEDICAL SCHOOL, DUKE UNIVERSITY SCHOOL OF MEDICINE, DURHAM, NC
BACHELOR OF SCIENCE IN BIOLOGY, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, CHAPEL HILL, NC
BOARD CERTIFIED IN EMERGENCY MEDICINE
ADVANCED TRAUMA LIFE SUPPORT
ADVANCED CARDIAC LIFE SUPPORT
PEDIATRIC ADVANCED LIFE SUPPORT
CERTIFIED MEDICAL INSURANCE SPECIALIST
CERTIFIED MEDICAL CODER

Honors

- Phi Beta Kappa, University of North Carolina at Chapel Hill
- Graduated with Highest Distinction, University of North Carolina at Chapel Hill
- AED Premedical Honors Society
- SAEM Medical Student Award
- Mercy Air Resident of the Year
- San Diego Magazine “Top Doc” Award 2005, 2006
- Palomar-Pomerado Quality Champion Award, CMS Core Measures, Pneumonia, 2007

- Volunteer Hospital Association Physician Champion Award, 2009
- CAL/ACEP Special Recognition Award
- CAL/ACEP Chapter Service Award
- CAL/ACEP House of Medicine Award
- CEP America 2012 Distinguished Service Award
- Emergency Department Practice Management Association Committee Task Force Service Award
- Emergency Department Practice Management Association Leadership Service Award

Publications

- Pao B, Hayden S. Cerebral gas embolism resulting from inhalation of pressurized helium. Annals of Emergency Medicine. 1996, 28, 3: 363-366.
- Cerebral Gas Embolism From Pressurized Helium Inhalation. Presented at the Undersea and Hyperbaric Medical Society Scientific Meeting, 1994.
- Pao B, Pelvic inflammatory disease, The 5 Minute Emergency Medicine Consult, Baltimore: Lippincott, Williams & Wilkins, 1999:832-833.
- Pao B, Screening, Brief Intervention, and Referral for Treatment (SBIRT) in the Emergency Department, Lifeline. September 2011: 11.
- Pao B, How to Deal with Problem Payers, Lifeline. December 2010: 6-9.
- Pao B, Is this the End of Section 1011, Lifeline. September 2009: 11.
- Pao B, Payer Audits. Lifeline. January 2013: 8-12.
- Pao B, Riner M, and Chan T. Impact of the Balance Billing ban on California Emergency Providers. Western Journal of Emergency Medicine. 2014, 15(4): 518-522.
- Pao BS, Chan TC. Patient Cost Share for Emergency Physician Services During the COVID-19 Pandemic. J Emerg Med. 2022 Sep;63(3):420-425.

2024 ACEP COUNCIL AWARDS

Council Service Milestone Award

(Staff will identify all who qualify)

Purpose: To commemorate accumulated years of service as a Councillor or Alternate Councillor.

Award: The Award is a pin indicating years of service given at 5-year service intervals.

Criteria: Any member who has served as a Councillor or Alternate councillor. Recipients will be automatically recognized by ACEP staff via the Councillor database.

Presentation: The award is given to individuals at council registration. Recipients will be

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Council Meritorious Service Award

Thomas J Sugarman, MD, FACEP

Purpose: Presented to a member of the College who has served as a councillor for at least three years and who, in that capacity has made consistent contributions to the growth and maturation of the ACEP Council.

Criteria: The nominee must be an active, life or honorary member of the College, and must have served as a councillor for at least three years. he nominee's contributions to the Council should include, but are not limited to, one or more of the following: Steering Committee membership; reference committee participation; participation on other Council committees; resolution development and debate; longevity as a councillor; or service as a Council officer.

Council Horizon Award

Kelly E. Quinley, MD

Purpose: Presented to an individual within the first five years of council service who demonstrates outstanding contributions and participation in Council activities. The award is given as needed, not necessarily annually.

Criteria: The nominee should have made an outstanding contribution to the Council of important resolutions, significant contributions to Council discussions, etc.

Council Horizon Award

Sophia Spadafore, MD

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.

2024 ACEP COUNCIL AWARDS

Council Teamwork Award

Alexandra"Niki" Thran, MD, FACEP

Purpose: Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.

Criteria: Contributions to be recognized may include development of important resolutions, significant contributions to Council discussions, etc.

Council Teamwork Award

Katherine L. Staats, MD, FACEP

Purpose: Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.

Criteria: Contributions to be recognized may include development of important resolutions, significant contributions to Council discussions, etc.

Council Champion in Diversity & Inclusion Award

Nicholas F Vasquez, MD, FACEP

Purpose: The award celebrates and promotes diversity of experience and thought, the merit of inclusivity, and the value of equity. It is presented to a councillor, group of councillors, or component body that has demonstrated a sustained commitment to fostering a diversity of contributions and an environment of inclusivity that directly enhances the work of the Council and provides excellence to ACEP.

Criteria: The nominee should exemplify service to the College through the promotion of diversity and inclusion. The nominee must demonstrate evidence of having a commitment to the promotion of a diverse leadership and/or membership and/or initiatives related to diversity and inclusion through mentorship, programmatic activities, professional development, and other contributions specifically purposed to promote the mission, support the policies, and enhance the work of the Council and the specialty of emergency medicine.

Council Curmudgeon Award

Phillip Luke LeBas, MD, FACEP

Purpose: To recognize, in a lighthearted way, deserving Council participants that have contributed to the Annual meeting in a unique, eccentric, humorous, or cleverly astute manner.

Criteria: The Curmudgeon Award will be presented to current or former Council participants (ie, Councillor or Alternate Councillor, President, Speaker, ACEP staff, etc.) that have embodied the essence of the description above.

ACEP HONORS 2024 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

The 2024 American College of Emergency Physicians Awards Program honors leadership and excellence.

The program provides an opportunity to recognize all members for significant professional contributions as well as service to the College. All members of ACEP are eligible to participate in one or more of the College's award programs.

John G. Wiegenstein Leadership Award

Debra G. Perina, MD, FACEP

Presented to a current or past national ACEP leader for outstanding contribution to the College. The award honors the late John G. Wiegenstein, MD, a founding member and the first president of ACEP.

James D. Mills Outstanding Contribution to Emergency Medicine Award

Earl J. Reisdorff, MD, FACEP

Presented to an active, life, or honorary member for significant contributions to emergency medicine. The award honors the late James D. Mills Jr., MD, second president of the College.

Colin C. Rorrie, Jr., PhD Award for Excellence in Health Policy

Brendan G. Carr, MD, MS, FACEP

Presented to a member who has made a significant contribution to achieving the College's health policy objectives, or who has demonstrated outstanding skills, talent and commitment as an administrative or political leader. The award is named after Colin C. Rorrie, Jr., PhD, who served as ACEP's Executive Director from 1982 to 2003.

Judith E. Tintinalli Award for Outstanding Contribution in Education

Susan B. Promes, MD, MBA, FACEP

Presented to a member who has made a significant contribution to the educational aspects of emergency medicine.

ACEP HONORS 2024 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

John A. Rupke Legacy Award

DW "Chip" Pettigrew, III, MD, FACEP

Presented to a current College member for outstanding lifetime contributions to the College. The award honors John A. Rupke, MD, one of the initial founding members of the College.

Award for Outstanding Contribution in Research

Robert M. Rodriguez, MD

Presented to a member who has made a significant contribution to research in emergency medicine.

Award for Outstanding Contribution in EMS

Sabina A. Braithwaite, MD, FACEP

Presented to an individual who has made an outstanding contribution of national significance or application in Emergency Medical Services. The award is not limited to ACEP members.

Disaster Medical Sciences Award

Eric Goralnick, MD, FACEP

Presented to an individual who has made outstanding contributions of national/international significance or impact to the field of disaster medicine.

Community Emergency Medicine Excellence Award

Amy Davis, MD

Presented to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.

ACEP HONORS 2024 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Innovative Change in Practice Management Award

William Francis, MD

Presented to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.

Pamela P. Bensen Trailblazer Award

Arjun K Venkatesh, MD, MBA, MHS, FACEP

Presented to a current College member for seminal contributions over time to the growth of the College and to the specialty of emergency medicine. The award is named after Pamela P. Bensen, MD, a charter member of ACEP and the first woman resident in emergency medicine (1971).

Diane K. Bollman Chapter Advocate Award

Tara Morrison, CAE

Presented to a current or recent (within the past 12 months) ACEP chapter executive or chapter staff member who has made a significant contribution to advancing emergency care and the objectives of an ACEP chapter and the College. The award is named after Diane K. Bollman, who served as the executive director of the Michigan College of Emergency Physicians for 25 years and was an honorary member of ACEP.

Honorary Membership Award

David McKenzie, CAE

Presented to individuals who have rendered outstanding service to the College or the medical profession.

Honorary Membership Award

Rick Murray, EMT-P, FAEMS

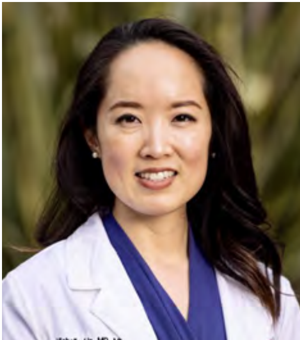
Presented to individuals who have rendered outstanding service to the College or the medical profession.

ACEP HONORS 2024 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Honorary Membership Award

James H. Slaughter, JD

Presented to individuals who have rendered outstanding service to the College or the medical profession.



Policy Pioneer Award

Michelle P. Lin, MD, FACEP

Presented to early- and mid-career members who have made outstanding contributions to the College's health policy and advocacy initiatives.

Council Meritorious Service Award

Thomas J. Sugarman, MD, FACEP

Presented to a member who has made consistent contributions to the growth and maturation of the ACEP Council.

Innovation & Excellence in Behavioral Health & Addiction Medicine Award

Aimee K. Moulin, MD, FACEP

Presented to an individual who has made a significant contribution in advancing the emergency department care of patients with behavioral health and substance use disorder.

Public Health Trailblazer Award

Richard Rothman, MD, PhD, FACEP

Presented to an individual who has made a significant contribution in advancing public health care and injury prevention measures locally, statewide, or nationally.

ACEP HONORS 2024 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Leon L. Haley, Jr. Award for Excellence in Diversity, Equity & Inclusion

Ugo Ezenkwele, MD, FACEP

In recognition of individuals who have significantly helped to advance diversity, inclusion, and health equity within their community, statewide, or nationally.

Lou Graff Award for Excellence in Observation Medicine

Sharon E Mace, MD, FAAP, FACEP

In recognition of emergency physicians who have made a significant contribution to the field of observation medicine within emergency medicine.

Weill Cornell Medicine
Emergency Medicine

EM Wellness Center of Excellence Award

Department of Emergency Medicine at New York-Presbyterian-Weill Cornell Medicine

Presented to an emergency medicine group, department, or clinical site that incorporates wellness and resilience on an institutional level and to use the information gathered in the nominations process to understand more about wellness best practices.

OUR MISSION: To promote the highest quality of emergency care and serve as the leading advocate for emergency physicians, their patients, and the public.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

OUR VISION: To ensure emergency physicians believe that ACEP is their home and community for career fulfillment and professional identity.

OUR STRATEGIC GOALS AND OBJECTIVES:

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Develop and implement ongoing, two-way systems to identify the issues that hinder career satisfaction and meaningfully demonstrate to members that we hear them.
- Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.
- Focus resources, education and networks to assist members in identifying career opportunities and having career fulfillment across different professional interests or life stages.
- Remain diligent in addressing workforce solutions to ensure emergency physicians set the course for the future.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

- Expand and strengthen the role, approach and impact of state-level advocacy.
- Streamline and innovate our advocacy approach and content to better communicate the relevance, impact and accomplishments of advocacy efforts and empower members to advocate for themselves within their own workplaces, regardless of employment model.
- Identify, test and adopt new funding strategies to support advocacy programs.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

- Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.
- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

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

- Build up the leadership pipeline within ACEP and throughout emergency medicine spheres of influence.
- Leverage personalization and opportunities for issue/interest-based participation to make a member's connection to ACEP more personally meaningful.
- Re-imagine the EMRA to ACEP pathway to retain more members upon residency completion.
- Develop recognition and rewards to redefine engagement.
- Measure and showcase the diversity and character of ACEP leaders and members.
- Enhance ACEP's brand positioning and communication strategies.

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

- Implement a systematic program evaluation process that considers new and on-going needs, return on investment/member value and ACEP's strategic plan.
- Invest in overhauling ACEP's digital infrastructure, processes and culture to modernize systems and improve the member and customer experience.
- Adopt effective project management techniques and data-driven decision-making processes.
- Re-examine membership and non-member models to fulfill our mission.
- Develop alternative or non-traditional revenue and in-kind sources and opportunities.
- Be more transparent and timelier in communicating College policies, processes, and initiatives.

EMF Emergency Medicine Foundation®
research → education → patient care

2024 Report to Council

Amy DeLaroche, MD presenting
EMF Funded Research at
2023 ACEP Scientific Assembly

In 2024, EMF proudly announces a new milestone of $21 million in funding, which supported more than 300 grant projects since 1972.

COUNCIL CHALLENGE IMPACT

444 Councillors and leaders at ACEP23 contributed over $195,000 to EMF. ACEP Council is the largest and longest sustaining supporter of EMF, having contributed $2.8 million over 28 years.

NEW 2024 GRANTS

The 2024 grant cycle is funding more than $1 million to 20 grant projects examining many critical EM topics including geriatric care, ED group ownership, diagnostic excellence, and hospital overcrowding.

UPCOMING RESEARCH PROPOSALS

EMF has released new RFPs for grant projects to begin July 1, 2025. Visit EMF's website to learn more. Apply before January 10, 2025.

2024 GRANTEE WORKSHOP

The EMF/SAEMF Grantee Workshop was held in January 2024, providing EMF grantees with training and networking opportunities with NIH program officers and EM research leaders.

EMF Supporters at ACEP23 VIP Reception

EMF Grantees and Board Trustees at ACEP23 Research Showcase

EMF Supporter Dr. Ugo Ezenkwele and EMF Trustee Dr. Savoy Brummer at ACEP23

Dr. Jane Muir presenting at the 2023 EMF/SAEMF Grantee Workshop

2024-2025 EMF RESEARCH AWARDEES

Investigator Initiated Research Grant

Ari B. Friedman, MD, PhD
University of Pennsylvania
The Impact of ED Group Ownership on Market Structure, Care Patterns, and Patients
$250,000

Early Career Research Development Grant

David J. Barton, MD
University of Pittsburgh
Blood-brain barrier dysfunction in mild traumatic brain injury
$150,000

Coagulation and DOAC Reversal Agent Knowledge Gaps Grant

Megan A. Rech, PharmD, MS, FCCM, FCCP, BCCCP
Chicago Association for Research and Education in Science
Reversal of Factor Xa Inhibitors in Veterans with Intracranial hEmoRrhage: the XaVIER study
$149,866

Diagnostic Excellence in Emergency Medicine Grant

Carl T Berdahl, MD, MS, FACEP
Cedars-Sinai Medical Center
Defining Diagnostic Excellence for Emergency Medicine and Establishing Research Priorities
$99,999

Pilot Research Grant

Colin F. Greineder, MD, PhD
University of Michigan Medical School
Unraveling molecular mechanisms of cerebral edema after TBI using non-invasive, brain cell type specific gene silencing
$100,000

Pilot Research Grant

Madeline H. Renny, MD, MS
Icahn School of Medicine at Mount Sinai
Adapting an Emergency Department Intervention to Support Linkage to Care for Youth with Substance Use
$100,000

Pilot Research Grant

John Haeseon Lee, MD, PhD
Beth Israel Deacones Medical Center
Monitoring peripheral tissue perfusion using diffuse correlation spectroscopy (DCS) in patients with sepsis
$100,000

Pilot Research Grant

Brock Daniels, MD MPH
"Weill Cornell Medicine, Department of Emergency Medicine"
Using Artificial Intelligence to Identify Undiagnosed Structural Heart Disease in the Emergency Department
$100,000

Pilot Research Grant

Amber Sabbatini, MD, MPH
University of Washington
Examining the Link Between Regional Skilled Nursing Facility Capacity and Hospital Crowding
$99,900

Pilot Research Grant

Nicklaus P. Ashburn, MD, MS
Wake Forest University Health Sciences
Chest Pain and ASCVD Risk Stratification in a Multisite Emergency Department Cohort (CHARISMA)
$99,890

Geriatric Emergency Care Applied Research (2.0) Network – Advancing Dementia Care / EMF/ West Health Institute

Michelle Lin, MD, MPH, MS
Stanford University
Functional and Cognitive Outcomes and Recovery after Emergency Department Visits among Older Adults with Dementia (FACTOR-ED)
$15,000

Geriatric Emergency Care Applied Research (2.0) Network – Advancing Dementia Care / EMF/ West Health Institute

Adrian Haimovich
Beth Israel Deaconess Medical Center
Feasibility of a stakeholder-informed sleep hygiene intervention for persons living with dementia in the Emergency Department (SLEEP-ED)
$15,000

Geriatric Emergency Care Applied Research (2.0) Network – Advancing Dementia Care / EMF/ West Health Institute

Michelle A. Fischer, MD, MPH
The Pennsylvania State University Hershey Medical Center
Penn State Emergency Medicine CarES: Care-partner Evaluation and Sourcing in the ED
$15,000

EMF/EMRA Resident Research Grant

Aria Shi, MD
Massachusetts General Hospital
Nanoparticle drug delivery for the acute-phase treatment of intracerebral hemorrhage in a mouse model
$10,000

EMF/EMRA Resident Research Grant

Katrina Muraglia, MD, PhD
University of Michigan
Adverse effects of adjuvant heat treatment for catheter salvage in central line associated bloodstream infection
$10,000

EMF/EMRA Resident Research Grant

Ryan Koski-Vacirca, MD, MPH
Yale University
Prices in Acute Care: Mapping Hospital and Market Influences
$9,999.28

EMF/EMRA Resident Research Grant

Caroline Raymond-King, MD, PhD, MPH
Yale University
Racial and ethnic differences in establishment of "Do Not Attempt Resuscitation" orders among patients resuscitated from cardiac arrest
$9,997

EMF/SAEMF Medical Student Research Grant

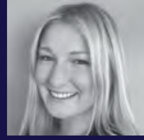
Kiersten Diercks, BA
UT Southwestern Medical Center (UTSW)
Qualitative Analysis of Coaching Perspectives Among Emergency Medicine Faculty and Key Stakeholders
$5,000

EMF/SAEMF Medical Student Research Grant

Emily Larson, BS
Johns Hopkins University School of Medicine
Evaluation and Optimization of Prehospital Trauma Triage
$5,000

EMF/SAEMF Medical Student Research Grant

Karen Reyes, BA
University of California, San Francisco School of Medicine
Emergency Department (ED) Vaccination Surveillance: Novel Assessment of Age-Group Recommended Vaccines in Undocumented Latino Immigrants
$5,000



EMF/SAEMF Medical Student Research Grant

Samantha L. Camp
University of Maryland, Baltimore
Biomarkers Predicting Functional Outcomes In Patients With Ischemic Stroke Requiring Thrombectomy
$3,500

SEE THE MISSION IN ACTION AT ACEP24

EMF RESEARCH SHOWCASE

September 29, 3:30 PM PST
Research Forum 1
See how your donor dollars are spent on practice-changing research by EMF grant recipients.

VIP RECEPTION

September 29, 7:30 PM PST
House of Blues (Mandalay Bay)
Donors who give $600 can unwind and celebrate at the House of Blues—where the rhythm of the night meets the heartbeat of Emergency Medicine.

MAJOR DONOR LOUNGE

September 29 - October 1, 7 AM – 4 PM PST
Mandalay Bay Foyer
The donor lounge allows those who give $600 and above annually to relax and enjoy refreshments and breakfast each day.

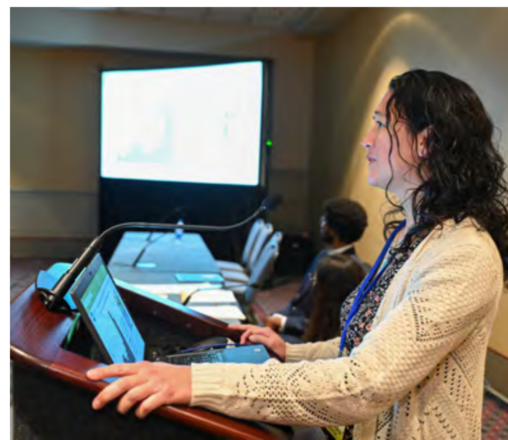
SILENT AUCTION

September 29 - October 1
Mandalay Bay Foyer
One-of-a-kind experiences, sports, music, celebrity memorabilia, art, jewelry, and more. Bid, buy, and support EMF!

2023 Council Members at the ACEP EMF Council Challenge

EMF Scientific Review Committee Member, Dr. Amy Kaji moderating the ACEP23 Research Forum

EMF Grantee, Dr. Stephanie Eucker presenting at EMF's ACEP23 Research Showcase



2023 EMF Chair, Dr. Chadd Kraus and Weigenstein Legacy Society members, Dr. Paul and Mrs. Barbara Pomeroy

This item will be provided as soon as it is available.