



American College of
Emergency Physicians®

ADVANCING EMERGENCY CARE 

COUNCIL MEETING

October 7-8, 2023

**Philadelphia Convention Center – 400 Level
Terrace Ballroom II-III
Philadelphia, PA**



Scientific Assembly

PHILADELPHIA, PA

23

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:

- The American College of Emergency Physicians or any committee, section, chapter, or activity of the College shall not be used for the purpose of bringing about or attempting to bring about any understanding or agreement, written or oral, formal or informal, expressed or implied, among two or more members or other competitors with regard to prices or terms and conditions of contracts for services or products. Therefore, discussions and exchanges of information about such topics will not be permitted at College meetings or other activities.
- There will be no discussions discouraging or withholding patronage or services from, or encouraging exclusive dealing with any health care provider or group of health care providers, any supplier or purchaser or group of suppliers or purchasers of health care products or services, any actual or potential competitor or group of actual potential competitors, any patients or group of patients, or any private or governmental reimbursers.
- There will be no discussions about allocating or dividing geographic or service markets, customers, or patients.
- There will be no discussions about restricting, limiting, prohibiting, or sanctioning advertising or solicitation that is not false, misleading, deceptive, or directly competitive with College products or services.
- There will be no discussions about discouraging entry into or competition in any segment of the health care market.
- There will be no discussions about whether the practices of any member, actual or potential competitor, or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the College's bylaws.
- Certain activities of the College and its members are deemed protected from antitrust laws under the First Amendment right to petition government. The antitrust exemption for these activities, referred to as the Noerr-Pennington Doctrine, protects ethical and proper actions or discussions by members designed to influence: 1) legislation at the national, state, or local level; 2) regulatory or policy-making activities (as opposed to commercial activities) of a governmental body; or 3) decisions of judicial bodies. However, the exemption does not protect actions constituting a “sham” to cover anticompetitive conduct.
- Speakers at committees, educational meetings, or other business meetings of the College shall be informed that they must comply with the College's antitrust policy in the preparation and the presentation of their remarks. Meetings will follow a written agenda approved in advance by the College or its legal counsel.
- Meetings will follow a written agenda. Minutes will be prepared after the meeting to provide a concise summary of important matters discussed and actions taken or conclusions reached.

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

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.

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.

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 publicly 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 publicly 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

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.

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,

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.

2023 Council Meeting

October 7-8, 2023

Pre-Meeting Events Occur Friday Evening, October 6, 2023
Pennsylvania Convention Center, Terrace Ballroom II-III (400 Level)
Philadelphia, PA

TIMED AGENDA

Saturday, October 7, 2023

| | | |
|--|----------------|----------------|
| <i>Continental breakfast available – Terrace Ballroom II-III</i> | | 7:30 am |
| 1. Call to Order | Dr. Gray-Eurom | 8:00 am |
| A. Meeting Dedication | | |
| B. Pledge of Allegiance | | |
| C. National Anthem | | |
| 2. Introductions | Dr. Gray-Eurom | 8:10 am |
| 3. Welcome from PA Chapter President | Dr. Hamilton | 8:12 am |
| 4. Tellers, Credentials, & Election Committee | Dr. Char | 8:14 am |
| A. Credentials Report | | |
| B. Meeting Etiquette | | |
| 5. Changes to the Agenda | Dr. Gray-Eurom | 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 | Dr. Gray-Eurom | 8:25 am |
| A. Council Meeting – September 29-30, 2022 | | |
| 10. Approval of Steering Committee Actions | Dr. Gray-Eurom | 8:26 am |
| A. Steering Committee Meeting – January 31, 2023 | | |
| B. Steering Committee Meeting – April 30, 2023 | | |
| 11. Executive Directors Report | Ms. Sedory | 8:27 am |
| 12. Call for and Presentation of Emergency Resolutions | Dr. Gray-Eurom | 8:47 am |
| 13. Steering Committee's Report on Late Resolutions | Dr. Gray-Eurom | 8:50 am |
| A. Reference Committee Assignments of Allowed Late Resolutions | | |
| B. Disallowed Late Resolutions | | |
| 14. Nominating Committee Report | Dr. Gray-Eurom | 9:00 am |
| A. Speaker | | |
| 1. Slate of Candidates | | |
| 2. Call for Floor Nominations | | |
| B. Vice Speaker | | |
| 1. Slate of Candidates | | |
| 2. Call for Floor Nominations | | |
| C. Board of Directors | | |
| 1. Slate of Candidates | | |
| 2. Call for Floor Nominations | | |

| | | |
|---|-------------------|----------------------------|
| D. President-Elect | | |
| 1. Slate of Candidates | | |
| 2. Call for Floor Nominations | | |
| 15. Candidate Opening Statements | Dr. Gray-Eurom | |
| A. Speaker Candidates (2 minutes each) | | 9:05 am |
| B. Vice Speaker Candidates (2 minutes each) | | 9:07 am |
| C. Board of Directors Candidates (2 minutes each) | | 9:15 am |
| D. President-Elect Candidates (5 minutes each) | | 9:30 am |
| 16. Reference Committee Assignments | Dr. Gray-Eurom | 9:45 am |
| BREAK | | 9:50 am – 10:00 am |
| 17. Reference Committee Hearings | | 10:00 am – 1:00 pm |
| A – Governance & Membership – Room 122A-B (100 Level) | | |
| B – Advocacy & Public Policy – Room 121A-C (100 Level) | | |
| C – Emergency Medicine Practice – Room 120A-C (100 Level) | | |
| Boxed Lunches Available – Room 121A-C Foyer (100 Level) | | 11:00 am – 12:30 pm |
| 18. Reference Committee Executive Sessions | | 1:00 pm – 2:30 pm |
| A – Room 122A-B (100 Level) | | |
| B – Room 121A-C (100 Level) | | |
| C – 120A-C (100 Level) | | |
| BREAK – Return to main Council meeting room – Terrace Ballroom | | 1:00 pm – 1:15 pm |
| 19. Town Hall Meeting – Terrace Ballroom II-III | Dr. Costello | 1:15 pm – 2:15 pm |
| A. What’s AI Got to Do With IT? The Future of Health Care Automation | | |
| 20. Candidate Forum for the President-Elect Candidates – Terrace Ballroom II-III | | 2:20 pm – 2:50 pm |
| BREAK – Return to Reference Committee meeting rooms Room 122A-B, Room 121A-C, Room 120A-C (100 Level) | | 2:50 pm – 3:00 pm |
| 21. Candidate Forum for Board of Directors and Council Officer Candidates Candidates rotate through Reference Committee meeting rooms. | | 3:00 pm – 4:45 pm |
| BREAK – Return to main Council meeting room – Terrace Ballroom II-III | | 4:45 pm – 5:00 pm |
| 22. Speaker’s Report | Dr. Gray-Eurom | 5:00 pm |
| 23. In Memoriam | Dr. Gray-Eurom | 5:15 pm |
| A. Reading and Presentation of Memorial Resolutions Adopt by observing a moment of silence. | Dr. Costello | |
| 24. EMRA Report | Dr. Adkins Murphy | 5:30 pm |
| 25. ABEM Report | Dr. Johnson | 5:35 pm |
| 26. Secretary-Treasurer’s Report | Dr. Shoemaker | 5:40 pm |
| 27. President’s Address | Dr. Kang | 5:45 pm |
| RECESS | | 6:05 pm |

Sunday, October 8, 2023**Continental breakfast available – Terrace Ballroom II-III****7:30 am**

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|---|-----------------------------|----------|
| 1. Call to Order | Dr. Gray-Eurom | 8:00 am |
| 2. Tellers, Credentials, & Elections Committee Report | Dr. Char | 8:00 am |
| 3. Electronic Voting | Dr. Char | 8:05 am |
| A. Electronic Voting Testing | | |
| 4. EMF Report | Dr. Kraus | 8:30 am |
| 5. NEMPAC Video Report | | 8:35 am |
| 6. Submitting Amendments Electronically | Dr. Gray-Eurom | 8:40 am |
| 7. Reference Committee Reports | | 8:45 am |
| A. Reference Committee ____ | | |
| B. Reference Committee ____ | | |
| 8. Awards Luncheon – <i>Terrace Ballroom I</i> | | 12:00 pm |
| A. Welcome | Dr. Gray-Eurom | 12:40 pm |
| 1. Recognition of Past Speakers and Past Presidents | | |
| 2. Recognition of Current and Past Board Members | | |
| 3. Recognition of Chapter Executives | | |
| B. ACEP Awards Announcements | Dr. Kang | |
| C. Reading and Presentation of Commendation Resolutions | Dr. Gray-Eurom/Dr. Costello | |
| <i>Adopt by acclamation.</i> | | |
| D. Council Award Presentations | Dr. Gray-Eurom/Dr. Costello | |
| 1. Council Service Milestone Awards – 5, 10, 15, 20, 25, 30, 35+ Year Councillors | | |
| 2. Council Teamwork Award | | |
| 3. Council Horizon Award | | |
| 4. Council Champion in Diversity & Inclusion Award | | |
| 5. Council Curmudgeon Award | | |
| 6. Council Meritorious Service Award | | |

LUNCHEON ADJOURNS – Return to main Council meeting room – Terrace Ballroom II-III**1:30 pm**

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|--|--------------------|---------|
| 9. Tellers, Credentials, & Elections Committee Report | Dr. Char | 1:40 pm |
| 10. Reference Committee Reports Continue | | 1:45 pm |
| C. Reference Committee ____ | | |
| 11. President-Elect's Address | Dr. Terry | 4:45 pm |
| 12. Installation of President | Dr. Kang/Dr. Terry | 5:05 pm |
| 13. Tellers, Credentials, & Elections Committee Report | Dr. Char | 5:10 pm |
| 14. Elections | Dr. Char | 5:10 pm |
| A. Speaker | | |
| B. Vice Speaker | | |
| C. Board of Directors | | |
| D. President-Elect | | |
| 15. Announcements | Dr. Gray-Eurom | 5:40 pm |

ADJOURN**5:45 pm****Next Annual Council Meeting • September 27-28, 2024 (Friday-Saturday) • Las Vegas**

2023 Council Meeting

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| 05 | Councillor Handbook |
| 06 | Council Standing Rules |
| 07 | Bylaws |
| 08 | College Manual |
| 09 | Minutes <ul style="list-style-type: none">a. Council Meeting Minutes – September 29-30, 2023b. Steering Committee Meeting Minutes – January 31, 2023c. Steering Committee Meeting Minutes – April 30, 2023 |
| 10 | Definition of Council Actions |
| 11 | Reference Committee Assignments |
| 12 | 2023 Resolutions |
| 13 | Reports from the Board of Directors <ul style="list-style-type: none">• ACEP Composition Annual Report• Compensation Committee Report• Position and Vote on Amended Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine (<i>second resolved</i>) |
| 14 | Town Hall Meeting Description <ul style="list-style-type: none">• Topic TBD |
| 15 | Board Action on 2022 Council Resolutions |
| 16 | Board Action on 2021 Council Resolutions |
| 17 | Board Action on 2020 Council Resolutions |
| 18 | President-Elect Candidates <ul style="list-style-type: none">• Jeffrey M. Goodloe, MD, FACEP• Alison J. Haddock, MD, FACEP• Ryan A. Stanton, MD, FACEP |

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| 20 | Council Speaker Candidate <ul style="list-style-type: none">• Melissa W. Costello, MD, FACEP <p>Council Vice Speaker Candidates</p> <ul style="list-style-type: none">• Kurtis A. Mayz, JD, MD, MBA, FACEP• Michael J. McCrea, MD, FACEP• Larisa M. Traill, MD, FACEP |
| 21 | 2023 Award Recipients |
| 22 | Strategic Plan FY 2023-24 |
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2023 Council Steering Committee

Updated February 2023



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

Jacksonville, FL



**Melissa W. Costello, MD, FACEP - Vice
Speaker**

Mobile, AL



Erik Blutinger, MD, MSc, FACEP

New York, NY



Sara Ann Brown, MD, FACEP

Monroeville, IN



Emily Fitz, MD, FACEP

Zionsville, IN



Vik Gulati, MD, FACEP

San Diego, CA



Carlton E. Heine, MD, PhD, FACEP

Spokane, WA



C. Ryan Keay, MD, FACEP

Lynnwood, WA



Alexander J. Kirk, MD, FACEP

Carrollton, TX



Phillip Luke LeBas, MD, FACEP

New Orleans, LA



Marc Mendelsohn, MD, FACEP

St. Louis, MO



Diana Nordlund, DO, JD, FACEP

Caledonia, MI

*2023 Council Steering Committee
Picture Roster (continued)*



Bing Pao, MD, MD, FACEP

Rancho Santa Fe, CA



Christopher S. Sampson, MD, FACEP

Columbia, MO



Matthew J. Sanders, DO, FACEP

Springboro, OH



Gary C. Starr, MD, MBA, FACEP

Montreal, Quebec CA



Thomas J. Sugarman, MD, FACEP

Evanston, IL



**Amanda Irish, MD
(EMRA REP to Steering Committee)**

Columbia, SC

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.

2023 Councillor Seating Chart

| | SECRETARY | PARLIAMENTARIAN | SPEAKER | VICE SPEAKER |
|----|--|--|---------|---|
| | PROJECTION STAFF | | | 427 + 41 Leaders=468 |
| 1 | TX=10 UT=4 WY=1 | VA=13 Tactical=1 Toxicology=1 | | WA=10 WV=4 YPS=1 |
| 2 | TX=13 Telehealth=1 | PA=10 Sports Med=1 Trauma=1 Underseas=1 Wellness=1 Wilderness=1 | | SC=6 VT=2 WI=6 |
| 3 | OK=3 OR=5 Palliative=1 SAEM=1 TN=5 | OH=3 PA=9 Rural=1 Pediatric EM=1 | | NY=12 RI=3 |
| 4 | MI=7 MO=7 | OH=14 | | NY=15 |
| 5 | MI=14 | NC=12 Social EM=1 SD=1 | | MN=8 PR=2 NY=5 |
| 6 | MA=10 NM=4 | MS=3 NJ=12 | | MD=8 NV=4 Observation=1 Pain Mgmt=1 Quality=1 |
| 7 | KS=3 KY=3 LA=5 MT=1 NE=2 | IA= 2 IN=7 ME=3 Medical Humanities=1 NH=2 | | IL=13 ND=1 |
| 8 | GS=13 | GA=11 ID=2 International=1 Med Directors=1 | | FL=12 HI=2 |
| 9 | DC=3 EMRA=8 Dual=1 EM Ultrasound=1 Freestanding=1 | CA=10 EM Research=1 EM Workforce=1 Event Med=1 Geriatrics=1 | | FL=15 |
| 10 | AZ=9 Careers=1 CORD=1 Critical Care=1 Cruise Ship=1 | CA=15 | | CT=7 DE=2 Diversity=1 EM Informatics=1 EMS=1 Forensics=1 |
| 11 | AACEM=1 AL=4 AK=2 AR=2 Air Medical=1 AAWEP=1 | CA=15 | | CO=8 Democratic=1 Disaster=1 EM Practice HP=1 |
| | | Board | | |
| | | Board | | |

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 2023 councillor seating chart includes the following:

| | |
|---------------------|---|
| Arizona | 8 councillors + 1 past leaders attending not serving as councillors = 9 seats |
| California | 34 councillors + 6 past leaders attending not serving as councillors = 40 seats |
| Colorado | 7 councillors + 1 past leader attending not serving as a councillor = 8 seats |
| Connecticut | 5 councillors + 2 past leader attending not serving as a councillors = 7 seats |
| Florida | 21 councillors + 6 past leaders attending not serving as a councillors = 26 seats |
| Georgia | 9 councillors + 2 past leader attending not serving as councillor = 11 seats |
| Government Services | 11 councillors + 2 past leaders attending not serving as councillor = 13 seats |
| Indiana | 6 councillors + 1 past leader attending not serving as councillor = 7 seats |
| Maryland | 7 councillors + 1 past leader attending not serving as councillor = 8 seats |
| Michigan | 20 councillors + 1 past leaders attending not serving as councillors = 21 seats |
| New Jersey | 10 councillors + 2 past leader attending and not serving as councilor = 12 seats |
| New Mexico | 3 councillors + 1 past leaders attending and not serving as councillor = 4 seats |
| New York | 30 councillors + 2 past leader attending not serving as a councillor = 32 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 + 4 past leaders not serving as a councillor = 13 seats |
| Washington | 8 councillors + 2 past leaders attending not serving as a councillor = 10 seats |
| West Virginia | 3 councillors + 1 past leader attending not serving as a councillor = 4 seats |

2023 COUNCILLORS & ALTERNATE COUNCILLORS

| Chapter/Section | Position | Name |
|--------------------|-----------------------------|---------------------------------------|
| AACEM | Councillor | Theodore A Christopher, MD, FACEP |
| ALABAMA CHAPTER | Councillor | Shea A Duerring, MD, FACEP |
| | Councillor | Paul Daniel Kivela, MD, MBA, FACEP |
| | Councillor | Jaron D Raper, MD, FACEP |
| | Councillor | Annalise Sorrentino, MD, FACEP |
| | <i>Alternate</i> | Muhammad N Husainy, DO, FACEP |
| ALASKA CHAPTER | Councillor | Nicholas Papacostas, MD, FACEP |
| | Councillor | Camilla Sulak, MD, FACEP |
| ARIZONA CHAPTER | Councillor | Lawrence A DeLuca, 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 | Rebecca B Parker, MD, FACEP |
| | Councillor | Todd Brian Taylor, MD, FACEP |
| ARKANSAS CHAPTER | Councillor | J Shane Hardin, MD, PhD, FACEP |
| | Councillor | Robert Thomas VanHook, MD, FACEP |
| | <i>Alternate</i> | Brian L Hohertz, MD, FACEP |
| | <i>Alternate</i> | Ariel S Noble, MD |
| CALIFORNIA CHAPTER | Councillor | Zahir I Basrai, MD |
| | Councillor | Reb J H Close, MD, FACEP |
| | Councillor | Fred Dennis, MD, MBA, FACEP |
| | Councillor | Adam P Dougherty, MD, FACEP |
| | Councillor | Carrieann E Drenten, MD, FACEP |
| | Councillor | Andrew N Fenton, MD, FACEP |
| | Councillor | Jorge A Fernandez, 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 | Roneet Lev, MD, FACEP |
| | Councillor | Christopher Libby, MD, MPH, FACEP |
| | Councillor | Nicole E McAmis, MD |
| | Councillor | Aimee K Moulin, MD, FACEP |
| | Councillor | Leslie Mukau, MD, FACEP |
| Councillor | Valerie C Norton, MD, FACEP | |
| Councillor | Bing S Pao, MD, FACEP | |
| Councillor | Chi Lee Perloth, MD, FACEP | |

2023 COUNCILLORS & ALTERNATE COUNCILLORS

| | |
|------------------|--------------------------------------|
| Councillor | Kelly E Quinley, MD |
| Councillor | Vivian Reyes, MD, FACEP |
| Councillor | Carolyn Joy Sachs, MD, MPH, FACEP |
| Councillor | Susanne J Spano, MD, FACEP |
| Councillor | Katherine Laurinda Staats, MD, FACEP |
| Councillor | Thomas Jerome Sugarman, MD, FACEP |
| Councillor | Gary William Tamkin, MD, FACEP |
| Councillor | David Terca, MD, FACEP |
| Councillor | Lori D Winston, MD, FACEP |
| Councillor | Anna L Yap, MD |
| Councillor | Randall J Young, MD, FACEP |
| <i>Alternate</i> | Joshua R Coddling, MD |
| <i>Alternate</i> | Luigi Di Stefano, MD, FACEP |
| <i>Alternate</i> | William E Franklin, DO, MBA, FACEP |
| <i>Alternate</i> | Rubeal S Mann, MD, FACEP |
| <i>Alternate</i> | Hunter M Pattison, MD |
| <i>Alternate</i> | Paul-Thomas Tremoulet, MD, FACEP |
| <i>Alternate</i> | Patrick Um, MD, FACEP |
| <i>Alternate</i> | Anna L Webster, MD, FACEP |
| <i>Alternate</i> | 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 |
| Councillor | Allison Marie Trop, MD, FACEP |
| <i>Alternate</i> | Evan Gerber, MD |
| <i>Alternate</i> | Douglas M Hill, DO, FACEP |
| <i>Alternate</i> | Carla Elizabeth Murphy, DO, FACEP |
| <i>Alternate</i> | Bradley D Shy, MD, FACEP |
| <i>Alternate</i> | James D Thompson, MD, FACEP |

CONNECTICUT CHAPTER

| | |
|------------------|-------------------------------|
| Councillor | Thomas A Brunell, MD, FACEP |
| Councillor | Michael L Carius, MD, FACEP |
| Councillor | Daniel Freess, MD, FACEP |
| Councillor | Elizabeth Schiller, MD, FACEP |
| Councillor | Gregory L Shangold, MD, FACEP |
| <i>Alternate</i> | David E Wilcox, MD, FACEP |

CORD

| | |
|------------|------------------------------|
| Councillor | Jason Cass Wagner, MD, FACEP |
|------------|------------------------------|

DELAWARE CHAPTER

| | |
|------------|---------------------------------|
| Councillor | Kathryn Groner, MD, FACEP |
| Councillor | John T Powell, MD, MHCDS, FACEP |

DISTRICT OF COLUMBIA CHAPTER

| | |
|------------|------------------------------------|
| Councillor | Christopher T Clifford, MD |
| Councillor | Stanislaw C Haciski, MD |
| Councillor | Rita A Manfredi-Shutler, MD, FACEP |

2023 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|--|---------------------------------------|-----------------------------------|
| | <i>Alternate</i> | Marisa Karina Dowling, MD, MPP |
| EMERGENCY MEDICINE RESIDENTS' ASSOCIATION | Councillor | Michaela Skylar Banks, MD |
| | Councillor | Blake Denley, MD |
| | Councillor | Amanda Kay Irish, MD, MPH |
| | Councillor | Erin R Karl, MD |
| | Councillor | Kenneth Taeyoung Kim, MD |
| | Councillor | Aaron R Kuzel, DO |
| | Councillor | Jessica Adkins Murphy, MD |
| | Councillor | Angela Wu, MD |
| | <i>Alternate</i> | Angela Cai, MD, MBA |
| | <i>Alternate</i> | Kimberly Herard, MD |
| | <i>Alternate</i> | Micaela A LaRose, MD |
| | <i>Alternate</i> | Derek Martinez, DO |
| | <i>Alternate</i> | Thuy Nguyen, MD |
| | <i>Alternate</i> | Jose Reyes, MD |
| | <i>Alternate</i> | Shane E Solger, MD |
| <i>Alternate</i> | Jordan N Vaughn , MD | |
| FLORIDA CHAPTER | Councillor | Thomas P Bentley, MD, FACEP |
| | Councillor | Andrew I Bern, MD, FACEP |
| | Councillor | Ricki A Brown, MD |
| | Councillor | Elizabeth A Calhoun, MD |
| | Councillor | Damian E Caraballo, MD, FACEP |
| | Councillor | Jordan Celeste, MD, FACEP |
| | Councillor | Edward A Descallar, MD, FACEP |
| | 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 | Tracy G Sanson, 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 |
| Councillor | Martin P Wegman, MD, PhD | |
| <i>Alternate</i> | Vidor E Friedman, MD, FACEP | |
| <i>Alternate</i> | Anton Gomez, DO | |
| <i>Alternate</i> | David Charles Seaberg, MD, CPE, FACEP | |
| <i>Alternate</i> | Cristina Zeretzke, MD, FACEP | |
| GEORGIA CHAPTER | Councillor | Matthew R Astin, MD, FACEP |
| | Councillor | Brett H Cannon, MD, FACEP |
| | Councillor | James Joseph Dugal, MD(E), FACEP |

2023 COUNCILLORS & ALTERNATE COUNCILLORS

| | |
|------------------|-------------------------------------|
| 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 |
| <i>Alternate</i> | Shamie Das, MD, MBA, MPH, FACEP |
| <i>Alternate</i> | Mark A Griffiths, MD |
| <i>Alternate</i> | Brendan Hawthorn, MD, FACEP |
| <i>Alternate</i> | Benjamin Lefkove, MD, FACEP |
| <i>Alternate</i> | Matthew Rudy, MD, FACEP |
| <i>Alternate</i> | Carmen D. Sulton, MD, FACEP |
| <i>Alternate</i> | Kathryn West, MD |
| <i>Alternate</i> | John L Wood, MD, FACEP |

GOVT SERVICES CHAPTER

| | |
|------------------|--------------------------------------|
| Councillor | Andrea Austin, MD, FACEP |
| Councillor | Joshua S da Silva, DO, FACEP |
| Councillor | Roderick Fontenette, MD, FACEP |
| Councillor | Amy Follmer Hildreth, MD, FACEP |
| Councillor | Katrina N Landa, MD, FACEP |
| Councillor | David S McClellan, MD, FACEP |
| Councillor | Torree M McGowan, MD, FACEP |
| Councillor | Paul James Diggins Roszko, MD, FACEP |
| Councillor | Justine K Stremick, MD, FACEP |
| Councillor | Sean Stuart, DO, FACEP |
| Councillor | Laura Tilley, MD, FACEP |
| <i>Alternate</i> | Matthew Christensen, MD |
| <i>Alternate</i> | Taylor T DesRosiers, MD |
| <i>Alternate</i> | Kevin X Durgun, MD |
| <i>Alternate</i> | Ryan M Hodgeman, DO |
| <i>Alternate</i> | Eric Steven Kretz, MD |
| <i>Alternate</i> | Linda L Lawrence, MD, CPE, FACEP |
| <i>Alternate</i> | Joshua Lesko, MD |
| <i>Alternate</i> | Katey Della Giustina Osborne, MD |
| <i>Alternate</i> | Danielle Wickman, MD |

HAWAII CHAPTER

| | |
|------------|---------------------------|
| Councillor | Mark Baker, MD, FACEP |
| Councillor | Alexander Berk, MD, FACEP |

IDAHO CHAPTER

| | |
|------------------|----------------------------------|
| Councillor | Ken John Gramyk, MD, FACEP |
| Councillor | Jonathan D Miller, MD, FACEP |
| <i>Alternate</i> | Heather S Hammerstedt, MD, FACEP |
| <i>Alternate</i> | Travis Aaron Newby, DO, FACEP |

ILLINOIS CHAPTER

| | |
|------------|-------------------------------------|
| Councillor | Amit D Arwindekar, MD, FACEP |
| Councillor | Kristen M Donaldson, MD, MPH, FACEP |
| Councillor | John W Hafner, MD, FACEP |
| Councillor | Adnan Hussain, MD, FACEP |
| Councillor | Jason A Kegg, MD, FACEP |

2023 COUNCILLORS & ALTERNATE COUNCILLORS

| | |
|------------------|--------------------------------------|
| Councillor | Janet Lin, MD, FACEP |
| Councillor | Howard K Mell, MD, MPH, CPE, FACEP |
| Councillor | Scott H Pasichow, MD, MPH, FACEP |
| Councillor | Henry Pitzele, MD, FACEP |
| Councillor | Monika Pitzele, MD, PhD, FACEP |
| Councillor | Yanina Purim-Shem-Tov, MD, MS, FACEP |
| Councillor | Willard W Sharp, MD, FACEP |
| Councillor | Deborah E Weber, MD, FACEP |
| <i>Alternate</i> | Halleh Akbarnia, MD, FACEP |
| <i>Alternate</i> | Nicholas Paul Cozzi, MD |
| <i>Alternate</i> | Kelly Jester Geldmacher, MD, FACEP |
| <i>Alternate</i> | Elisabeth M Giblin, MD |
| <i>Alternate</i> | Cai Glushak, MD, FACEP |
| <i>Alternate</i> | Asma S Hashim, DO |
| <i>Alternate</i> | Julie A Lewis, MD |
| <i>Alternate</i> | Christopher M McDowell, MD, FACEP |

INDIANA CHAPTER

| | |
|------------------|-----------------------------------|
| Councillor | Michael D Bishop, MD, FACEP |
| Councillor | Timothy A Burrell, MD, MBA, FACEP |
| Councillor | Daniel W Elliott, MD, FACEP |
| Councillor | Kyle D English, MD, FACEP |
| Councillor | Emily M Fitz, MD, FACEP |
| Councillor | Lindsay Zimmerman, MD, FACEP |
| <i>Alternate</i> | Sara Ann Brown, MD, FACEP |
| <i>Alternate</i> | Daniel Slubowski, MD |

IOWA CHAPTER

| | |
|------------------|-------------------------------------|
| Councillor | Ryan M Dowden, MD, FACEP |
| Councillor | Rachael Sokol, DO, FACEP |
| <i>Alternate</i> | Nicholas Holden Kluesner, MD, FACEP |
| <i>Alternate</i> | Cory Wittrock, MD, FACEP |

KANSAS CHAPTER

| | |
|------------------|---|
| Councillor | Howard Chang, MD, FACEP |
| Councillor | John F McMaster, MD, FACEP |
| Councillor | Jeffrey G Norvell, MD, MBA, RDMS, FACEP |
| <i>Alternate</i> | Matthew S Sinnwell, MD, FACEP |

KENTUCKY CHAPTER

| | |
|------------------|-------------------------------------|
| Councillor | Christopher W Pergrem, MD, FACEP |
| Councillor | Melissa Platt, MD, FACEP |
| Councillor | Hugh W Shoff, MD MS, FACEP |
| <i>Alternate</i> | Steven Joseph Stack, MD, MBA, FACEP |

LOUISIANA CHAPTER

| | |
|------------------|------------------------------------|
| Councillor | James B Aiken, MD, FACEP |
| Councillor | Deborah D Fletcher, MD, FACEP |
| Councillor | Jamie Hoitien Do Kuo, MD |
| Councillor | Phillip Luke LeBas, MD, FACEP |
| Councillor | Michael D Smith, MD MBA CPE, FACEP |
| <i>Alternate</i> | Nicole Streiff McCoin, MD, FACEP |

MAINE CHAPTER

| | |
|------------|-----------------------------|
| Councillor | Thomas C Dancoes, DO, FACEP |
|------------|-----------------------------|

2023 COUNCILLORS & ALTERNATE COUNCILLORS

| | |
|------------------|-------------------------------------|
| Councillor | Garreth C Debiegun, MD, FACEP |
| Councillor | James B Mullen, III, MD, FACEP |
| <i>Alternate</i> | Nathan G Donaldson, DO, FACEP |
| <i>Alternate</i> | Andrew Ehrhard, MD, FACEP |
| <i>Alternate</i> | Brandon E Giberson, DO, FACEP |
| <i>Alternate</i> | Kelly Ann Meehan-Coussee, MD, FACEP |
| <i>Alternate</i> | Laurel Parker, MD, FACEP |
| <i>Alternate</i> | Jessica Stevens, MD, MPH |

MARYLAND CHAPTER

| | |
|------------|-------------------------------------|
| Councillor | Michael C Bond, MD, FACEP |
| Councillor | Arjun S Chanmugam, MD, FACEP |
| Councillor | Karen Dixon, MD, FACEP |
| Councillor | Jonathan Lewis Hansen, MD, FACEP |
| Councillor | Kathleen D Keefe, MD, FACEP |
| Councillor | Edana Denise Mann, MD, FACEP |
| Councillor | Richard Gentry Wilkerson, MD, FACEP |

MASSACHUSETTS CHAPTER

| | |
|------------------|-----------------------------------|
| Councillor | Brien Alfred Barnewolt, MD, FACEP |
| Councillor | Amy Costigan, MD, FACEP |
| Councillor | Stephen K Epstein, MD, MPP, FACEP |
| Councillor | Kathleen Kerrigan, MD, FACEP |
| Councillor | Matthew B Mostofi, DO, FACEP |
| Councillor | Mark D Pearlmutter, MD, FACEP |
| Councillor | Jesse Rideout, MD, FACEP |
| Councillor | Michele Schroeder, MD, FACEP |
| Councillor | James Joseph Sullivan, Jr, MD |
| Councillor | Joseph C Tennyson, MD, FACEP |
| <i>Alternate</i> | James Blum, MD |
| <i>Alternate</i> | Samantha A Hay, 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 | 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 |
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I. COMPOSITION OF THE COUNCIL

Introduction

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

What is the Council?

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

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

What Does the Council Do?

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

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

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

II. COUNCILLOR PREPARATION

How Does a Councillor Prepare for the Annual Meeting?

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

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

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

How Does the Council Conduct its Business?

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

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

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

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

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

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

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

What is a Resolution?

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

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

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

Amendments to Resolutions

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

Late Resolutions

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

Emergency Resolutions

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

What if I Have Questions About the Council?

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

How are Nominations and Elections Conducted?

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

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

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

Each year a Candidate Forum is held. This year the Candidate Forum for the president-elect candidates will be held from 2:00 – 2:30 pm in the main Council meeting room, following the Town Hall meeting. The Candidate

Forum for the Council officer candidates and Board of Directors candidates will be held from 2:45 pm – 4:30 pm in each of the Reference Committee meeting rooms with the candidates rotating between rooms. Members of the Candidate Forum Subcommittee will moderate each session with the candidates. Candidates will answer questions and declare their views on issues facing emergency medicine. An informal reception will be held for members to personally meet and speak with candidates. All councillors are encouraged to attend the Candidate Forum and the reception that follows.

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

What is the Steering Committee?

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

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

2022 Council Steering Committee

Kelly Gray-Eurom, MD, MMM, FACEP, Chair
Melissa W. Costello, MD, FACEP, Vice Chair
Eileen F. Baker, MD, PhD, FACEP (OH)
Lisa M. Bundy, MD, FACEP (AL)
Carrie de Moor, MD, FACEP (TX)
Hilary E. Fairbrother, MD, FACEP (TX)
William D. Falco, MD, MS, FACEP (WI)
Carlton Heine, MD, FACEP (WA)

Steven B. Kailes, MD, FACEP (FL) Phillip Luke
LeBas, MD, FACEP (LA)
Kristin McCabe-Kline, MD, FACEP (FL)
Christina Millhouse, MD, FACEP (SC)
Bing Pao, MD, FACEP (CA)
Michael Ruzek, DO, FACEP (NJ)
Gary Starr, MD, MBA, FACEP (MN)
Thomas J. Sugarman, MD, FACEP (CA)
Larisa M. Traill, MD, FACEP (MI)

III. COUNCIL REFERENCE COMMITTEES

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

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

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

Asynchronous Testimony

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

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

Please include the following information when commenting:

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

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

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

Procedures

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

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

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

Proceedings

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

The chair will decide the order and/or grouping of resolutions and will post times to start each discussion. Before beginning discussion on the first resolution, the chair will ask if there is a “pressing need” for any resolutions to be taken out of order to allow individuals to provide testimony to a particular issue.

Determination of a “pressing need” will be left to the discretion of the chair. The chair will ask if the primary author(s) of the resolution is present or if another individual is present who may speak to the intent of the resolution, and if the individual wishes to provide guidance to the committee. Reference Committees may

take brief breaks if the chair determines that time is available. The Reference Committee chair is requested to designate a member of the committee to keep track of all pro and con comments pertaining to each resolution. If an individual arrives to present testimony before or after the time the resolution was scheduled for discussion, it is at the discretion of the chair as to when that member may speak to the resolution. When presenting testimony, the individual should state their name, component body, and whether speaking in support of or against the resolution. No one should speak more than once on a resolution unless it is to clarify a point. Prior to closing debate, the chair will ask Board members, officers, staff, and others with particular expertise for their testimony.

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

Reports

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

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

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

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

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

Examples of our common variants employing the procedure are:

1. The Reference Committee recommends that a resolution not be adopted. The speaker places the resolution before the Council for discussion. In the absence of other motions from the floor, the speaker places the question on adoption of the resolution, making it clear that the Reference Committee has recommended that it not be adopted (a negative vote).
2. The Reference Committee recommends amending a resolution by adding, striking out, inserting, or substituting. The matter that is placed before the Council for discussion is the amended version as presented by the Reference Committee together with the recommendation for its adoption. It is then in

order for the Council to apply to this Reference Committee version amendments in the usual fashion. Such procedure is clear and orderly and does not preclude the possibility that an individual may wish to restore the matter to its original unamended form. This may be accomplished quite simply by moving to amend the Reference Committee version by restoring the original language.

3. The Reference Committee recommends referral of a resolution to the Board of Directors, Council Steering Committee, or Bylaws Interpretation Committee of the College. The speaker places the motion to refer before the Council for discussion. Adoption of the motion to refer removes the matter from consideration by the Council. If the motion to refer is not adopted, the resolution comes before the body for discussion. The Council is then free to adopt, not adopt, or amend the resolution.
4. The Reference Committee recommends consolidation of two or more kindred resolutions into a single resolution, or it recommends adoption of one of these items in its own right as a substitute for the rest. The matter before the Council consideration is the recommendation of the Reference Committee or the substitute or consolidate version. A motion to adopt this substitute is the main motion. If the Reference Committee's version is not adopted the entire group of proposals has been rejected but it is in order for any councillor to then propose consideration and adoption of any one of the original resolutions or reports.

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

Summary of Council Actions on Reference Committee Reports

| 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

| <u>Order of precedence</u> ¹ | <u>Can interrupt</u> | <u>Requires second?</u> | <u>Debatable</u> | <u>Amendable</u> | <u>Vote Required?</u> | <u>Applies to what other motions?</u> | <u>Can have what other motions applied (in addition to withdraw)⁴ ?</u> |
|--|----------------------|-------------------------|------------------|------------------|-----------------------|---------------------------------------|--|
| 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 | 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

| <u>No order of precedence</u> | <u>Can interrupt</u> | <u>Requires second?</u> | <u>Debatable</u> | <u>Amendable</u> | <u>Vote Required?</u> | <u>Applies to what other motions</u> | <u>Can have what other motions applied (in addition to withdraw)?</u> |
|-------------------------------|----------------------|-------------------------|------------------|------------------|-----------------------|--------------------------------------|---|
| 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

Definition

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

Submission and Deadline

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

All resolutions should be submitted to:

Sonja Montgomery, CAE
Governance Operations Director
American College of Emergency Physicians
PO Box 619911
Dallas, TX 75261-9911

E-mail: smontgomery@acep.org
Phone: 800-798-1822 x3202 or 469-499-0282
Fax: 972-580-2816

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

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

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

Questions

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

Format

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

Whereas Statements

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

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

Resolved Statements

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

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

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

Bylaws Amendments

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

General Resolutions

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

Council Actions on Resolutions

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

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

Board Actions on Resolutions

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

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

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

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

Sample Resolutions

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

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

RESOLUTION 9(06)

WHEREAS, The College Bylaws provides for an Executive Committee of the Board of Directors;
and

WHEREAS, The speaker has informally served on the Executive Committee; and

WHEREAS, The Executive Committee would benefit from having more formal and standard composition, including the membership of the speaker and the chair of the Board of Directors; and

WHEREAS, The College would benefit from having an Executive Committee appointed every year;
therefore be it

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

ARTICLE XI – COMMITTEES Section 2 – Executive Committee

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

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

Resolution 23(06) shows how communication between the College and another organization can be stated.

RESOLUTION 23(06)

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

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

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

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

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

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

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

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

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

RESOLUTION 16(99)

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

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

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

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

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

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

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

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

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

VIII.

ACEP Parliamentary Motions Guide

Based on *Sturgis Standard Code of Parliamentary Procedure (4th Ed.)*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 |

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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.

| | | | | | | |
|-------------------------------------|--|-----|-----|-----|-----|----------|
| (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 |



Council Standing Rules

Revised October 2022

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.

Credentiaing 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 2022

Bylaws

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BYLAWS

October 2022

ARTICLE I — NAME

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

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES

Section 1 — Mission

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

Section 2 — Purposes and Objectives

The purposes and objectives of the College are:

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

ARTICLE III — COLLEGE MEETINGS

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

ARTICLE IV — MEMBERSHIP

Section 1 — Eligibility

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

Section 2 — Classes of Membership

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

Section 2.1 — Regular Members

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

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

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

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

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

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

Section 2.2 — Honorary Members

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

Section 2.3 — Candidate Members

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

participating in a pediatric emergency medicine fellowship training program; or 5) physician in the uniformed services while serving as general medical officer. General medical officers shall be eligible for candidate membership for a maximum of four years. All candidate members will be assigned by the Board of Directors to either active or inactive status.

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

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

Section 2.4 — International Members

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

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

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

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

Section 3 — Agreement

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

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

Section 4 — Disciplinary Action

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

Section 5 — Dues, Fees, and Assessments

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

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

nonpayment of dues and assessments.

Section 6 — Official Publications

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

ARTICLE V — ACEP FELLOWS

Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

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

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

Section 2 — Fellow Status

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

ARTICLE VI — CHAPTERS

Section 1 — Charters

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

Section 2 — Chapter Bylaws

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

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

Section 3 — Qualifications

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

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

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

Section 4 — Component Branches

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

Section 5 — Charter Suspension – Revocation

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

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

Section 6 — Ultimate Authority by College

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

ARTICLE VII — SECTIONS

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

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

ARTICLE VIII — COUNCIL

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

Section 1 — Composition of the Council

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

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

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

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

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

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

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

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

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

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

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

Section 2 — Powers of the Council

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

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

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

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

Section 3 — Meetings

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

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

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

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

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

Section 4 — Quorum

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

Section 5 — Voting Rights

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

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

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

Section 6 — Resolutions

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

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

Section 7 — Nominating Committee

A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members, 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 president, and secretary-treasurer. The officers of the Council shall be the speaker and vice speaker. The Board of Directors may appoint other officers as described in these Bylaws.

Section 2 — Election of Officers

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

Section 3 — Removal

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

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

Section 4 — Vacancy

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

Section 4.1 — President

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

Section 4.2 — President-Elect

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

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

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

Section 4.4 — Council Officers

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

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

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

Section 4.5 — Vacancy by Removal of a Board Officer

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

Section 4.6 — Vacancy by Removal of a Council Officer

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

Section 5 — President

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

Section 6 — Chair

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

Section 7 — Vice President

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

Section 8 — President-Elect

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

Section 9 — Secretary-Treasurer

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

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

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

Section 10 — Immediate Past President

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

Section 11 — Speaker

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

Section 12 — Vice Speaker

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

Section 13 — Executive Director

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

Section 14 — Assistant Secretary-Treasurer

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

ARTICLE XI — COMMITTEES

Section 1 — General Committees

The president shall annually appoint committees and task forces to address issues pertinent to the College as deemed advisable. The members thereof need not consist of members of the Board, nor shall it be necessary that the chair of a committee be a member of the Board. 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 president, secretary-treasurer, immediate past president, and chair. The speaker shall attend meetings of the Executive Committee. The Executive Committee shall have the authority to act on behalf of the Board, subject to ratification by the Board at its next meeting.

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

Section 3 — Steering Committee

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

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

Section 4 — Bylaws Interpretation Committee

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

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

Section 5 — Finance Committee

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

Section 6 — Bylaws Committee

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

Section 7 — Compensation Committee

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

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

ARTICLE XII — ETHICS

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

ARTICLE XIII — AMENDMENTS

Section 1 — Submission

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

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

Section 2 — Notice

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

Section 3 — Amendment Under Initial Consideration

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

Section 4 — Contested Amendment

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

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

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

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

ARTICLE XIV — MISCELLANEOUS

Section 1 — Inspection of Records

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

Section 2 — Annual Report

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

Section 3 — Parliamentary Authority

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

Section 4 — College Manual

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

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

ARTICLE XV — MANDATORY INDEMNIFICATION

Section 1 — Policy of Indemnification and Advancement of Expenses

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

Section 2 — Definitions

For purposes of this Article XV:

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

Section 3 — Non-Exclusive; Continuation

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

Section 4 — Insurance or Other Arrangement

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

Section 5 — Exclusion of Certain Acts from Indemnification

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



COLLEGE MANUAL

Revised October 2020



College Manual

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College Manual

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I. Applications for Membership

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

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

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

A. Definitions

1. ACEP means the American College of Emergency Physicians.
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
September 29-30, 2022
Hilton San Francisco Union Square Hotel
San Francisco, CA

Minutes

The 51st annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:02 am Central time on Thursday, September 29, 2022, 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 provided a meeting dedication and then led the Council in reciting the Pledge of Allegiance and singing the National Anthem. She then welcomed new councillors, new alternate councillors, first time attendees, and guests.

Lori D. Winston, MD, FACEP, president of the California Chapter, welcomed councillors and other meeting attendees.

Chadd K. Kraus, DO, DrPH, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 346 councillors of the 433 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

Eric Joy provided an overview of the Council meeting 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 2022 Council meeting:

- | | |
|-----------------|---|
| AACEM | Theodore A Christopher, MD, FACEP |
| ALABAMA CHAPTER | Matt Heimann, MD, FACEP Stephen William Knight, MD, FACEP Annalise Sorrentino, MD, FACEP |
| ALASKA CHAPTER | Anne Zink, MD, FACEP |
| ARIZONA CHAPTER | Lawrence A DeLuca, MD Bradley A Dreifuss, MD, FACEP Olga Gokova, MD, FACEP Nicole R Hodgson, MD, FACEP Paul Andrew Kozak, MD, FACEP Megan L McElhinny, MD Rebecca B Parker, MD, FACEP Todd Brian Taylor, MD, FACEP Dale P Woolridge, MD, PhD, FACEP |

ARKANSAS CHAPTER

J Shane Hardin, MD, PhD, FACEP
Joshua N Keithley, MD
Robert Thomas VanHook, MD, FACEP

CALIFORNIA CHAPTER

Zahir I Basrai, MD
Rodney W Borger, MD, FACEP
Reb J H Close, MD, FACEP
Adam P Dougherty, MD, FACEP
Carriann E Drenten, MD, FACEP
Andrew N Fenton, MD, FACEP
Jorge A Fernandez, MD, FACEP
Marc Allan Futernick, MD, FACEP
Michael Gertz, MD, FACEP
Alicia Mikolaycik Gonzalez, MD, FACEP
Kamara W Graham, MD, FACEP
Vikant Gulati, MD, FACEP
Puneet Gupta, MD, FACEP
Roneet Lev, MD, FACEP
Christopher Libby, MD, MPH
Aimee K Moulin, MD, FACEP
Leslie Mukau, MD, FACEP
Valerie C Norton, MD, FACEP
Bing S Pao, MD, FACEP
Hunter M Pattison, MD
Joshua Perese, MD
Vivian Reyes, MD, FACEP
Carolyn Joy Sachs, MD, MPH, FACEP
Susanne J Spano, MD, FACEP
Katherine Laurinda Staats, MD, FACEP
Lawrence M Stock, 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

Jasmeet Singh Dhaliwal, MD, MPH, MBA
Ramnik S Dhaliwal, MD, JD
Laura Edgerley-Gibb, MD, FACEP
Anna Engeln, MD, FACEP
Douglas M Hill, DO, FACEP
Rebecca L Kornas, MD, FACEP
Carla Elizabeth Murphy, DO, FACEP

CORD

Jason Cass Wagner, MD, FACEP

CONNECTICUT CHAPTER

Thomas A Brunell, MD, FACEP
Daniel Freess, MD, FACEP
Thuy Nguyen, MD
Elizabeth Schiller, MD, FACEP
David E Wilcox, MD, FACEP

DELAWARE CHAPTER

Emily M Granitto, MD, FACEP
Kathryn Groner, MD, FACEP

DISTRICT OF COLUMBIA CHAPTER

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

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Angela Cai, MD, MBA
Nicholas Paul Cozzi, MD
Blake Denley, MD
Amanda Kay Irish, MD, MPH
Maggie Moran, MD
Abbey M Smiley, MD
Sophia Spadafore, MD
Ashley Tarchione, MD

FLORIDA CHAPTER

Jordan G R Celeste, MD, FACEP
Edward A Descallar, MD, FACEP
Elizabeth L DeVos, MD, FACEP
Andrzej T Dmowski, MD, FACEP
Vidor E Friedman, MD, FACEP
Gabriel Gomez, DO
Shayne M Gue, MD, FACEP
Carolyn K Holland, MD, FACEP
Saundra A Jackson, MD, FACEP
William Paul Jaquis, MD, MS, FACEP
Steven B Kailes, MD, FACEP
Amy S Kelley, MD, FACEP
Dakota R Lane, MD
Kristin McCabe-Kline, MD, FACEP
Patrick McKeny, DO
Tracy G Sanson, MD, FACEP
David Charles Seaberg, MD, CPE, FACEP
Todd L Slesinger, MD, FACEP
Zachary C Terwilliger, MD
Martin P Wegman, MD, PhD

GEORGIA CHAPTER

Matthew R Astin, MD, FACEP
Brett H Cannon, MD, FACEP
Shamie Das, MD, MBA, MPH, FACEP
James Joseph Dugal, MD(E), FACEP
Mark A Griffiths, MD, FACEP
Jeffrey F Linzer, Sr, MD, FACEP
DW "Chip" Pettigrew, III, MD, FACEP
Matthew Rudy, MD, FACEP
James L Smith, Jr, MD, FACEP

GOVT SERVICES CHAPTER

Joshua S da Silva, DO
Christine A DeForest, DO, FACEP
Roderick Fontenette, MD, FACEP
Katrina N Landa, MD, FACEP
Micaela A LaRose, MD
Linda L Lawrence, MD, CPE, FACEP
Joshua Lesko, MD
David S McClellan, MD, FACEP
Torree M McGowan, MD, FACEP
Justine K Stremick, MD
Danielle Wickman, MD

HAWAII CHAPTER

John M Gallagher, MD, FACEP
Lisa Jacobson, MD, FACEP

| | |
|-----------------------|---|
| IDAHO CHAPTER | Sierra P Debenham, MD, MSPH Ken John Gramyk, MD, FACEP |
| ILLINOIS CHAPTER | Halleh Akbarnia, MD, FACEP Amit D Arwindekar, MD, FACEP E Bradshaw Bunney, MD, FACEP Kristen M Donaldson, MD, MPH, FACEP Cai Glushak, MD, FACEP John W Hafner, MD, FACEP Adnan Hussain, MD, FACEP Janet Lin, MD, FACEP Howard K Mell, MD, MPH, CPE, FACEP Henry Pitzele, MD, FACEP Yanina Purim-Shem-Tov, MD, MS, FACEP Lauren M Smith, MD 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 | Nicholas Holden Kluesner, MD, FACEP Stacey Marie Marlow, MD, JD, 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 | Christopher W Pergrem, MD, FACEP Melissa Platt, MD, FACEP Hugh W Shoff, MD, FACEP Steven Joseph Stack, MD, MBA, FACEP |
| LOUISIANA CHAPTER | James B Aiken, MD, FACEP Deborah D Fletcher, MD, FACEP Jamie Hoitien Do Kuo, MD Phillip Luke LeBas, MD, FACEP Michael D Smith, MD MBA CPE, FACEP |
| MAINE CHAPTER | Thomas C Dancoes, DO, FACEP Garreth C Debiegun, MD, FACEP Charles F Pattavina, MD, FACEP |
| MARYLAND CHAPTER | Michael C Bond, MD, FACEP Sydney E DeAngelis, MD, FACEP Karen Dixon, MD, FACEP Kerry Forrestal, MD, FACEP Jonathan Lewis Hansen, MD, FACEP Edana Denise Mann, MD, FACEP Richard Gentry Wilkerson, MD, FACEP |
| MASSACHUSETTS CHAPTER | Brien Alfred Barnewolt, MD, FACEP Alice Bukhman, MD |

Stephen K Epstein, MD, MPP, FACEP
Kathleen Kerrigan, MD, FACEP
Matthew B Mostofi, DO, FACEP
Mark D Pearlmutter, MD, FACEP
Jesse Rideout, MD, FACEP
Deesha Sarma, MD
James Joseph Sullivan, Jr, MD
Joseph C Tennyson, MD, FACEP

MICHIGAN CHAPTER

Michael J Baker, MD, FACEP
Abigail Brackney, MD, FACEP
Sara S Chakel, MD, FACEP
Pamela N Coffey, MD, FACEP
Nicholas Dyc, MD, FACEP
Michael W Fill, DO, FACEP
Gregory Gafni-Pappas, DO, FACEP
Michael Vincent Gratson, 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
Donald L Lum, MD, FACEP
David A Milbrandt, MD, FACEP
David Nestler, MD, MS, FACEP
Thomas E Wyatt, MD, FACEP
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MISSISSIPPI CHAPTER

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Fred E Kency, Jr, MD, FACEP
Chester Duane Shermer, MD, FACEP

MISSOURI CHAPTER

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Jonathan Heidt, MD, MHA, FACEP
Dennis E Hughes, DO, FACEP
Louis D Jamtgaard, MD, FACEP
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MONTANA CHAPTER

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NEBRASKA CHAPTER

Renee Engler, MD, FACEP
Julie Query, MD

NEVADA CHAPTER

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Bret Frey, MD, FACEP

Gregory Alan Juhl, MD, FACEP
Brian M Trimmer, MD, FACEP

NEW HAMPSHIRE CHAPTER

Sarah Garlan Johansen, MD, FACEP

NEW JERSEY CHAPTER

Navin Ariyaprakai, MD, NRP, FAEMS, FACEP
Kimberly T Baldino, MD, FACEP
Michael Joseph Gerardi, MD, FACEP
Rachelle Ann Greenman, MD, FACEP
Patrick Blaine Hinfey, MD, FACEP
Steven M Hochman, MD, FACEP
Tara Knox, MD
Jessica M Maye, DO, FACEP
J Mark Meredith, MD, FACEP
Michael Ruzek, DO, FACEP

NEW MEXICO CHAPTER

Sarah Bridge, MD
Eric M Ketcham, MD, MBA, FACHE, FACEP
Scott Mueller, DO, FACEP

NEW YORK CHAPTER

Brahim Ardolic, MD, FACEP
Joseph Basile, MD, FACEP
Kirby Black, MD, FACEP
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Virgil W Smaltz, MD, FACEP
Wilson Smith, MD
Jeffrey J Thompson, MD, FACEP
Asa Viccellio, MD, FACEP
Luis Carlos Zapata, MD, FACEP

NORTH CAROLINA CHAPTER

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Gregory J Cannon, MD, FACEP
Jennifer Casaletto, MD, FACEP
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Stephen A Small, MD, FACEP

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Ryan Squier, MD, FACEP
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Derek Martinez, DO
Kurtis A Mayz, JD, MD, MBA, FACEP

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John C Moorhead, MD, FACEP
Chris F Richards, MD, FACEP
Christian Smith, MD, FACEP

PENNSYLVANIA CHAPTER

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Monisha Bindra, DO, MPH, FACEP
Karen M Custodio, DO
Eleanor Dunham, MD, FACEP
Marcus Eubanks, MD, FACEP
Ronald V Hall, MD, FACEP
Richard Hamilton, MD, FACEP
Kirk S Hinkley, MD, FACEP
Annahieta Kalantari, DO, FACEP
Erik Ian Kochert, MD, FACEP
Chadd K Kraus, DO, DrPH, CPE, FACEP
Hannah M Mishkin, MD, FACEP
Danielle Nesbit, DO
Shawn M Quinn, DO, FACEP
Meaghan L Reid, DO, FACEP
Jennifer L Savino, DO, FACEP
Rachael K Trupp, DO
Theresa Ann Walls, MD, MPH
Elizabeth Barrall Werley, MD, FACEP

PUERTO RICO CHAPTER

Angelisse M Almodovar Bernier, MD, FACEP
Edwin J Garcia La Torre, MD, FACEP

RHODE ISLAND CHAPTER

Achyut B Kamat, MD, FACEP
Michael Stephen Siclari, MD, FACEP
Jessica Smith, MD, FACEP

SOCIETY FOR ACADEMIC EMERGENCY MEDICINE

Kathleen J. Clem, MD, FACEP

SOUTH CAROLINA CHAPTER

Ryan M Barnes, DO
Matthew D Bitner, MD, FACEP
Allison Leigh Harvey, MD, FACEP
Kelly M Johnson, MD, FACEP
Christina Millhouse, MD, FACEP
Angel Lee Rochester, MD, FACEP

SOUTH DAKOTA CHAPTER

Donald Neilson, MD

TENNESSEE CHAPTER

Sanford H Herman, MD, FACEP
Kenneth L Holbert, MD, FACEP
Sudave D Mendiratta, MD, FACEP
Matthew Neal, MD
John H Proctor, MD, MBA, FACEP

TEXAS CHAPTER

Sara Andrabi, MD, FACEP
Angela Pettit Cornelius, MD, FACEP
Carrie de Moor, 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
Laura N Medford-Davis, MD, FACEP
Sterling Evan Overstreet, MD, FACEP
Heather S Owen, MD, FACEP
Anant Patel, DO, FACEP
Daniel Eugene Peckenpaugh, MD, FACEP
R Lynn Rea, MD, FACEP
Richard Dean Robinson, 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
Alexander Franke, MD
Alison L Smith, MD, MPH, FACEP
Henry T Yeates, DO, FACEP

VERMONT CHAPTER

Matthew S Siket, MD, FACEP
Alexandra Nicole Thran, MD, FACEP

VIRGINIA CHAPTER

Trisha Danielle Anest, MD MBA MPH, FACEP
Caroline Hollis Cox, MD
James R Humble, MD
Sarah Klemencic, MD, FACEP
Jessica Maerz, MD
Joseph Mason, MD, FACEP
Todd Parker, MD, FACEP

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| | Joran Sequeira, MD, FACEP Jesse D Spangler, MD, FACEP Theodore I Tzavaras, MD |
| WASHINGTON CHAPTER | Herbert C Duber, MD, MPH, FACEP Joshua R Frank, MD, FACEP Harlan Gallinger, MD, FACEP Sarah M Hansen, MD Carlton E Heine, MD, PhD, FACEP C Ryan Keay, MD, FACEP Elizabeth A McMurtry, DO, FACEP Jessica J Wall, MD, FACEP |
| WEST VIRGINIA CHAPTER | Adam Thomas Crawford, DO, FACEP David Benjamin Deuell, DO, FACEP Carol Lea Wright Becker, MD, FACEP |
| WISCONSIN CHAPTER | William D Falco, MD, MS, FACEP Jeffrey J Pothof, MD, FACEP Michael Dean Repplinger, MD, PhD, FACEP Jamie Schneider, MD Brian Sharp, MD, FACEP Christopher Torkilsen, DO |
| WYOMING CHAPTER | Stephen Pecevich, MD |
| AAWEP SECTION | Andrea Austin, MD, FACEP |
| AIR MEDICAL TRANSPORT SECTION | Sabina A Braithwaite, MD, FACEP |
| CAREERS IN EMERGENCY MEDICINE SECTION | Constance J Doyle, MD, FACEP |
| CRITICAL CARE MEDICINE SECTION | Nicholas Johnson, MD, FACEP |
| CRUISE SHIP MEDICINE SECTION | Ruben Dario Parejo, MD |
| DEMOCRATIC GROUP PRACTICE SECTION | David G Hall, MD, FACEP |
| DISASTER MEDICINE SECTION | Samantha Noll, MD, FACEP |
| DIVERSITY & INCLUSION SECTION | Ugo A Ezenkwele, MD, FACEP |
| DUAL TRAINING SECTION | Vinay Mikkilineni, MD |
| EM PRACTICE MGMT & HEALTH POLICY SECTION | Robert M McNamara, MD |
| EMERGENCY MEDICAL INFORMATICS SECTION | Mark Baker, MD, FACEP |
| EMERGENCY MEDICINE LOCUM TENENS SECTION | Angela F Mattke, MD, FACEP |
| EMERGENCY MEDICINE WORKFORCE SECTION | Harry W Severance, MD, FACEP |
| EMERGENCY TELEHEALTH SECTION | Deborah A Mulligan, MD, FACEP |
| EMERGENCY ULTRASOUND SECTION | Jeremy Boyd, MD, FACEP |
| EMS-PREHOSPITAL CARE SECTION | Dustin Holland, MD MPH, FACEP |

| | |
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| EVENT MEDICINE SECTION | George-Thomas M Pugh, MD |
| FORENSIC MEDICINE SECTION | Monika Pitzele, MD, FACEP |
| FREESTANDING EMERGENCY CENTERS | Paul Daniel Kivela, MD, MBA, FACEP |
| GERIATRIC EMERGENCY MEDICINE SECTION | Shan W Liu, MD, FACEP |
| INTERNATIONAL EMERGENCY MEDICINE SECTION | Shama Patel, MD |
| MEDICAL DIRECTORS SECTION | Thomas F Spiegel, MD, MBA, MS, FACEP |
| MEDICAL HUMANITIES SECTION | Rachel H Kowalsky, MD |
| OBSERVATION SERVICES SECTION | Anthony R Rosania, MD, FACEP |
| PAIN MANAGEMENT SECTION | Donald E Stader, MD, FACEP |
| PALLIATIVE MEDICINE SECTION | Rebecca R Goett, MD, FACEP |
| PEDIATRIC EMERGENCY MEDICINE SECTION | Jason T Lowe, DO |
| QUALITY IMPROVEMENT AND PATIENT SAFETY SECTION | Collin Michels, MD |
| RESEARCH, SCHOLARLY ACTIVITY, & INNOVATION SECTION | Justin B Belsky, MD MPH |
| RURAL EMERGENCY MEDICINE SECTION | Benjamin Knutson, MD |
| SOCIAL EMERGENCY MEDICINE SECTION | Laura Janneck, MD, FACEP |
| SPORTS MEDICINE SECTION | Anne M Verlangieri, MD |
| TACTICAL EMERGENCY MEDICINE SECTION | Unrepresented |
| TOXICOLOGY SECTION | Jennifer Hannum, MD, FACEP |
| TRAUMA & INJURY PREVENTION SECTION | Gregory Luke Larkin, MD, FACEP |
| UNDERSEA & HYPERBARIC MEDICINE SECTION | Drue Orwig, DO |
| WELLNESS SECTION | Susan T Haney, MD, FACEP |
| WILDERNESS MEDICINE SECTION | Brendan Harry Milliner, MD |
| YOUNG PHYSICIANS SECTION | Scott H Pasichow, MD, MPH, 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 Bedard, MD, FACEP (CA) | George Molzen, MD, FACEP (NM) |
| Brooks F. Bock, MD, FACEP (CO) | Andrew Sama, MD, FACEP (NY) |
| Michael Carius, MD, FACEP (CT) | Robert W. Schafermeyer, MD, FACEP(NC) |
| Angela F. Gardner, MD, FACEP (TX) | Sandra M. Schneider, MD, FACEP (TX) |
| James Brian Hancock, MD, FACEP (MI) | Richard L. Stennes, MD, FACEP (CA) |
| Nicholas J. Jouriles, MD, FACEP (OH) | Robert E. Suter, DO, MPH, FACEP (TX) |

Past Speakers

Michael J. Bresler, MD, FACEP
James M. Cusick, MD, FACEP (FL)
Peter J. Jacoby, MD, FACEP (CT)

Past Chairs of the Board

Stephen H. Anderson, MD, FACEP (WA)
Andrew I. Bern, MD, FACEP (FL)
John D. Bibb, MD, FACEP (CA)
Jon Mark Hirshon, MD, PhD, FACEP (MD)

Ramon W. Johnson, MD, FACEP (CA)
Robert E. O'Connor, MD, MPH, FACEP (VA)
David P. Sklar, MD, FACEP (NM)

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

Council Standing Rules

Preamble

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

Alternate Councillors

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

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

Amendments to Council Standing Rules

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

Announcements

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

Appeals of Decisions from the Chair

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

Board of Directors Seating

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

Campaign Rules

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

Conflict of Interest Disclosure

All councillors and alternate councillors will be familiar with and comply with ACEP's Conflict of Interest policy. Individuals who have a financial interest in a commercial enterprise, which interest will be

materially affected by a matter before the Council, will declare their conflict prior to providing testimony.

Councillor Allocation for Sections of Membership

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

Councillor Seating

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

Credentialing and Proper Identification

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

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

Debate

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

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

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

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

Distribution of Printed or Other Material During the Annual Meeting

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

Election Procedures

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

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

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

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their

respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, the candidate with the lowest number of valid votes is removed from subsequent ballots. In the event of a tie for the lowest number of valid votes on a ballot in which no candidate is elected, a run-off will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

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

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

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

Electronic Devices

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

Leadership Development Advisory Committee

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

Limiting Debate

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

Nominating Committee

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

Nominations

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

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

Parliamentary Procedure

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

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

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

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

Policy Review

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

Reference Committees

Resolutions meeting the filing and transmittal requirements in these Standing Rules will be assigned by the speaker to a Reference Committee for deliberation and recommendation to the Council, 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, 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.

The councillors reviewed and accepted the minutes of the October 23-24, 2021, Council meeting and approved the actions of the Steering Committee taken at their January 24, 2022, and May 1, 2022, meetings.

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

Dr. Gray-Eurom reported that seven late resolutions were received and reviewed by the Steering Committee. Six memorial resolutions were accepted by the Steering Committee. Memorial resolutions are not assigned to a Reference Committee for testimony. One late resolution was accepted for submission to the Council. "Emergency Physician Protection from Legal Jeopardy Related to Elective Abortion Management" was numbered 65 and assigned to Reference Committee B.

Dr. Gray-Eurom presented the Nominating Committee report.

Seven members were nominated for four positions on the Board of Directors: William B. Felegi, DO, FACEP; Jeffrey M. Goodloe, MD, FACEP; Gabor D. Kelen, MD, FACEP; Jeffrey F. Linzer, Sr., MD, FACEP; Kristin B. McCabe-Kline, MD, FACEP; Henry Z. Pitzele, MD, FACEP; and Ryan A. Stanton, MD, FACEP. Dr. Gray-Eurom announced that Dr. Felegi withdrew his name from nomination and then read a personal statement from him. Dr. Gray-Eurom called for floor nominations. There were no nominees. The nominations were then closed.

One member was nominated for President-Elect: Aisha T. Terry, MD, MPH, FACEP. Dr. Gray-Eurom called for floor nominations. There were no floor nominees. The nominations were then closed. With no objections, Dr. Terry was declared as the 2022-23 president-elect.

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

The Council recessed at 9:15 am for the Reference Committee hearings. The resolutions considered by the 2022 Council appear below as submitted.

2022 Council Resolutions

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting

impact of the contributions of Michael L. Callaham, MD, FACEP, to the advancement of science and success of *Annals of Emergency Medicine*; and be it further

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

RESOLUTION 2

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

RESOLUTION 3

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

RESOLUTION 4

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

RESOLUTION 5

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

RESOLUTION 6

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Carey D. Chisholm, MD, to the specialty of emergency medicine, especially as an educator, and extends the College's condolences to his wife of almost 40 years, Robin Chisholm, as well as to their daughters, Kelsey and Tyler.

RESOLUTION 7

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Loren A. Crown, MD, FACEP, and extends condolences and gratitude to his wife, Elaine Kathleen Ellis, family, and friends for his service to the specialty of emergency medicine and to patient care.

RESOLUTION 8

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

RESOLUTION 9

RESOLVED, That the American College of Emergency Physicians extends to the family of Adetolu "Tolu" Odufuye MD, FACEP, her friends, and her colleagues our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the patients and physicians of Florida and the United States.

RESOLUTION 10

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

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

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

“Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such

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

RESOLUTION 11

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

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

RESOLUTION 12

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

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

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

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

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

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

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

A Board report on each resolution referred, in whole or part, by the Council to the Board of Directors, will be prepared and become business of the subsequent Council meeting. The Board report will include a summary of the discussion and the Board’s recommendations regarding the referred matter. As business of the Council, the Board’s recommendations will be subject to Council approval. The Council will review, discuss, and act on the Board report. This may include approval, rejection, amendment, or referral of the recommendations.

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

RESOLUTION 13

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 5 – Voting Rights, paragraph two be

amended to read:

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

RESOLUTION 14

RESOLVED, That the “Debate” section, paragraph one, of the Council Standing Rules be amended to read:

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

RESOLVED, That the Council Standing Rules “Past Presidents, Past Speakers, and Past Chairs of the Board Seating” section be amended to read as follows with the proviso that the changes will become effective after the 2022 Council meeting and only upon adoption of the companion Bylaws amendment titled “Past Leader Participation in Council Meetings”:

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

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

PROVISO: The provisions of this resolution shall not go into effect unless Resolution 13(22) Past Leader Participation in Council Meetings – Bylaws Amendment is adopted by the Council and the Board of Directors.

RESOLUTION 15

RESOLVED, That the ACEP Council Standing Rules, “Election Procedures” section, paragraph one, and the “Voting on Resolutions and Motions” section be amended to read:

Election Procedures

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

Voting on Resolutions and Motions

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

RESOLUTION 16

RESOLVED, That the ACEP Council Standing Rules, “Nominations” section, be amended to read:

Nominations

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

Members not nominated by the Nominating Committee may **self-nominate by** declaring themselves “floor candidates” at any time after the release of the Nominating Committee report and before the speaker closes nominations during the Council meeting. All floor candidates must notify the Council speaker in writing. Upon

receipt of this notification, the candidate becomes a “declared floor candidate,” has all the rights and responsibilities of candidates otherwise nominated by the Nominating Committee, and must comply with all rules and requirements of the candidates. All required candidate materials (including but not limited to professional photo, CV, Candidate Campaign Rules Attestation, responses to written questions, candidate data sheet, conflict of interest disclosure statement) must be available immediately at the time of floor nomination – either completed by the due date for all nominees or at the time of notification to the Speaker of intent to seek nomination, whichever date is later. See also Election Procedures.

RESOLUTION 17

RESOLVED, That ACEP study the feasibility of moving previously scheduled national-level ACEP events away from states that do not offer access to a full range of reproductive health care options; and be it further

RESOLVED, That ACEP not schedule future national-level ACEP events in states that do not offer access to a full range of reproductive health care options; and be it further

RESOLVED, That with recognition of the necessity for both the College and its chapters to continue to function in states that limit access to a full range of reproductive health care options, the prohibition of scheduling meetings in these states shall apply to national-level ACEP events only, and shall not apply to individual chapters of the College.

RESOLUTION 18

RESOLVED, That information on the sources and amount of revenue for the Clinical Emergency Data Registry be disclosed in the Treasurer’s report to the Council and to the membership.

RESOLUTION 19

RESOLVED, That ACEP adopt this policy: “Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support, or otherwise be associated with the ACEP, as of January 1, 2023, shall remove all contractual restrictions on or waivers of due process for emergency physicians. Physicians cannot be asked to waive this right as it can be detrimental to the quality and safety of patient care. The entities affected include but are not limited to physician group practices, hospitals and staffing companies.”; and be it further

RESOLVED, That ACEP create a method for members to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying such that are of concern, and to investigate the matter allowing the entity an opportunity to respond or modify its policy prior to exclusion for violation of this policy.

RESOLUTION 20

RESOLVED, That ACEP provide, as a member benefit at no charge, legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

RESOLUTION 21

RESOLVED, That ACEP directly support the American Academy of Emergency Medicine – Physician Group litigation versus Envision by a donation of \$1 million of the members’ equity to the American Academy of Emergency Medicine Foundation.

RESOLUTION 22

RESOLVED, That ACEP return 10% of national dues to each chapter calculated by $0.1 \times$ number of state dues-paying members every year.

RESOLUTION 23

RESOLVED, That the Council Steering Committee study limits to the number of years individuals may serve in the ACEP Council and report back to the Council with actionable recommendations by the 2024 Council meeting.

RESOLUTION 24

RESOLVED, That ACEP support nationwide access to a full array of reproductive health care options.

RESOLUTION 25

RESOLVED, That ACEP affirms that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual’s state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure; and be it further

RESOLVED, That ACEP supports the position that the early termination of pregnancy (publicly referred to as “abortion”) is a medical procedure, and as such, involves shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients; and be it further

RESOLVED, That ACEP opposes the criminalization or mandatory reporting for non-public health monitoring reasons of self-induced abortion as it increases patients’ medical risks and deters patients from seeking medically necessary services and will advocate against any legislative efforts to criminalize self-induced abortion; and be it further

RESOLVED, That ACEP supports an individual’s ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care; and be it further

RESOLVED, That ACEP opposes the criminalization, imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals.

RESOLUTION 26

RESOLVED, That ACEP promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the emergency department irrespective of the state in which the patient is seeking reproductive health care; and be it further

RESOLVED, That ACEP promote legal protections for doctors practicing within the best practices and laws of their own states, irrespective of the state of origin of their patients; and be it further

RESOLVED, That ACEP encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best clinical practices on miscarriage and post-abortion care, including for patients who have self-managed abortions; and be it further

RESOLVED, That ACEP broaden its clinical policy on Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy to include considerations for miscarriage management; and be it further

RESOLVED, That ACEP continue to develop practices and policies that protect the integrity of the physician-patient relationship including developing legal resources for physicians caring for peri-abortion and post-abortion patients in states where abortion access is limited; and be it further

RESOLVED, That ACEP promote adherence to laws that provide the strongest possible protections for high quality patient care including its continued support of adhering to the federal Emergency Medical Treatment and Labor Act (EMTALA) over state abortion laws when failure to treat or securely transfer a patient with a potentially life-threatening pregnancy-related complication, including but not limited to ectopic pregnancy, severe hemorrhage or uterine infection from either abortion or miscarriage contradicts EMTALA.

RESOLUTION 27

RESOLVED, That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and be it further

RESOLVED, ACEP advocate for universal access to emergency contraception in the emergency department.

RESOLUTION 28

RESOLVED, That ACEP will petition the appropriate state or federal legislative and regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, will directly provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis; and be it further

RESOLVED, That ACEP adopt this policy: “Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with ACEP, will, as of January 1, 2023, provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed information on monetary amounts billed and collected in the physician’s name. This information must be provided without the need for the physician to request it. Physicians cannot be asked to waive access to this information. The entities affected include but are not limited to revenue cycle management companies, physician group practices, hospitals, and staffing companies.”

RESOLUTION 29

RESOLVED, That ACEP advocate on behalf of its patients and members that the FDA add buprenorphine to

its list of essential medications; and be it further

RESOLVED, That ACEP recommend and advocate that every emergency department stock buprenorphine and medications for opioid use disorder so that patients with opioid use disorder or in opioid withdrawal may receive the best evidence-based care; and be it further

RESOLVED, That ACEP work with the American Hospital Association, American Medical Association, state agencies, and federal agencies to promote availability of medications for opioid use disorder in emergency departments and hospital settings; and be it further

RESOLVED, That ACEP support hospitals and emergency physicians in initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder to enhance best evidence-based practices in emergency medicine throughout the United States.

RESOLUTION 30

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 31

RESOLVED, That ACEP endorse and support the decriminalization of the personal possession and use of small amounts of all illicit drugs in the United States instead making that a civil penalty with referral to treatment; and 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 and instead making that a civil penalty with referral to treatment.

RESOLUTION 32

RESOLVED, That ACEP support the development and implementation of Supervised Consumption Facilities/Supervised Injection Sites (SCF/SIS) in the United States that would be designed, monitored, and evaluated to include additional data to inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harm and health care costs related to injection drug use.

RESOLUTION 33

RESOLVED, That ACEP support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder care; and be it further

RESOLVED, That ACEP advocate for state and federal regulatory and legislative solutions that will permit the ongoing integration of opioid use disorder treatment including medication therapy through telehealth into the continuum of addiction care.

RESOLUTION 34

RESOLVED, That ACEP work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

RESOLUTION 35

RESOLVED, That ACEP advocate legislation at the state and federal level that includes clear penalty language outlining punishment and consequences for those who assault a healthcare worker who is at work and delivering care.

RESOLUTION 36

RESOLVED, That ACEP declare EMS an essential service and engage in a public information campaign to educate the public in this regard; and be it further

RESOLVED, That ACEP work with the American Medical Association and other stakeholder organizations to actively promote the inclusion of Emergency Medical Services among federally- and locally-funded essential services.

RESOLUTION 37

RESOLVED, That ACEP support the protection of all participants in discussions of cases of potential medical error, whether Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), or any patient safety forum,

from legal discovery; and be it further

RESOLVED, That ACEP encourage and support state chapters in identifying pending or existing state laws limiting free discussion of cases of potential medical error in quality assurance/quality improvement, Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), and similar environments, and in lobbying against them.

RESOLUTION 38

RESOLVED, That ACEP, through legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; and be it further

RESOLVED, That ACEP publish best-practice action plans for hospitals to improve emergency department capacity; and be it further

RESOLVED, That ACEP, through task force work, define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

RESOLUTION 39

RESOLVED, That ACEP advocate for requiring Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient Emergency Departments without onsite emergency medicine physicians to post clear signage in the waiting room and exam rooms noting the lack of physician coverage.

RESOLUTION 40

RESOLVED, That ACEP develop a policy statement in support of the expansion of Medicaid to the levels allowable by federal law in recognition of the benefit of increasing health care access to eligible patients, including some of our most vulnerable, while decreasing the uncompensated care provided by emergency physicians; and be it further

RESOLVED, That ACEP develop a toolkit to assist ACEP state chapters in their efforts to advocate for such expansion of Medicaid in their states.

RESOLUTION 41

RESOLVED, That ACEP develop an educational program on identifying and addressing stigma in the emergency department that can be provided to residency programs as a standard part of residency training, highlighting the role of important practices such as person-first language.

RESOLUTION 42

RESOLVED, That ACEP establish policy to appreciate and support the efforts of other specialties to require emergency department or emergency medicine experience of their residents, with specific support for the equity of their experience with that of emergency medicine residents; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education to reaffirm existing requirements that residents from other specialties do not detract from the education of emergency medicine residents; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education to expand the program requirements for emergency medicine regarding the education of residents from other services; specifically stating that the following requirements apply equally:

- a. Training site resources (e.g., clinical support personnel).
- b. Training site volume and acuity, with sites for these residents subject to the same requirements as the primary clinical site for emergency medicine residents.
- c. Qualifications of faculty members supervising these residents.
- d. Designation of a physician qualified to supervise emergency medicine residents as a core faculty member of the other residency or residencies who is responsible for the emergency medicine experience of that residency.; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education and other specialties to reference emergency medicine new requirements in the requirements for other residencies that require emergency department or emergency medicine experience (e.g., internal medicine, family medicine, transitional year, etc.) such that the required experience is substantially similar for all residents and specifically all residents who require emergency medicine or emergency department experience should receive a substantially similar experience at training sites with or without an emergency medicine residency regarding:

- a. Training site resources.
- b. Training site volume and acuity.
- c. Faculty qualifications.

Designation of a core faculty member, qualified to supervise emergency medicine residents, responsible for the emergency medicine experience of the residency.

RESOLUTION 43

RESOLVED, That ACEP support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and be it further

RESOLVED, That ACEP coordinate with other organizations in emergency medicine (Council of Residency Directors in Emergency Medicine, Society for Academic Emergency Medicine, and the American Board of Emergency Medicine) to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency and should focus on identification of patients with opioid use disorder and initiation of buprenorphine treatment as well as sharing harm reduction information and resources such as clean syringes, naloxone, and fentanyl test strips, depending on local practice and availability.

RESOLUTION 44

RESOLVED, That ACEP adopt as policy, a position that every patient presenting to an emergency department should be assessed, in person, by a board-certified/board-eligible emergency physician as defined by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or a physician formerly board certified in emergency medicine as defined by ABEM or ABOEM who is now board certified by an alternate national board; and be it further

RESOLVED, That ACEP adopt as policy a position that if no board-certified/board-eligible emergency physician is available, that the absolute minimum standard to providing emergency care is that every patient presenting to an emergency department is assessed, in person, by a licensed physician who is board certified/board eligible in an medical specialty as defined by the American Board of Medical Specialties or the American Osteopathic Association, or who was formerly so certified and is now a member of an alternate national board; and be it further

RESOLVED, That ACEP adopt as policy, a position that nurse practitioners and physician assistants should never practice emergency medicine without in-person, real-time physician supervision; and be it further

RESOLVED, That ACEP advocate with the Centers for Medicare & Medicaid Services and third-party payers to exclude care provided by a nurse practitioners and physician assistants without in-person, real-time physician supervision from the definition of emergency medicine for the purposes of billing or reimbursement.

RESOLUTION 45

RESOLVED, That the ACEP policy statement “Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department” be revised so that onsite emergency physician presence to supervise nurse practitioners and physician assistants is stated as the gold standard for staffing all emergency departments.

RESOLUTION 46

RESOLVED, That ACEP research and make recommendations regarding the minimum staffing ratios of physicians to nurse practitioners and physician assistants, taking into account appropriate variables (such as patient acuity, non-physician provider competencies, available clinical resources, etc.) to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

RESOLUTION 47

RESOLVED, That ACEP work with the American Medical Association and call for an unbiased outside agency survey and report of nurse practitioner schools to provide recommendations for nurse practitioner reform to improve the quality of nurse practitioner education and to improve patient care.

RESOLUTION 48

RESOLVED, That ACEP endorse that before a physician assistant or nurse practitioner can work in a Critical Access Hospital (CAH), Rural Emergency Hospital (REH) or Outpatient Emergency Department (OED) that they have a minimum of five years of experience working in an emergency department with onsite supervision.

RESOLUTION 49

RESOLVED, That ACEP support initiatives that encourage the placement of emergency medicine-trained and board-certified medical directors in all U.S. EDs, whether in person or virtual; and be it further

RESOLVED, That ACEP support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board-certified physicians; and be it further

RESOLVED, That ACEP support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-emergency medicine physicians, physician assistants, and nurse practitioners already working in rural EDs.

RESOLUTION 50

RESOLVED, That ACEP support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; and be it further

RESOLVED, That ACEP help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work rural; and be it further

RESOLVED, That ACEP support working with the Accreditation Council for Graduate Medical Education to increase resident exposure to rural emergency medicine.

RESOLUTION 51

RESOLVED, That ACEP support screening for social determinants of health with validated tools; and be it further

RESOLVED, That ACEP encourage screening for social determinants of health to be paired with feasible and appropriate responses.

RESOLUTION 52

RESOLVED, That ACEP appoint a task force or committee to identify minimum standards of care for health-related social complaints in the emergency department, acknowledging that these standards are only advisory in nature and must be reflective of standards that can be reasonably achieved in all emergency departments, with particular attention given to the feasibility of recommended standards in low resource and/or rural settings, and submit a report to the 2023 Council.

RESOLUTION 53

RESOLVED, That ACEP investigate alternative care models to evaluate patients in police custody, such as telehealth, to determine necessity of an in-person evaluation; and be it further

RESOLVED, That ACEP encourage law enforcement to stay with any patient they choose to bring to the ED who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed.

RESOLUTION 54

RESOLVED, That, to safeguard the welfare of our membership and patients, ACEP task a committee with developing a process to identify employers of emergency physicians and quantify the degree of moral injury imposed by said employers on their emergency physician employees and further making these findings available to the general membership.

RESOLUTION 55

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

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

RESOLUTION 56

RESOLVED, That ACEP adopt the following policy statement based on the California Medical Board's guidance:

ACEP Policy Statement on the Corporate Practice of Medicine

ACEP strongly believes that the physician-patient relationship should be free of commercialization and undue influence by business interests. The corporate practice of medicine prohibition is intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment. The decisions described below are examples of some of the types of behaviors and subtle controls that the corporate practice doctrine is intended to prevent. The following health care decisions should be made by a licensed physician and would constitute the unlicensed practice of medicine if performed by an unlicensed person:

- Determining what diagnostic tests are appropriate for a particular condition.
- Determining the need for referrals to, or consultation with, another physician/specialist.
- Responsibility for the ultimate overall care of the patient, including treatment options available to the patient.
- Determining how many patients a physician must see in a given period of time or how many hours a physician must work.

In addition, the following "business" or "management" decisions and activities, resulting in control over the physician's practice of medicine, should be made by a licensed physician and not by an unlicensed person or entity:

- Ownership is an indicator of control of a patient's medical records, including determining the contents thereof, and should be retained by a licensed physician.
- Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants.
- Setting the parameters under which the physician will enter into contractual relationships with third-party payers.
- Decisions regarding coding and billing procedures for patient care services.
- Approving of the selection of medical equipment and medical supplies for the medical practice.

The types of decisions and activities described above cannot be delegated to an unlicensed person, including (for example) management service organizations. While a physician may consult with unlicensed persons in making the "business" or "management" decisions described above, the physician must retain the ultimate responsibility for, or approval of, those decisions.

The following types of medical practice ownership and operating structures also are prohibited:

- Non-physicians owning or operating a business that offers patient evaluation, diagnosis, care, or treatment.
- Management service organizations arranging for or providing medical services rather than only providing administrative staff and services for a physician's medical practice (non-physician exercising controls over a physician's medical practice, even where physicians own and operate the business).

In the examples above, non-physicians would be engaged in the unlicensed practice of medicine, and the physician may be aiding and abetting the unlicensed practice of medicine.

RESOLUTION 57

RESOLVED, That ACEP amend its policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine" to reflect that alternate organizations that claim to provide "board certification" but that do not provide ongoing assessment of their diplomates, do not provide transparency about their certification process, do not provide transparency about the specialties and numbers of certified physicians, or merely verify continuing medical education and training, are not recognized by ACEP as equivalent to board certification by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or the American Board of Pediatrics for any purpose; and

RESOLVED, That ACEP affirm that board certification through the American Board of Medical Specialties or the American Osteopathic Association are currently the only ACEP-recognized means for emergency physician board certification in the United States.

RESOLUTION 58

RESOLVED, That ACEP support the cessation of invasive medical evaluation exams and questionnaires that may unduly and unnecessarily invade the privacy of emergency medicine physicians seeking employment beyond that which is necessary to confirm ability to perform duties associated with the individual's role as hired.

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

RESOLVED, That the American College of Emergency Physicians recognize and salute Brian Robb, DO,

MBA, FACEP, and offer our heartfelt condolence to his wife of 43 years, Sharon, his three children, and many grandchildren.

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

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of James R. Roberts, MD, FACMT, FAAEM, FACEP, who was a pioneer in the specialty and dedicated himself to his patients, to his profession, and to his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extend to his partner Lydia (Forte) to whom he was married for over 40 years, daughter Martha, son Matthew, his grandchildren Eleanor Cronin and Liam Roberts, his brother George Roberts, his sister Mary Peterlin, nieces, nephews, and family-in-law gratitude for his tremendous service as one of the pillars of emergency medicine, a consummate clinician and educator, as well as for his dedication and commitment to the specialty of emergency medicine.

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

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Douglas D. Rockacy, MD, FACEP, who dedicated himself to his patients, to his trainees, to his profession, and to his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extend to his wife Wendy, daughter Claire, and son Russell gratitude for his tremendous service as one of the finest emergency physicians the University of Pittsburgh has ever seen, as well as for his dedication and commitment to the specialty of emergency medicine.

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

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Robert J. Teichman, MD, PhD, and extends condolences and gratitude to his wife, Geri Young, MD, of Kapa'a, Kaua'i, and his sons Kurt Teichman of Brooklyn, NY and Grant Teichman of Honolulu, Hawaii, and other family members for his service to the community, his patients, his students, and the specialty of emergency medicine.

RESOLUTION 63 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Jason M White, MD, FACEP, to the specialty of emergency medicine and extends the College's condolences to his wife of almost 40 years, Carol, and also to their sons and daughters, Ken, Christopher, Brittany, and Allison, and grandchildren Olivia, Finn, Rosalyn, Easton, and Cassius.

RESOLUTION 64 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by J. David Barry, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of J. David Barry MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of the Department of Defense, Veteran's Affairs, and the United States.

RESOLUTION 65 *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP shall not establish policies or assert an ethical standard of care regarding management of patients seeking elective abortions in the emergency department.

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

Resolutions 10-23 were assigned to Reference Committee A. Nicole Veitinger, DO, FACEP, chaired Reference Committee A and other members were: Debra Fletcher; MD, FACEP; John M. Gallagher, MD, FACEP; Kurtis A. Mayz, JD, MD, MBA, FACEP; Alexandra N. Thran, MD, FACEP; Brad L. Walters, MD, FACEP; Maude Surprenant Hancock, CAE; and Laura Lang, JD.

Resolutions 24-40 and 65 were assigned to Reference Committee B. Abhi Mehrotra, MD, MBA, FACEP, chaired Reference Committee B and other members were: Erik Blutinger, MD, MSc; Angela P. Cornelius, MD, FACEP; Hilary E. Fairbrother, MD, FACEP; Puneet Gupta, MD, FACEP; Diana Nordlund, DO, JD, FACEP; Jeff Davis; and Ryan McBride, MPP.

Resolutions 41-58 were assigned to Reference Committee C. Dan Freess, MD, FACEP, chaired Reference Committee C and other members were: Andrea Austin, MD, FACEP; Lisa M. Bundy, MD, FACEP; Antony P. Hsu, MD, FACEP; James D. Maloy, MD, MPH; David Nestler, MD, MS, FACEP; Jonathan Fisher, MD, FACEP and Travis Schulz, MLS, AHIP.

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

At 12:45 pm a Town Hall Meeting was convened. The topic was “Strange Changes: Practice Innovations, Payment Impacts and Predicting the Future. Council Vice Speaker Melissa Costello, MD, FACEP, served as the moderator and the discussants were Angela Cai, MD, MBA; Nicholas Cozzi, MD, MBA; Sandy Schneider MD, FACEP; and James L. Shoemaker, Jr., MD, FACEP.

A Candidate Forum for president-elect candidates was not held since Dr. Terry was unopposed.

Dr. Gray-Eurom moderated a second Town Hall Meeting. The topic was “Running Up That Hill.” Discussants were: Gillian R. Schmitz, MD, FACEP; Christopher S. Kang, MD, FACEP; and Susan E. Sedory, MA, CAE.

The Candidate Forum for the Board of Directors candidates began at 2:45 pm with candidates rotating through each of the Reference Committee meeting rooms.

At 4:45 pm Dr. Gray-Eurom addressed the Council and then reviewed the procedure for the adoption of the 2022 memorial resolutions. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. Gray-Eurom then read the resolves of the memorial resolutions for J. David, Barry, MD, FACEP; Carey Chisholm, MD; Loren Crown, MD, FACEP; Sherrill Mullenix; Adetolu Odufuye, MD, FACEP; Brian Robb, DO, MBA, FACEP; James Roberts, MD, FACEP; Douglas Rockacy, MD, FACEP; Robert Teichman, MD, PhD; and Jason White 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.

Samuel M. Keim, MD, FACEP, president of the American Board of Emergency Medicine, addressed the Council.

Dr. Goodloe presented the secretary-treasurer’s report.

Angela Cai, MD, MBA, president of the Emergency Medicine Residents’ Association, addressed the Council.

A video report regarding the activities of the Emergency Medicine Foundation was shown to the Council.

A video report regarding the activities of National Emergency Medicine Political Action Committee was shown to the Council.

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

The Council recessed at 5:56 pm for the candidate reception and reconvened at 8:04 am on Friday, September 30, 2022.

Dr. Kraus reported that 418 councillors of the 433 eligible for seating had been credentialed.

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

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. Veitinger 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 11 and Resolution 16.

For adoption as amended or substituted: Amended Resolution 15.

Not for adoption: Resolution 12, Resolution, 13, Resolution 14, Resolution 17, Resolution 18, Resolution 21, Resolution 22, and Resolution 23.

Not for adoption and for adoption as amended: Resolution 19

For referral to the Board of Directors: Resolution 10 and Resolution 20.

Resolution 13, Resolution 14, Amended Resolution 15, Resolution 17, Resolution 19, Resolution 20, and Resolution 22 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

The committee recommended that Resolution 13 not be adopted.

It was moved THAT RESOLUTION 13 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 14 not be adopted.

It was moved THAT RESOLUTION 14 BE ADOPTED. The motion was not adopted.

The committee recommended that Amended Resolution 15 be adopted.

It was moved THAT AMENDED RESOLUTION 15 BE ADOPTED:

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.**

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. The motion was adopted.

The committee recommended that Resolution 17 not be adopted.

It was moved THAT RESOLUTION 17 BE ADOPTED.

It was moved THAT RESOLUTION 17 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT IN CONSIDERING WHERE TO SCHEDULE FUTURE NATIONAL LEVEL ACEP EVENTS, ACEP SHALL TAKE INTO CONSIDERATION WHETHER THAT LOCATION RESTRICTS ACCESS TO REPRODUCTIVE HEALTH CARE.

It was moved THAT SUBSTITUTE RESOLUTION 17 BE REFERRED TO THE BOARD. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that the first resolved of Resolution 19 not be adopted.

It was moved THAT THE FIRST RESOLVED OF RESOLUTION 19 BE ADOPTED. The motion was not adopted.

The committee recommended that Amended Resolution 19 be adopted.

It was moved THAT AMENDED RESOLUTION 19 BE ADOPTED:

RESOLVED, THAT ACEP CREATE A METHOD FOR MEMBERS TO REPORT INCIDENTS OF DENIAL OF DUE PROCESS, REVIEW MEMBER-SUBMITTED CONTRACTUAL CLAUSES OR OTHER METHODS OF DENYING SUCH THAT ARE OF CONCERN, ~~AND TO INVESTIGATE THE MATTER ALLOWING THE ENTITY AN OPPORTUNITY TO RESPOND OR MODIFY ITS POLICY PRIOR TO EXCLUSION FOR VIOLATION OF THIS POLICY.~~

It was moved THAT AMENDED RESOLUITON 19 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP BELIEVES THAT EMPLOYEMENT AGREEMENTS SHOULD CONTAIN CLEAR PROVISIONS TO BOTH PROTECT A PHYSICIAN'S RIGHT TO DUE PROCESS BEFORE TERMINATION FOR CAUSE AND TO PROTECT A PHYSICIAN'S RIGHT TO REASONABLE NOTICE BEFORE TERMINATION WITHOUT CAUSE. PHYSICIAN EMPLOYMENT AGREEMENTS SHOULD ALSO SPECIFY WHETHER OR NOT TERMINATION OF EMPLOYMENT IS GROUNDS FOR AUTOMATIC TERMINATION OF HOSPITAL MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES. PHYSICIANS CANNOT BE ASKED TO WAIVE THESE RIGHTS AS DOING SO CAN BE DETRIMENTAL TO THE QUALITY AND SAFETY OF PATIENT CARE; AND BE IT FURTHER

RESOLVED, THAT ADOPT THIS POLICY: "ANY ENTITY THAT WISHES TO ADVERTISE IN ACEP VEHICLES, EXHIBIT AT ITS MEETINGS, PROVIDE SPONSORSHIP, OTHER SUPPORT, OR OTHERWISE BE ASSOCIATED WITH THE ACEP, AS OF JANUARY 1, 2023, SHALL BE REQUIRED TO CLEARLY DISCLOSE ENTITY CONTRACTUAL RESTRICTIONS ON AND/OR WAIVERS OF DUE PROCESS FOR EMERGENCY PHYSICIANS AND TO STATE (YES OR NO) WHETHER OR NOT THESE RESTRICTIONS AND/OR WAIVERS COMPLY WITH THE CURRENT PEER REVIEW AND DUE PROCESS POLICY DESCRIBED IN THE AMA CODE OF MEDICAL ETHICS OPINION 9.4.1. PHYSICIANS CANNOT BE ASKED TO WAIVE THIS RIGHT AS IT CAN BE DETRIMENTAL TO THE QUALITY AND SAFETY OF PATIENT CARE. THE ENTITIES AFFECTED INCLUDE BUT ARE NOT LIMITED TO PHYSICIAN GROUP PRACTICES, HOSPITALS AND STAFFING COMPANIES."

It was moved THAT THE SECOND RESOLVED BE DELETED. The motion was adopted.

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

The main motion was then voted on and was adopted.

The committee recommended that Resolution 20 be referred to the Board of Directors.

It was moved THAT RESOLUTION 20 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Resolution 22 not be adopted.

It was moved THAT RESOLUTION 22 BE ADOPTED.

It was moved THAT RESOLUTION 22 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP HAVE AN INCENTIVE SYSTEM IN PLACE FOR CHAPTERS OF 750 MEMBERS OR LESS AND REGULATED BY THE STATE LEGISLATIVE COMMITTEE TO PROVIDE 10% OF THE COST OF NATIONAL DUES PER REGULAR DUES-PAYING STATE MEMBER RETURNED BACK TO EACH CHAPTER PER YEAR FOR THE PURPOSE OF STATE-LEVEL ADVOCACY FOR EMERGENC PHYSICIANS. The motion was not adopted.

It was moved THAT RESOLUTION 22 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 45 with the amended title ~~Offsite~~ **Onsite** Supervision of Nurse Practitioners and Physician Assistants.

For adoption as amended or substituted: Amended Resolution 41, Amended Resolution 43, Amended Resolution 46, Amended Resolution 47, Amended Resolution 50, Amended Resolution 51, Amended Resolution 56, Amended Resolution 57, and Amended Resolution 58.

Not for adoption: Resolution 42, Amended Resolution 44, Resolution 48, Resolution 49, Resolution 52, Resolution 53, Resolution 54, and Resolution 55

Amended Resolution 44, Amended Resolution 46, Amended Resolution 47, and Resolution 53 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 41

RESOLVED, THAT ACEP DEVELOP AN EDUCATIONAL **PROGRAM RESOURCE** ON IDENTIFYING AND ADDRESSING STIGMA IN THE EMERGENCY DEPARTMENT THAT CAN BE PROVIDED TO **EMERGENCY PHYSICIANS** AND RESIDENCY PROGRAMS ~~AS A STANDARD PART OFFOR USE IN RESIDENCY TRAINING~~, HIGHLIGHTING THE ROLE OF IMPORTANT PRACTICES SUCH AS PERSON-FIRST LANGUAGE.

AMENDED RESOLUTION 43

RESOLVED, THAT ACEP SUPPORT THE INTEGRATION OF BUPRENORPHINE TRAINING AND HARM REDUCTION SKILLS INTO THE CORE CURRICULUM FOR RESIDENTS GRADUATING FROM ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

ACCREDITED EMERGENCY MEDICINE PROGRAMS; AND BE IT FURTHER

RESOLVED, THAT ACEP COORDINATE WITH OTHER ORGANIZATIONS IN EMERGENCY MEDICINE (COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE, SOCIETY FOR ACADEMIC EMERGENCY MEDICINE, AND THE AMERICAN BOARD OF EMERGENCY MEDICINE) TO FURTHER ENDORSE INTEGRATION OF BUPRENORPHINE TRAINING AND HARM REDUCTION SKILLS INTO CURRICULUM OR SIMULATION SESSIONS DURING RESIDENCY AND SHOULD FOCUS ON IDENTIFICATION OF PATIENTS WITH OPIOID USE DISORDER AND INITIATION OF BUPRENORPHINE TREATMENT AS WELL AS SHARING HARM REDUCTION INFORMATION AND RESOURCES ~~SUCH AS CLEAN SYRINGES, NALOXONE, AND FENTANYL TEST STRIPS, DEPENDING ON LOCAL PRACTICE AND AVAILABILITY.~~

AMENDED RESOLUTION 50 SUPPORTING EMERGENCY PHYSICIANS TO WORK **IN RURAL SETTINGS**

RESOLVED, THAT ACEP SUPPORT AND ENCOURAGE EMERGENCY MEDICINE TRAINED AND BOARD CERTIFIED EMERGENCY PHYSICIANS TO WORK IN RURAL EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP HELP ESTABLISH, WITH THE COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE, A STANDARDIZED TRAINING PROGRAM FOR EMERGENCY MEDICINE RESIDENTS WITH ASPIRATIONS TO WORK **IN RURAL SETTINGS**; AND BE IT FURTHER

RESOLVED, THAT ACEP 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.

AMENDED RESOLUTION 51 IMPLEMENTATION OF SOCIAL DETERMINANTS OF HEALTH **SCREENING EVALUATION**

RESOLVED, THAT ACEP SUPPORT **SCREENING EVALUATION** OF SOCIAL DETERMINANTS OF HEALTH ~~WITH VALIDATED TOOLS~~ **IN THE EMERGENCY DEPARTMENT**; AND BE IT FURTHER

~~RESOLVED, THAT ACEP ENCOURAGE SCREENING FOR SOCIAL DETERMINANTS OF HEALTH TO BE PAIRED WITH FEASIBLE AND APPROPRIATE RESPONSES.~~

RESOLVED, THAT ACEP ADVOCATE FOR NATIONAL, STATE, AND LOCAL RESOURCES AND RESPONSES TO BE PAIRED WITH THE EVALUATION FOR SOCIAL DETERMINANTS OF HEALTH.

AMENDED RESOLUTION 56

RESOLVED, THAT ACEP ~~ADOPT THE FOLLOWING POLICY STATEMENT BASED ON THE CALIFORNIA MEDICAL BOARD'S GUIDANCE:~~ **WORK WITH RELEVANT EXPERTS TO DEVELOP A POLICY STATEMENT OPPOSING THE CORPORATE PRACTICE OF MEDICINE.**

~~ACEP POLICY STATEMENT ON THE CORPORATE PRACTICE OF MEDICINE~~

~~ACEP STRONGLY BELIEVES THAT THE PHYSICIAN-PATIENT RELATIONSHIP SHOULD BE FREE OF COMMERCIALIZATION AND UNDUE INFLUENCE BY BUSINESS INTERESTS. THE CORPORATE PRACTICE OF MEDICINE PROHIBITION IS INTENDED TO PREVENT UNLICENSED PERSONS FROM INTERFERING WITH OR INFLUENCING THE PHYSICIAN'S PROFESSIONAL JUDGMENT. THE DECISIONS DESCRIBED BELOW ARE EXAMPLES OF SOME OF THE TYPES OF BEHAVIORS AND SUBTLE CONTROLS THAT THE CORPORATE PRACTICE DOCTRINE IS INTENDED TO PREVENT. THE FOLLOWING HEALTH CARE DECISIONS SHOULD BE MADE BY A LICENSED PHYSICIAN AND WOULD CONSTITUTE THE UNLICENSED PRACTICE OF MEDICINE IF PERFORMED BY AN UNLICENSED PERSON:~~

- ~~• DETERMINING WHAT DIAGNOSTIC TESTS ARE APPROPRIATE FOR A PARTICULAR CONDITION.~~
- ~~• DETERMINING THE NEED FOR REFERRALS TO, OR CONSULTATION WITH, ANOTHER PHYSICIAN/SPECIALIST.~~
- ~~• RESPONSIBILITY FOR THE ULTIMATE OVERALL CARE OF THE PATIENT, INCLUDING TREATMENT OPTIONS AVAILABLE TO THE PATIENT.~~

- ~~DETERMINING HOW MANY PATIENTS A PHYSICIAN MUST SEE IN A GIVEN PERIOD OF TIME OR HOW MANY HOURS A PHYSICIAN MUST WORK.~~

~~IN ADDITION, THE FOLLOWING “BUSINESS” OR “MANAGEMENT” DECISIONS AND ACTIVITIES, RESULTING IN CONTROL OVER THE PHYSICIAN’S PRACTICE OF MEDICINE, SHOULD BE MADE BY A LICENSED PHYSICIAN AND NOT BY AN UNLICENSED PERSON OR ENTITY:~~

- ~~OWNERSHIP IS AN INDICATOR OF CONTROL OF A PATIENT’S MEDICAL RECORDS, INCLUDING DETERMINING THE CONTENTS THEREOF, AND SHOULD BE RETAINED BY A LICENSED PHYSICIAN.~~
- ~~SELECTION, HIRING/FIRING (AS IT RELATES TO CLINICAL COMPETENCY OR PROFICIENCY) OF PHYSICIANS, ALLIED HEALTH STAFF AND MEDICAL ASSISTANTS.~~
- ~~SETTING THE PARAMETERS UNDER WHICH THE PHYSICIAN WILL ENTER INTO CONTRACTUAL RELATIONSHIPS WITH THIRD PARTY PAYERS.~~
- ~~DECISIONS REGARDING CODING AND BILLING PROCEDURES FOR PATIENT CARE SERVICES.~~
- ~~APPROVING OF THE SELECTION OF MEDICAL EQUIPMENT AND MEDICAL SUPPLIES FOR THE MEDICAL PRACTICE.~~

~~THE TYPES OF DECISIONS AND ACTIVITIES DESCRIBED ABOVE CANNOT BE DELEGATED TO AN UNLICENSED PERSON, INCLUDING (FOR EXAMPLE) MANAGEMENT SERVICE ORGANIZATIONS. WHILE A PHYSICIAN MAY CONSULT WITH UNLICENSED PERSONS IN MAKING THE “BUSINESS” OR “MANAGEMENT” DECISIONS DESCRIBED ABOVE, THE PHYSICIAN MUST RETAIN THE ULTIMATE RESPONSIBILITY FOR, OR APPROVAL OF, THOSE DECISIONS.~~

~~THE FOLLOWING TYPES OF MEDICAL PRACTICE OWNERSHIP AND OPERATING STRUCTURES ALSO ARE PROHIBITED:~~

- ~~NON PHYSICIANS OWNING OR OPERATING A BUSINESS THAT OFFERS PATIENT EVALUATION, DIAGNOSIS, CARE, OR TREATMENT.~~
- ~~MANAGEMENT SERVICE ORGANIZATIONS ARRANGING FOR OR PROVIDING MEDICAL SERVICES RATHER THAN ONLY PROVIDING ADMINISTRATIVE STAFF AND SERVICES FOR A PHYSICIAN’S MEDICAL PRACTICE (NON PHYSICIAN EXERCISING CONTROLS OVER A PHYSICIAN’S MEDICAL PRACTICE, EVEN WHERE PHYSICIANS OWN AND OPERATE THE BUSINESS).~~

~~IN THE EXAMPLES ABOVE, NON PHYSICIANS WOULD BE ENGAGED IN THE UNLICENSED PRACTICE OF MEDICINE, AND THE PHYSICIAN MAY BE AIDING AND ABETTING THE UNLICENSED PRACTICE OF MEDICINE.~~

AMENDED RESOLUTION 57

~~RESOLVED, THAT ACEP AMEND ITS POLICY STATEMENT “ACEP RECOGNIZED CERTIFYING BODIES IN EMERGENCY MEDICINE” TO REFLECT THAT **NO ALTERNATE CERTIFYING ORGANIZATIONS BEYOND THOSE ALREADY LISTED IN THE POLICY STATEMENT** THAT CLAIM TO PROVIDE “BOARD CERTIFICATION” BUT THAT DO NOT PROVIDE ONGOING ASSESSMENT OF THEIR DIPLOMATES, DO NOT PROVIDE TRANSPARENCY ABOUT THEIR CERTIFICATION PROCESS, DO NOT PROVIDE TRANSPARENCY ABOUT THE SPECIALTIES AND NUMBERS OF CERTIFIED PHYSICIANS, OR MERELY VERIFY CONTINUING MEDICAL EDUCATION AND TRAINING, ARE NOT RECOGNIZED BY ACEP AS EQUIVALENT TO BOARD CERTIFICATION BY THE AMERICAN BOARD OF EMERGENCY MEDICINE, THE AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE, OR THE AMERICAN BOARD OF PEDIATRICS FOR ANY PURPOSE; AND.~~

~~RESOLVED, THAT ACEP AFFIRM THAT BOARD CERTIFICATION THROUGH THE AMERICAN BOARD OF MEDICAL SPECIALTIES OR THE AMERICAN OSTEOPATHIC ASSOCIATION ARE CURRENTLY THE ONLY ACEP RECOGNIZED MEANS FOR EMERGENCY PHYSICIAN BOARD CERTIFICATION IN THE UNITED STATES.~~

AMENDED RESOLUTION 58 REMOVING **UNNECESSARY AND INVASIVE INTRUSIVE** MEDICAL EXAMS AND QUESTIONNAIRES FROM EMPLOYMENT CONTRACTS

~~RESOLVED, THAT ACEP SUPPORT THE CESSATION OF **INVASIVE INTRUSIVE** MEDICAL EVALUATION EXAMS AND QUESTIONNAIRES THAT MAY UNDULY AND UNNECESSARILY INVADE THE PRIVACY OF EMERGENCY MEDICINE PHYSICIANS SEEKING **AND CONTINUING**~~

EMPLOYMENT BEYOND THAT ~~WHICH IS~~ NECESSARY TO CONFIRM ABILITY TO PERFORM DUTIES ASSOCIATED WITH THE INDIVIDUAL'S ROLE AS HIRED.

The committee recommended that Amended Resolution 44 not be adopted.

It was moved THAT AMENDED RESOLUTION 44 BE ADOPTED. The motion was not adopted.

The committee recommended that Amended Resolution 46 be adopted.

It was moved THAT AMENDED RESOLUTION 46 BE ADOPTED:

RESOLVED, THAT ACEP ~~RESEARCH~~ INVESTIGATE AND MAKE RECOMMENDATIONS REGARDING ~~THE MINIMUM~~ APPROPRIATE AND SAFE STAFFING ROLES, RATIOS, ~~OF PHYSICIANS TO NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS~~ RESPONSIBILITIES, AND MODELS OF EMERGENCY PHYSICIAN-LED TEAMS, TAKING INTO ACCOUNT APPROPRIATE VARIABLES (~~SUCH AS PATIENT ACUITY, NON-PHYSICIAN PROVIDER COMPETENCIES, AVAILABLE CLINICAL RESOURCES, ETC.~~) TO ALLOW FOR SAFE, HIGH-QUALITY CARE AND APPROPRIATE SUPERVISION IN THE SETTING OF A PHYSICIAN-LED EMERGENCY MEDICINE TEAM.

It was moved THAT THE WORD "RATIOS" BE DELETED. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 47 with the amended title ~~Unbiased~~ Independent ~~Outside~~ Agency Report for Nurse Practitioner Schools be adopted.

It was moved THAT AMENDED RESOLUTION 47 BE ADOPTED:

RESOLVED, THAT ACEP WORK WITH THE AMERICAN MEDICAL ASSOCIATION AND CALL FOR AN ~~UNBIASED~~ INDEPENDENT OUTSIDE AGENCY SURVEY AND REPORT OF NURSE PRACTITIONER SCHOOLS TO PROVIDE RECOMMENDATIONS FOR NURSE PRACTITIONER EDUCATION REFORM TO IMPROVE THE QUALITY AND STANDARDS OF NURSE PRACTITIONER ~~EDUCATION~~ TRAINING ~~AND TO IMPROVE~~ FOR THE PURPOSE OF IMPROVING PHYSICIAN-LED PATIENT CARE.

It was moved THAT THE WORDS "AND CALL FOR AN INDEPENDENT OUTSIDE AGENCY SURVEY AND REPORT OF NURSE PRACTITIONER SCHOOLS" BE DELETED. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 53 not be adopted.

It was moved THAT RESOLUTION 53 BE ADOPTED.

It was moved THAT THE TITLE OF THE RESOLUTION BE AMENDED TO "LAW ENFORCEMENT AND SAFE HANDOFFS AND INTOXICATED PATIENTS IN THE ED" AND THE RESOLUTION BE AMENDED TO READ:

~~RESOLVED, THAT ACEP INVESTIGATE ALTERNATIVE CARE MODELS TO EVALUATE PATIENTS IN POLICE CUSTODY, SUCH AS TELEHEALTH, TO DETERMINE NECESSITY OF AN IN-PERSON EVALUATION; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ENCOURAGE LAW ENFORCEMENT TO STAY WITH ANY PATIENT THEY CHOOSE TO BRING TO THE ED WHO ARE INTOXICATED, ALTERED, AGITATED, OR OTHERWISE POSE A RISK TO THE SAFETY OF THEMSELVES OR OTHERS UNTIL ~~A DISPOSITION HAS BEEN DETERMINED OR THE PHYSICIAN DETERMINES THEIR ASSISTANCE IS NO LONGER NEEDED~~ THE ED PHYSICIAN AND LAW ENFORCEMENT

AGREE THAT THE PATIENT NO LONGER POSES A SAFETY RISK TO THE STAFF OF THE EMERGENCY DEPARTMENT; AND BE IT FURTHER RESOLVED, THAT ACEP DEVELOP A SAFE HANDOFF TOOL TO TRANSITION CARE FROM LAW ENFORCEMENT TO ED STAFF. The motion was not adopted.

It was moved THAT RESOLUTION 53 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The Council recessed at 12:00 pm for the awards luncheon and reconvened at 1:45 pm on Friday, September 30, 2022.

Dr. Kraus reported that 427 councillors of the 433 eligible for seating had been credentialed.

REFERENCE COMMITTEE B

Dr. Mehrotra 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 27, Resolution 29, Resolution 32, Resolution 33, Resolution 34, Resolution 37, and Resolution 40.

For adoption as Amended or Substituted: Amended Resolution 24, Amended Resolution 25, Amended Resolution 26, Amended Resolution 28, Amended Resolution 35, Amended Resolution 36, Amended Resolution 38, and Amended Resolution 39 with the amended title “Signage at **Emergency Departments Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient EDs** Without Onsite **Emergency Physicians.** ”

Not for adoption: Resolution 30, Resolution 31, and Resolution 65.

Amended Resolution 24, Amended Resolution 25, Amended Resolution 28, Resolution 31, Resolution 32, Amended Resolution 35, Amended Resolution 39, and Resolution 65 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 26

~~RESOLVED, THAT ACEP PROMOTE THE EQUITABLE AND KNOWLEDGEABLE TREATMENT OF PATIENTS SEEKING PERI-ABORTION AND POST-ABORTION CARE IN THE EMERGENCY DEPARTMENT IRRESPECTIVE OF THE STATE IN WHICH THE PATIENT IS SEEKING REPRODUCTIVE HEALTH CARE; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP PROMOTE LEGAL PROTECTIONS FOR DOCTORS PRACTICING WITHIN THE BEST PRACTICES AND LAWS OF THEIR OWN STATES, IRRESPECTIVE OF THE STATE OF ORIGIN OF THEIR PATIENTS; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ENCOURAGE HOSPITALS AND EMERGENCY MEDICINE RESIDENCY TRAINING PROGRAMS TO PROVIDE EDUCATION, TRAINING, AND RESOURCES OUTLINING **BEST EVIDENCE-BASED** CLINICAL PRACTICES ON **ACUTE PRESENTATIONS OF PREGNANCY-RELATED COMPLICATIONS, INCLUDING** MISCARRIAGE, **AND** POST-ABORTION CARE, ~~AND INCLUDING FOR PATIENTS WHO HAVE~~ SELF-MANAGED ABORTIONS; AND BE IT FURTHER

~~RESOLVED, THAT ACEP BROADEN ITS CLINICAL POLICY ON ISSUES IN THE INITIAL EVALUATION AND MANAGEMENT OF PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT IN EARLY PREGNANCY TO INCLUDE CONSIDERATIONS FOR MISCARRIAGE MANAGEMENT; AND BE IT FURTHER~~

RESOLVED, THAT ACEP CONTINUE TO DEVELOP **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).** ~~INCLUDING DEVELOPING LEGAL RESOURCES FOR~~

~~PHYSICIANS CARING FOR PERI-ABORTION AND POST-ABORTION PATIENTS IN STATES WHERE ABORTION ACCESS IS LIMITED; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP SUPPORT CLEAR LEGAL PROMOTE ADHERENCE TO LAWS THAT PROVIDE THE STRONGEST POSSIBLE PROTECTIONS FOR EMERGENCY PHYSICIANS PROVIDING FEDERALLY-MANDATED EMERGENCY CARE, PARTICULARLY IN CASES OF CONFLICT BETWEEN FEDERAL LAW AND STATE REPRODUCTIVE HEALTH LAWS HIGH QUALITY PATIENT CARE INCLUDING ITS CONTINUED SUPPORT OF ADHERING TO THE FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) OVER STATE ABORTION LAWS WHEN FAILURE TO TREAT OR SECURELY TRANSFER A PATIENT WITH A POTENTIALLY LIFE-THREATENING PREGNANCY-RELATED COMPLICATION, INCLUDING BUT NOT LIMITED TO ECTOPIC PREGNANCY, SEVERE HEMORRHAGE OR UTERINE INFECTION FROM EITHER ABORTION OR MISCARRIAGE CONTRADICTS EMTALA.~~

AMENDED RESOLUTION 36

~~RESOLVED, THAT ACEP DECLARE ADVOCATE FOR EMS TO BE CONSIDERED AND FUNDED AS AN ESSENTIAL SERVICE AND ENGAGE IN A PUBLIC INFORMATION CAMPAIGN TO EDUCATE THE PUBLIC IN THIS REGARD; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP WORK WITH THE AMERICAN MEDICAL ASSOCIATION, 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 IN THIS REGARD.~~

AMENDED RESOLUTION 38

~~RESOLVED, THAT ACEP, THROUGH LEGISLATIVE VENUES AND LOBBYING EFFORTS, FOCUS REGULATORY BODIES, I.E., CENTERS FOR MEDICARE & MEDICAID SERVICES, THE JOINT COMMISSION, ETC., TO ESTABLISH A REASONABLE MATRIX OF STANDARDS INCLUDING ACCEPTABLE BOARDING TIMES AND HANDOFF OF CLINICAL RESPONSIBILITY FOR BOARDING PATIENTS; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP PUBLISH BEST-PRACTICE ACTION PLANS FOR HOSPITALS TO IMPROVE EMERGENCY DEPARTMENT CAPACITY; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP, THROUGH TASK FORCE WORK, TO DEFINE CRITERIA TO DETERMINE WHEN AN EMERGENCY DEPARTMENT IS CONSIDERED OVER CAPACITY AND HOSPITAL ACTION PLANS ARE TRIGGERED TO ACTIVATE.~~

The committee recommended that Amended Resolution 24 be adopted.

It was moved THAT AMENDED RESOLUTION 24 BE ADOPTED:

~~RESOLVED, THAT ACEP SUPPORTS EQUITABLE, NATIONWIDE ACCESS TO A-FULL ARRAY OF EMERGENCY REPRODUCTIVE HEALTH CARE OPTIONS PROCEDURES, MEDICATIONS, AND OTHER INTERVENTIONS IN THE EMERGENCY DEPARTMENT.~~

It was moved THAT THE WORD “EMERGENCY” BEFORE THE WORD “REPRODUCTIVE” BE REINSTATED. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 25 be adopted.

It was moved THAT AMENDED RESOLUTION 25 BE ADOPTED:

~~RESOLVED, THAT ACEP AFFIRMS THAT: 1) ABORTION IS A MEDICAL PROCEDURE AND SHOULD BE PERFORMED ONLY BY A DULY LICENSED PHYSICIAN, SURGEON, OR OTHER MEDICAL PROFESSIONAL IN CONFORMANCE WITH STANDARDS OF GOOD MEDICAL PRACTICE AND THE MEDICAL PRACTICE ACT OF THAT INDIVIDUAL’S STATE; AND 2) NO PHYSICIAN OR OTHER PROFESSIONAL PERSONNEL SHALL BE REQUIRED TO PERFORM AN~~

ACT VIOLATIVE OF GOOD MEDICAL JUDGMENT AND THIS PROTECTION SHALL NOT BE CONSTRUED TO REMOVE THE ETHICAL OBLIGATION FOR REFERRAL FOR ANY MEDICALLY INDICATED PROCEDURE; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORTS THE POSITION THAT THE EARLY TERMINATION OF PREGNANCY (PUBLICLY REFERRED TO AS “ABORTION”) IS A MEDICAL PROCEDURE, AND AS SUCH, INVOLVES SHARED DECISION MAKING BETWEEN PATIENTS AND THEIR PHYSICIAN REGARDING: 1) DISCUSSION OF REPRODUCTIVE HEALTH CARE; 2) PERFORMANCE OF INDICATED CLINICAL ASSESSMENTS; 3) EVALUATION OF THE VIABILITY OF PREGNANCY AND SAFETY OF THE PREGNANT PERSON; 4) AVAILABILITY OF APPROPRIATE RESOURCES TO PERFORM INDICATED PROCEDURE(S); AND 5) IS TO BE MADE ONLY BY HEALTH CARE PROFESSIONALS WITH THEIR PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSES THE CRIMINALIZATION OR MANDATORY REPORTING OF REPRODUCTIVE HEALTH-RELATED PATIENT CONCERNS IN THE EMERGENCY DEPARTMENT WHEN PERSONAL PRIVACY, SAFETY, AND/OR HEALTH ARE POTENTIALLY AT RISK IN THE ACUTE SETTING FOR NON-PUBLIC HEALTH MONITORING REASONS OF SELF-INDUCED ABORTION AS IT INCREASES PATIENTS’ MEDICAL RISKS AND DETERS PATIENTS FROM SEEKING MEDICALLY NECESSARY SERVICES AND WILL ADVOCATE AGAINST ANY LEGISLATIVE EFFORTS TO CRIMINALIZE SELF-INDUCED ABORTION; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORTS AN INDIVIDUAL’S ABILITY TO ACCESS THE FULL SPECTRUM OF EVIDENCE-BASED PRE-PREGNANCY, PRENATAL, PERIPARTUM, AND POSTPARTUM PHYSICAL AND MENTAL HEALTH CARE, AND SUPPORTS THE ADEQUATE PAYMENT FROM ALL PAYERS FOR SAID CARE; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSES THE CRIMINALIZATION, IMPOSITION OF PENALTIES, OR OTHER RETALIATORY EFFORTS AGAINST PATIENTS, PATIENT ADVOCATES, PHYSICIANS, HEALTH CARE WORKERS, AND HEALTH SYSTEMS FOR RECEIVING, ASSISTING, OR REFERRING PATIENTS WITHIN A STATE OR ACROSS STATE LINES TO RECEIVE REPRODUCTIVE HEALTH SERVICES OR MEDICATIONS FOR CONTRACEPTION AND ABORTION, AND WILL FURTHER ADVOCATE FOR LEGAL PROTECTION OF SAID INDIVIDUALS.

It was moved THAT THE FIRST RESOLVED BE AMENDED BY INSERTING THE WORD “AND” BEFORE THE WORD “SURGEON” AND THE WORDS “OR OTHER MEDICAL PROFESSIONAL” BE DELETED. The motion was not adopted.

It was moved THAT THE THIRD RESOLVED BE AMENDED BY DELETING THE WORDS “WHEN PERSONAL PRIVACY, SAFETY, AND/OR HEALTH ARE POTENTIALLY AT RISK IN THE ACUTE SETTING” BE DELETED. The motion was adopted.

It was moved THAT AMENDED RESOLUTION 25 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 28 be adopted.

It was moved THAT AMENDED RESOLUTION 28 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATE ~~PETITION THE APPROPRIATE STATE OR FEDERAL LEGISLATIVE AND REGULATORY BODIES~~ TO ESTABLISH THE REQUIREMENT THAT REVENUE CYCLE MANAGEMENT ENTITIES, ~~REGARDLESS OF THEIR OWNERSHIP STRUCTURE,~~ WILL, UPON REQUEST, DIRECTLY PROVIDE EVERY EMERGENCY PHYSICIAN IT BILLS OR COLLECTS FOR WITH; A DETAILED ITEMIZED STATEMENT OF BILLING AND REMITTANCES FOR MEDICAL SERVICES THEY PROVIDE ~~ON AT LEAST A MONTHLY BASIS;~~ AND BE IT FURTHER.

~~RESOLVED, THAT ACEP ADOPT THIS POLICY: “ANY ENTITY THAT WISHES TO ADVERTISE IN ACEP VEHICLES, EXHIBIT AT ITS MEETINGS, PROVIDE SPONSORSHIP, OTHER SUPPORT OR OTHERWISE BE ASSOCIATED WITH ACEP, WILL, AS OF JANUARY 1, 2023,~~

~~PROVIDE EVERY EMERGENCY PHYSICIAN ASSOCIATED WITH THAT ENTITY, AT A MINIMUM, A MONTHLY STATEMENT WITH DETAILED INFORMATION ON MONETARY AMOUNTS BILLED AND COLLECTED IN THE PHYSICIAN'S NAME. THIS INFORMATION MUST BE PROVIDED WITHOUT THE NEED FOR THE PHYSICIAN TO REQUEST IT. PHYSICIANS CANNOT BE ASKED TO WAIVE ACCESS TO THIS INFORMATION. THE ENTITIES AFFECTED INCLUDE BUT ARE NOT LIMITED TO REVENUE CYCLE MANAGEMENT COMPANIES, PHYSICIAN GROUP PRACTICES, HOSPITALS, AND STAFFING COMPANIES."~~

It was moved THAT THE SECOND RESOLVED BE REINSTATED. The motion was not adopted.

It was moved THAT THE WORDS "UPON REQUEST" BE DELETED. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Resolution 31 not be adopted.

It was moved THAT RESOLUTION 31 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 32 be adopted.

It was moved THAT RESOLUTION 32 BE ADOPTED.

It was moved THAT RESOLUTION 32 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 35 be adopted.

It was moved THAT AMENDED RESOLUTION 35 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATE **FOR** LEGISLATION AT THE STATE AND FEDERAL LEVEL THAT INCLUDES CLEAR ~~PENALTY~~ LANGUAGE OUTLINING ~~PUNISHMENT AND CONSEQUENCES~~ FOR THOSE WHO ASSAULT A HEALTHCARE WORKER **AT THE WORKPLACE** ~~WHO IS AT WORK AND DELIVERING CARE.~~

It was moved THAT AMENDED RESOLUTION 35 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP ADVOCATE FOR LEGISLATION AT THE STATE AND FEDERAL LEVEL THAT INCLUDES RESTORATIVE JUSTICE FOR THOSE WHO ASSAULT A HEALTHCARE WORKER AT THE WORKPLACE. The motion was not adopted.

The main motion was then voted on adopted.

The committee recommended that Amended Resolution 39 be adopted.

It was moved THAT AMENDED RESOLUTION 39 BE ADOPTED:

RESOLVED, THAT ACEP ~~ADVOCATE FOR REQUIRING~~ **ENCOURAGE ALL EMERGENCY DEPARTMENTS** ~~CRITICAL ACCESS HOSPITALS, RURAL EMERGENCY HOSPITALS, AND OUTPATIENT EMERGENCY DEPARTMENTS WITHOUT ONSITE EMERGENCY MEDICINE PHYSICIANS~~ **TO ADVERTISE THAT THEY ARE STAFFED BY A BOARD-CERTIFIED OR - ELIGIBLE EMERGENCY PHYSICIAN WHERE CARE IS DELIVERED** ~~POST CLEAR SIGNAGE IN THE WAITING ROOM AND EXAM ROOMS NOTING THE LACK OF PHYSICIAN COVERAGE.~~

It was moved THAT THE WORDS "BOARD-CERTIFIED OR ELIGIBLE EMERGENCY" BE DELETED. The motion was not adopted..

The main motion was then voted on and adopted.

The committee recommended that Resolution 65 not be adopted.

It was moved THAT RESOLUTION 65 BE ADOPTED.

It was moved THAT RESOLUTION 65 BE TABLED. The motion was adopted.

Christopher S. Kang, MD, FACEP, president-elect, addressed the Council.

Dr. Kraus reported that 429 councillors of the 433 eligible for seating had been credentialed.

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

There being no further business, Dr. Gray-Eurom adjourned the 2022 Council meeting at 5:46 pm on Friday, September 30, 2022.

The next meeting of the ACEP Council is scheduled for October 7-8, 2023, at the Philadelphia Convention Center in Philadelphia, PA.

Respectfully submitted,

Approved by,



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

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



Steering Committee Conference Call
January 31, 2023

Minutes

Speaker Kelly Gray-Eurom, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 10:03 am Central time on Tuesday, January 31, 2023.

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, vice speaker; Emily Fitz, MD, FACEP; Kelly Gray-Eurom, MD, FACEP, speaker; Vik Gulati, MD, FACEP; Carlton Heine, MD, PhD, FACEP; C. Ryan Keay, MD, FACEP; Alexander Kirk, MD, FACEP; Phillip Luke LeBas, MD, FACEP; Marc Mendelsohn, MD, FACEP; Diana Nordlund, DO, JD, FACEP; Bing Pao, MD, FACEP; Christopher Sampson, MD, FACEP; Matthew Sanders, DO, FACEP; Gary Starr, MD, FACEP; and Thomas Sugarman, MD, FACEP .

Other members and guests present for all or portions of the meeting were: J. T. Finnell, MD, FACEP, vice president; Jeffrey Goodloe, MD, FACEP; Alison Haddock, MD, FACEP; Christopher Kang, MD, FACEP, president; Gabor Kelen, MD, FACEP; Rami Khoury, MD, FACEP; Aaron Kuzel, DO; James Shoemaker, MD, FACEP, secretary-treasurer; and Aisha Terry, MD, FACEP, president-elect.

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

Officer and Staff Reports

Speaker

Dr. Gray-Eurom welcomed everyone and thanked them for their participation and commitment to the College. She reflected on the successful 2022 Council meeting.

Vice Speaker

Dr. Costello reported that the vice speaker typically serves as chair of the Candidate Forum Subcommittee, however, she will be seeking nomination for speaker and Dr. Gray-Eurom will chair the subcommittee this year. There are no major revisions to the Candidate Campaign Rules that are needed this year.

President

Dr. Kang expressed his appreciation to the Steering Committee for their leadership. He encouraged their awareness of key issues of the College and to contact him at any time to discuss any of those issues if desired.

President-Elect

Dr. Terry stated she will focus on wellness, workforce, and membership issues during her term as president. She reported on her Board liaison duties as president-elect and the various meetings she has attended since her election. She also highlighted some of ACEP's collaboration initiatives.

Executive Director

Ms. Sedory reported on components of the Strategic Plan implementation regarding career fulfillment, advocacy initiatives, and practice innovations and other priorities for ACEP. She stressed the importance of attending the Leadership & Advocacy Conference for federal advocacy and leadership opportunities. She also discussed the transition of the Clinical Emergency Data Registry to the Emergency Medicine Data Institute, the upcoming membership campaign, and an ongoing analysis of ACEP programs and activities.

Steering Committee Expectations

Dr. Gray-Eurom reminded the Steering Committee of their expectation to attend the April 30, 2023, Steering Committee meeting and the Leadership & Advocacy Conference April 30-May 3, 2023, in Washington, DC. The Steering Committee will also meet at 6:00 pm on Friday, October 6, 2023, in Philadelphia, the evening prior to the Council meeting.

Tellers, Credentials, & Elections Committee Report

Dr. Gray-Eurom reviewed the Tellers, Credentials, & Elections Committee report from the 2022 Council meeting. There were 433 councillors allocated for the 2022 meeting and 429 were credentialed. The Tactical Emergency Medicine Section was unrepresented. The following chapters were underrepresented by one councillor: Alabama, New Hampshire, and Oregon. 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. This year the voting software was able to be updated onsite with any last minute changes to delegations. There were no problems identified regarding the electronic voting system, including voting on resolutions and the elections.

Five survey questions were prepared for the Council meeting. There were connectivity problems related to the Wi-Fi and responses to only four of the questions were completed. The survey results were distributed to the Steering Committee.

Councillor Allocation

Dr. Gray-Eurom reported that councillor allocation for 2023 is 427 based on the total membership as of December 31, 2022. This is 6 less councillors than were allocated for the 2022 meeting. Three chapters gained a councillor this year: Alaska, California, and Florida. The following chapters each lost one councillor: Arizona, Arkansas, Iowa, Kentucky, Ohio, Oklahoma, Pennsylvania, and 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 and the Locum Tenens Section did not meet the minimum membership requirement and will not have a councillor for the 2023 Council meeting. All other sections met the minimum membership requirement of 100 members and will have one councillor for the 2023 Council meeting.

2022 Council Meeting

Dr. Gray-Eurom and Dr. Costello discussed various aspects of the 2022 Council meeting and requested suggestions for potential changes for the 2023 meeting.

There was consensus to continue allowing asynchronous testimony on resolutions submitted for the 2023 Council meeting and to develop preliminary Reference Committee reports. Some Steering Committee members favored including recommendations (adopt, not adopt, amend or substitute, refer) and any suggested amended or substituted language in the preliminary Reference Committee reports while others suggested leaving the original resolution language without any suggested amendments or substituted language and without recommendations (adopt, not adopt, amend or substitute, refer) and include only a summary of the asynchronous testimony. It was noted that comments on the preliminary Reference Committee reports can be posted on the Council engagED once they are distributed.

Ms. Montgomery informed the Steering Committee that the 2023 Council meeting will be held at the Philadelphia Convention Center to allow for: 1) cost savings by sharing the audio visual costs with the opening general session of *ACEP23*; 2) meeting space is large enough to accommodate the needs of the Council; 3) cost savings by sharing the audio visual costs for Reference Committee hearings with *ACEP23* course rooms; 4) larger meeting room capacity for the Reference Committees; and 5) increased Wi-Fi capacity compared to the hotel. The convention center is connected by skybridge to the Philadelphia Marriott Hotel. All Council-related meetings held the evening prior to the Council meeting will be at the Philadelphia Marriott.

Dr. Gray-Eurom reminded the Steering Committee that the FY 2022-23 budget did not include continental breakfast for the Council meeting because of budget constraints, however, breakfast was provided both days because of miscommunication with the hotel. The costs were not charged to the Council meeting budget. There was consensus from the Steering Committee to include continental breakfast in the FY 2023-24 budget if possible. The traditional Council Awards Luncheon was reinstated for the Council meeting and will be included in the proposed FY 2023-24 budget.

The Town Hall meeting topic was “Practice Innovations, Payment Impacts, and Predicting the Future.” The Annual Meeting Subcommittee will be asked to identify potential Town Hall meeting topics for the 2023 Council meeting and provide their suggestions at the April 30 Steering Committee meeting. The Council officers will determine the topic during the summer.

2023 Council Meeting Agenda

The Steering Committee reviewed the draft 2023 Council meeting agenda and discussed potential changes. There was support for moving the executive director’s report to the first day of the Council meeting before recessing to the Reference Committee hearings and to retain the EMF and NEMPAC Council Challenges on the agenda. The Annual Meeting Subcommittee will review the Council meeting agenda and provide their suggestions at the April 30 Steering Committee meeting.

Electronic Voting

Dr. Gray-Eurom discussed 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 2023 Council meeting.

Elections Process

Dr. Gray-Eurom reminded the Steering Committee that several changes were made to the Candidate Campaign Rules last year. An issue raised by a candidate during the 2022 election process was the prohibition of logos that appear in photos on the flyer. There was consensus from the Steering Committee to leave the rule as currently written. There were no changes identified regarding the format of the Candidate Forum.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care

The 2022 Council adopted Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care. The Board of Directors discussed the resolution during their October 3, 2022, meeting. The Board deferred action on the resolution to their February 1-2, 2023, meeting, pending review of the third resolved and concerns about its mandatory reporting requirements in some states. The Board requested the Emergency Medicine Reproductive Health & Patient Safety Task Force to review the third resolved, determine if any revisions are needed, and provide a recommendation to the Board regarding any suggested revisions that do not alter the intent of the resolution. The Steering Committee reviewed the amended language developed by the task force and there was consensus that the recommended revisions are consistent with the Council’s intent. It was noted that the word “provider” in the third resolved of the proposed language should be changed. The Board will take action on the proposed amended language during their February 1-2, 2023, meeting. The Steering Committee will take formal action to accept or reject the amended language approved by the Board at the April 30 Steering Committee meeting.

Action on Resolutions

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2022, 2021, and 2020 Council meetings were provided for review. The reports were assigned to the Annual Meeting Subcommittee for further review.

Subcommittee Appointments

Dr. Gray-Eurom asked Steering Committee members to notify Ms. Montgomery of their interest in serving on the Annual Meeting Subcommittee, Bylaws & Council Standing Rules Subcommittee, or the Candidate Forum Subcommittee. All subcommittee members should plan to serve on at least two subcommittees. All second year Steering

Committee members will be appointed to the Candidate Forum Subcommittee unless planning to seek nomination to the Board of Directors. Ms. Montgomery will email the objectives and deadlines of the subcommittees. The subcommittee reports will be discussed at the April 30, 2023, Steering Committee meeting.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Sunday, April 30, 2023, during the Leadership & Advocacy Conference in Washington, DC.

With no further business, the meeting was adjourned at 12:57 pm Central time on Tuesday, January 31, 2023.

Respectfully submitted,



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



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



Steering Committee Conference Call
April 30, 2023

Minutes

Speaker Kelly Gray-Eurom, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:09 Eastern time on Sunday, April 30, 2023.

Steering Committee members present for all or portions of the meeting were: Eric Blutinger, MD, MSc, FACEP; Melissa Costello, MD, FACEP, vice speaker; Emily Fitz, MD, FACEP; Kelly Gray-Eurom, MD, FACEP, speaker; Vik Gulati, MD, FACEP; Carlton Heine, MD, PhD, FACEP; Amanda Irish, MD; C. Ryan Keay, MD, FACEP; Alexander Kirk, MD, FACEP; Phillip Luke LeBas, MD, FACEP; Marc Mendelsohn, MD, FACEP; Diana Nordlund, DO, JD, FACEP; Bing Pao, MD, FACEP; Christopher Sampson, MD, FACEP; Matthew Sanders, DO, FACEP; Gary C. Starr, MD, FACEP; and Thomas Sugarman, MD, FACEP.

Other members and guests present for all or portions of the meeting were: Stephen H. Anderson, MD, FACEP; L. Anthony Cirillo, MD, FACEP; J. T. Finnell, MD, FACEP, vice president; Deborah Fletcher, MD, FACEP; Jeffrey Goodloe, MD, FACEP; Alison Haddock, MD, FACEP; Sanford Herman, MD, FACEP; Christopher Kang, MD, FACEP, president; Gabor Kelen, MD, FACEP; Rami Khoury, MD, FACEP; Heidi C. Knowles, MD, FACEP; Chadd Kraus, DO, FACEP; Aaron Kuzel, DO; Michael McCrea, MD, FACEP; Harry Severance, MD, FACEP; James Shoemaker, MD, FACEP, secretary-treasurer; and Aisha Terry, MD, FACEP, president-elect.

Staff present for all or portions of the meeting were: Adriana Alvarez; Mary Ellen Fletcher, CPC, CEDC, CAE; Robert Heard, MBA, CAE; Sonja Montgomery, CAE; Leslie Moore, JD; Jennifer Moulton; Sandra Schneider, MD, FACEP; Susan Sedory, MA, CAE; Sam Shahid, MBBS, MPH; and Jessica Vaughn.

Minutes

The minutes of the January 31, 2023, Steering Committee meeting were approved as written.

Officer and Staff Reports Speaker

Dr. Gray-Eurom welcomed everyone and thanked them for their participation and commitment to the College. She then announced the 2023 Council awards recipients:

Council Meritorious Service Award – Gary R. Katz, MD, MBA, FACEP
Council Horizon Award – George RJ Sontag, MD
Council Teamwork Award – Pain Management & Addiction Medicine Section
Council Champion in Diversity & Inclusion Award – Adetolu Odufuye, MD, FACEP (posthumously)
Council Curmudgeon Award – John D. Bibb, MD, FACEP

Dr. Gray-Eurom announced the 2023 candidates:

| | |
|------------------|---|
| President-Elect: | Jeffrey M. Goodloe MD, FACEP Alison J. Haddock, MD, FACEP Ryan A. Stanton, MD, FACEP |
| Speaker | Melissa W. Costello, MD, FACEP (unopposed) |
| Vice Speaker | Kurtis A. Mayz, JD, MD, MBA, FACEP Michael J. McCrea, MD, FACEP Larisa M. Traill, MD, FACEP |

Board of Directors: William B. Felegi, DO, FACEP
Robert J. Hancock, MD, FACEP
Chadd K. Kraus, DO, DrPH, CPE, FACEP
Abhi Mehrotra, MD, MBA, FACEP
Henry Z. Pitzele, MD, FACEP
James L. Shoemaker, MD, FACEP

Dr. Gray-Eurom reminded the Steering Committee of the June 6, 2023, Resolution Preparation Session that will be held virtually and the various meetings that will be held on Friday, October 6, 2023, Philadelphia.

Vice Speaker

Dr. Costello reported on her service on the Finance Committee as the speaker's designee.

President

Dr. Kang expressed his appreciation to the Steering Committee for their leadership. He discussed several challenges ACEP is facing and the priorities he is addressing for the remainder of his year as president. He announced that a Practice Essentials course will debut at ACEP23.

President-Elect

Dr. Terry discussed the priorities she will address during her year as president. She reported on recent meetings she has attended and building relationships with other organizations.

Executive Director

Ms. Sedory highlighted key successes of the College and the challenges ahead for ACEP in addressing member needs. Staff are working to further refine personalization of membership value for members and adapting education needs and delivery methods. She urged everyone to reinforce with colleagues everything that ACEP does for all emergency physicians.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care

Dr. Gray-Eurom reminded the Steering Committee of their discussion during the January 31, 2023, Steering Committee regarding the Board's deferred action on Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care. The Board requested the Emergency Medicine Reproductive Health & Patient Safety Task Force to review the third resolved, determine if any revisions were needed, and provide a recommendation to the Board regarding any suggested revisions that do not alter the intent of the resolution. The Steering Committee reviewed the proposed revisions at the January 31, 2023, meeting and agreed that the recommended revisions were consistent with the Council's intent. The Board adopted Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care with additional revisions as recommended by the Emergency Medicine Reproductive Health & Patient Safety Task Force on February 2, 2023:

RESOLVED, That ACEP affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure; and be it further

RESOLVED, That ACEP support the position that the early termination of pregnancy (publicly referred to as "abortion") is a medical procedure, and as such, involves shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients; and be it further

RESOLVED, That ACEP oppose ~~the criminalization or mandatory reporting of reproductive health-related patient concerns~~ **statutory provision of criminal penalties for any medically appropriate care provided** in the emergency department **and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, which includes, but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss**; and be it further

RESOLVED, That ACEP **specifically** oppose the ~~criminalization~~, imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals; **and be it further** [this was previously the last resolved]

RESOLVED, That ACEP support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care; ~~and be it further.~~

~~RESOLVED, That ACEP oppose the criminalization, imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals.~~ [moved to 4th resolved]

It was moved THAT THE STEERING COMMITTEE ACCEPT THE AMENDED LANGUAGE OF AMENDED RESOLUTION 25(22) ADVOCACY FOR SAFE ACCESS TO FULL SPECTRUM PREGNANCY RELATED HEALTH CARE AS ADOPTED BY THE BOARD OF DIRECTORS ON FEBRUARY 2, 2023. The motion was adopted.

There were concerns expressed about the third resolved opposing mandatory reporting as it relates to other state laws pertaining to mandatory reporting of other things such as child abuse.

Annual Meeting Subcommittee

Dr. Keay presented the subcommittee's report on their assigned objectives.

The subcommittee reviewed the format and topics from previous Town Hall meetings and provided suggestions for the 2023 Town Hall meeting topic. The subcommittee supports the current format of the Town Hall meeting that includes a pro/con debate of various aspects of an issue by high-level speakers/content experts followed by a period of Q & A. The subcommittee suggested the following topics for consideration:

The Future of EM in a broken healthcare system

- What happened in the match?
- Scope of practice? Will AI/technology replace medicine?

Workforce/environment

- How to create a palatable work environment.
- How do we continue to love the work we do?
- Independent Dispute Resolution/No Surprises Act/Billing Changes
- Providing mental health for us and them in a world with no services.
- Pediatric access – what's the future for our kids?

The Council officers will make the final determination about the format, topic, and speakers for this year's Town Hall meeting this summer.

The subcommittee reviewed the implementation actions on 2020-2022 resolutions and concurred that the actions taken are consistent with the Council's expectations. Updates to the implementation action on the resolutions can be accessed on the ACEP website by all members. <https://www.acep.org/what-we-believe/actions-on-council-resolutions/>

The subcommittee provided suggestions for questions that should be considered to use as survey questions during the Council meeting:

- Tie questions to the Town Hall topic.
- Do you use AI systems in the ED?
- Where do you practice clinical emergency medicine? (List various settings instead of asking how many clinical hours do you work. For example, urgent care, telehealth, EMS, addiction medicine, etc.)
- What makes you want to continue practicing emergency medicine? (clinical, camaraderie, non-clinical, patients, population health focus, financial, etc.)
- Availability of pediatrics or other specialty care.
- What do you think is the impact of the 2023 Match on emergency medicine? (positive, negative, neutral)

The Council officers will determine the final survey questions this summer.

The subcommittee reviewed the draft 2023 Council meeting agenda and supported moving the executive director's report to the first day of the Council meeting before recessing to the Reference Committee hearings and moving the EMF and NEMPAC reports to the second day morning before discussion of the Reference Committee reports. It was noted that video reports for EMF and NEMPAC could be played as the Council meeting goes into a break and could be played on demand through the Council meeting website.

Bylaws & Council Standing Rules Subcommittee

Dr. Heine reported that the subcommittee was scheduled to hold a virtual meeting on April 4, 2023, to discuss their assigned objectives. The meeting was cancelled because there were no revisions to the Council Standing Rules identified by the Steering Committee or subcommittee members. Additionally, there were no Bylaws or Council Standing Rules resolutions that had been submitted for the 2023 Council meeting (at that time) for the subcommittee to review.

Candidate Forum Subcommittee

Dr. Gray-Eurom presented the subcommittee's report on their assigned objectives. The majority of the subcommittee's objectives will be completed this summer and during the 2023 Council meeting. The subcommittee will meet immediately following this Steering Committee meeting to finalize the candidate written questions and to review the assignments for moderators, coordinators, and door monitors. The subcommittee will meet 4:30 – 6:00 pm in Philadelphia on Friday October 6, 2023, to review the format for the Candidate Forum, finalize questions for the Candidate Forum, and meet with the candidates.

Council Horizon Award

Dr. Gray-Eurom led a discussion regarding the eligibility criteria for the Council Horizon Award and reviewed the history of the award. There was consensus to retain the current eligibility criteria of the first five years of service to the Council, consider service as a councillor only (i.e., do not include alternate councillor service), and do not include any gap years in Council service when determining the first five years. For example, an individual served as a councillor 2017-20, did not serve in 2021, and served again in 2022. The time is calculated based only on the years actually served. The eligibility criteria will be updated to reflect the Steering Committee's discussion and will be used by the 2024 Council Awards Committee to determine the 2024 award recipient.

Board Action on Three 2023 Resolutions

Dr. Gray-Eurom informed the Steering Committee about three resolutions that the Board of Directors will discuss at their meeting later today:

1. Substitute Resolution 61(21) Advocating for a Required Emergency Medicine Experience at All U.S. Medical Schools – The Academic Affairs Committee revised the “Guidelines for Undergraduate Education in Emergency Medicine” policy statement to address the resolution.

2. Amended Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine – The first resolved resolution was assigned to the State Legislative/Regulatory Committee to develop a policy statement. The committee developed a proposed new policy statement “State Board of Medicine Regulation of Non-Physician Practitioners Practicing Medicine.” The second resolved was assigned to the AMA Section Council on Emergency Medicine to develop and submit a resolution to the AMA as directed in the resolution. The AMA Section Council is recommending that the Board rescind its decision to adopt the second resolved and overrule it instead. If the Board approves the recommendations to rescind its previous decision and overrule the second resolved, the vote and position of each Board member must be reported to the Steering Committee and the Council.
3. Amended Resolution 57(22) Recognized Bodies for Emergency Physician Board Certification – The Academic Affairs Committee revised the “ACEP Recognized Certifying Bodies in Emergency Medicine” policy statement as directed in the resolution.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for 6:00 pm, Friday, October 6, 2023, at the Philadelphia Marriott in Philadelphia, PA.

With no further business, the meeting was adjourned at 10:53 am Eastern time on Sunday, April 30, 2023.

Respectfully submitted,



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



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



DEFINITION OF COUNCIL ACTIONS

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

ADOPT

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

ADOPT AS AMENDED

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

NOT ADOPT (DEFEAT)

Defeat (or reject) the resolution in original or amended form.

REFER

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

2023 Council Meeting Reference Committees

Reference Committee A – Governance, Membership, & Other Issues Resolutions 15-26

Scott H. Pasichow, MD, MPH, FACEP (IL) – Chair
William D. Falco, MD, FACEP (WI)
Gregory Gafni-Pappas, DO, FACEP (MI)
Catherine A. Marco, MD, FACEP (PA)
Laura Oh, MD, FACEP (GA)
Stephen C. Viel, MD, FACEP (FL)

Maude Surprenant Hancock, CAE
Laura Lang, JD

Reference Committee B – Advocacy & Public Policy Resolutions 27-42

Diana Nordlund, DO, JD, FACEP (MI) – Chair
Lisa M. Bundy, MD, FACEP (MS)
Puneet Gupta, MD, FACEP (CA)
Joshua S. da Silva, DO, FACEP (GS)
Torree M. McGowan, MD, FACEP (GS)
Michael Ruzek, DO, FACEP (NJ)

Erin Grossmann
Ryan McBride, MPP

Reference Committee C – Emergency Medicine Practice Resolutions 43-55

Dan Freess, MD, FACEP (CT) – Chair
Angela P. Cornelius, MD, FACEP (TX)
Joshua R. Frank, MD, FACEP (WA)
Patrick B. Hinfey, MD, FACEP (NJ)
Jeffrey F. Linzer, Sr., MD, FACEP (GA)
Jennifer L. Savino, DO, FACEP (PA)

Jonathan Fisher, MD, FACEP
Travis Schulz, MLS, AHIP



INTRODUCTION

2023 Annual Council Meeting
Friday Evening, October 6, 2023 through Sunday, October 8, 2023
Philadelphia Marriott and Philadelphia 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 September 8 for all resolutions assigned to a Reference Committee. An announcement with the link to the 2023 resolutions will be posted on the Council engagED when asynchronous testimony is open. After clicking on the link provided:

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

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

1. Whether you are commenting on behalf of yourself or your component body
 - a. chapter, section, 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 meetings in Philadelphia. 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 Speaker. **Please do not direct any communications to another member, including those who have posted before you, with whom you may or may not agree.** Just as the in-person Reference Committee hearings during the Council meeting, proper decorum is expected within the asynchronous testimony platform.

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

Asynchronous testimony will close at 12:00 noon Central time on Wednesday, September 27. 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, October 2 and will be the starting point for the live Reference Committee debate during the Council meeting in Philadelphia on Saturday, October 7.

Visit the Council Meeting Web site: <https://acep.elevate.commpartners.com/> to access all materials and information for the Council meeting. The resolutions and other resource documents for the meeting are located under the "Document Library" tab. You may download and print the entire Council notebook compendium, or individual section tabs from the Table of Contents. You will also find separate compendiums of the President-

Elect candidates, Board of Directors candidates, Council Speaker and Council Vice Speaker 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 Philadelphia!

Your Council Officers,

Kelly Gray-Eurom, MD, MMM, FACEP
Speaker

Melissa W. Costello, MD, FACEP
Vice Speaker

2023 Council Resolutions

| Resolution # | Subject/Submitted by | Reference Committee |
|--------------|--|---------------------|
| 1 | Commendation for Patrick Elmes, EMT-P <i>Jeffrey Jarvis, MD, FACEP</i> <i>Disaster Medicine Section</i> <i>EMS-Prehospital Care Section</i> <i>Tactical & Law Enforcement Medicine Section</i> | |
| 2 | Commendation for Kelly Gray-Eurom, MD, MMM, FACEP <i>Florida College of Emergency Physicians</i> | |
| 3 | Commendation for Russell H. Harris, MD, FACEP <i>New Jersey Chapter</i> | |
| 4 | Commendation for Rick Murray, EMT-P, FAEMS <i>Angela Cornelius, MD, MA, FACEP</i> <i>Richard C. Hunt, MD, FACEP</i> <i>Jeffrey Jarvis, MD, FACEP</i> <i>Jon Krohmer, MD, FACEP</i> <i>Disaster Medicine Section</i> <i>EMS-Prehospital Care Section</i> <i>Event Medicine Section</i> <i>Tactical & Law Enforcement Medicine Section</i> | |
| 5 | Commendation for Gillian R. Schmitz, MD, FACEP <i>Government Services Chapter</i> | |
| 6 | Commendation for JoAnne Tarantelli <i>New York Chapter</i> | |
| 7 | In Memory of Clifford Findeiss, MD <i>Florida College of Emergency Physicians</i> | |
| 8 | In Memory of Scott A. Hall, MD <i>Kansas Chapter</i> <i>Missouri Chapter</i> | |
| 9 | In Memory of Gene W. Kallsen, MD <i>Alicia Mikolaycik Gonzalez, MD, FACEP</i> <i>Susanne Spano, MD, FACEP</i> <i>California Chapter</i> | |
| 10 | In Memory of Michael Kleinman, DO <i>Pennsylvania College of Emergency Physicians</i> | |
| 11 | In Memory of Gloria J. Kuhn, DO, PhD <i>Michigan College of Emergency Physicians</i> | |
| 12 | In Memory of Richard M. Nowak, MD, MBA, FACEP <i>Michigan College of Emergency Physicians</i> | |

| Resolution # | Subject/Submitted by | Reference Committee |
|---------------------|---|----------------------------|
| 13 | In Memory of Barbara W. Trainor <i>Valerie Norton, MD, FACEP</i> <i>Lori Winston MD, FACEP</i> <i>California Chapter</i> | |
| 14 | In Memory of Lori Weichenthal, MD, FACEP <i>Alicia Mikolaycik Gonzalez, MD, FACEP</i> <i>Susanne Spano, MD, FACEP</i> <i>California Chapter</i> <i>Wellness Section</i> <i>Wilderness Medicine Section</i> | |
| 15 | Additional Vice President Position on the ACEP Board of Directors – Bylaws Amendment <i>Board of Directors</i> | A |
| 16 | Council Quorum – Defining “Present” – Housekeeping Bylaws Amendment <i>Bylaws Committee</i> <i>Board of Directors</i> | A |
| 17 | Establishing the Position and Succession of a Speaker-Elect for the Council -Bylaws Amendment <i>Marco Coppola, DO FACEP</i> <i>Melissa Costello, MD, MS, FACEP</i> <i>Gary Katz, MD, MBA, FACEP</i> <i>Arlo Weltge, MD, MPH, FACEP</i> | A |
| 18 | Referred Resolutions <i>Emergency Medicine Workforce Section</i> | A |
| 19 | Scientific Assembly Vendor Transparency <i>Emergency Medicine Workforce Section</i> | A |
| 20 | Emergency Medicine Research Mentorship Program <i>Kalev Freeman, MD, FACEP</i> <i>Antony Hsu, MD, FACEP</i> <i>James Paxton, MD, MBA, FACEP</i> <i>Nicholas Vasquez, MD, FACEP</i> | A |
| 21 | Mitigation of Competition for Procedures Between Emergency Medicine Resident Physicians and Other Learners <i>Emergency Medicine Residents’ Association</i> | A |
| 22 | Supporting Three-Year and Four-Year Emergency Medicine Residency Program Accreditation <i>Emergency Medicine Residents’ Association</i> | A |
| 23 | Opposing Sale-Leaseback Transactions by Health Systems <i>Pennsylvania College of Emergency Physicians</i> | A |
| 24 | Addressing the Growing Epidemic of Pediatric Cannabis Exposure <i>Pennsylvania College of Emergency Physicians</i> | A |
| 25 | Compassionate Access to Medical Cannabis Act – “Ryan’s Law” <i>Larry Bedard, MD, FACEP</i> <i>Dan Morhaim, DO, FACEP</i> | A |

| Resolution # | Subject/Submitted by | Reference Committee |
|---------------------|---|----------------------------|
| 26 | Decriminalization of All Illicit Drugs <i>Larry Bedard, MD, FACEP</i> <i>Dan Morhaim, DO, FACEP</i> | A |
| 27 | Addressing Interhospital Transfer Challenges for Rural EDs <i>Rural Emergency Medicine Section</i> <i>Social Emergency Medicine Section</i> <i>Arizona Chapter</i> <i>Colorado Chapter</i> <i>New Mexico Chapter</i> <i>Oklahoma Chapter</i> <i>Vermont Chapter</i> <i>Washington Chapter</i> | B |
| 28 | Facilitating EMTALA Interhospital Transfers <i>Andrew Fenton, MD, FACEP</i> <i>Roneet Lev, MD, FACEP</i> <i>Aimee Moulin, MD, FACEP</i> <i>California Chapter</i> | B |
| 29 | Addressing Pediatric Mental Health Boarding in Emergency Departments <i>Pennsylvania College of Emergency Physicians</i> <i>Pediatric Emergency Medicine Section</i> | B |
| 30 | Advocating for Increased Funding for EMS <i>Pennsylvania College of Emergency Physicians</i> | B |
| 31 | Combating Mental Health Stigma in Insurance Policies <i>New York Chapter</i> | B |
| 32 | Healthcare Insurers Waive Network Considerations During Declarations of Emergency <i>Gary Gaddis, MD, PhD, FACEP</i> <i>David Schriger, MD, MPH, FACEP</i> | B |
| 33 | Ban on Weapons Intended for Military or Law Enforcement Use <i>Kathy Staats, MD, FACEP</i> <i>Niki Thran, MD, FACEP</i> <i>California Chapter</i> | B |
| 34 | White Paper on Weapons Intended for Military or Law Enforcement Use <i>Kathy Staats, MD, FACEP</i> <i>Niki Thran, MD, FACEP</i> <i>California Chapter</i> | B |
| 35 | Declaring Firearm Violence a Public Health Crisis <i>District of Columbia Chapter</i> | |
| 36 | Mandatory Waiting Period for Firearm Purchases <i>California Chapter</i> <i>Leslie Mukau, MD, FACEP</i> <i>Valerie Norton, MD, FACEP</i> <i>Bing Pao, MD, FACEP</i> <i>Scott Pasichow, MD, MPH, FACEP</i> <i>Katherine Staats, MD, FACEP</i> <i>Niki Thran, MD, FACEP</i> <i>Randall Young, MD, FACEP</i> | B |

| Resolution # | Subject/Submitted by | Reference Committee |
|---------------------|--|----------------------------|
| 37 | Support for Child-Protective Safety Firearm Safety and Storage Systems <i>Leslie Mukau, MD, FACEP</i> <i>Valerie Norton, MD, FACEP</i> <i>Bing Pao, MD, FACEP</i> <i>Katherine Staats, MD, FACEP</i> <i>Niki Thran, MD, FACEP</i> <i>Randall Young, MD, FACEP</i> <i>California Chapter</i> | B |
| 38 | Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals <i>Pennsylvania College of Emergency Physicians</i> | B |
| 39 | Medicaid Reimbursement for Emergency Services <i>Bing Pao, MD, FACEP</i> <i>Thomas Sugarman, MD, FACEP</i> <i>California Chapter</i> | B |
| 40 | Support for Reimbursement of Geriatric ED Care Processes <i>Dual Training Section</i> <i>Geriatric Emergency Medicine Section</i> <i>Observation Medicine Section</i> <i>Maryland Chapter</i> | B |
| 41 | Use of Medical Coders in Payment Arbitration <i>Michigan College of Emergency Physicians</i> | B |
| 42 | On-Site Physician Staffing in Emergency Departments <i>Indiana Chapter</i> | B |
| 43 | Adopt Terminology “Unsupervised Practice of Medicine” <i>Emergency Medicine Workforce Section</i> | C |
| 44 | Clinical Policy – Emergency Physicians’ Role in the Medication & Procedural Management of Early Pregnancy Loss <i>Emily Ager, MD</i> <i>Kimberly Chernoby, MD</i> <i>Kelly Quinley, MD</i> <i>Rachel Solnick, MD</i> <i>Katherine Wegman, MD</i> <i>American Association of Women Emergency Physicians Section</i> | C |
| 45 | Emergency Physicians’ Role in the Medication and Procedural Management of Early Pregnancy Loss <i>American Association of Women Emergency Physicians Section</i> <i>Social Emergency Medicine Section</i> | C |
| 46 | Consensus with ACOG on the Care of Pregnant Individuals with Substance Use Disorder <i>Emily Ager, MD</i> <i>Kimberly Chernoby, MD</i> <i>James Feldman, MD, FACEP</i> <i>Kelly Quinley, MD</i> <i>Rachel Solnick, MD</i> <i>Katherine Wegman, MD</i> <i>Social Emergency Medicine Section</i> | C |

| Resolution # | Subject/Submitted by | Reference Committee |
|---------------------|--|----------------------------|
| 47 | Clarification of and Taking a Position Against Use of Excited Delirium Syndrome <i>Kevin Durgun MD</i> <i>Adam Kruse, MD</i> <i>Brooks Walsh MD</i> <i>District of Columbia Chapter</i> <i>Social Emergency Medicine Section</i> <i>EMS-Prehospital Care Section</i> | C |
| 48 | Medical Malpractice Certificate of Merit <i>New York Chapter</i> | C |
| 49 | Patients Leaving the ED Prior to Completion of Care Against Medical Advice <i>Jennifer Conn, MD, FACEP</i> <i>Olga Gokova, MD, FACEP</i> <i>Rachel Levitan, MD</i> <i>Anne Richter, MD, FACEP</i> <i>Arizona College of Emergency Physicians</i> | C |
| 50 | Metric Shaming <i>American Association of Women Emergency Physicians Section</i> <i>Government Services Chapter</i> | C |
| 51 | Quality Measures and Patient Satisfaction Scores <i>Ohio Chapter</i> | C |
| 52 | Summit & New Tools for Transforming Acute Care <i>New York Chapter</i> | C |
| 53 | Treating Physician Determines Patient Stability <i>Andrew Fenton, MD, FACEP</i> <i>Roneet Lev, MD, FACEP</i> <i>Aimee Moulin, MD, FACEP</i> <i>California Chapter</i> | C |
| 54 | Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions <i>Michigan College of Emergency Physicians</i> | C |
| 55 | Uncompensated Required Training <i>American Association of Women Emergency Physicians Section</i> <i>Government Services Chapter</i> | C |

Late Resolutions

| | | |
|----|--|--|
| 56 | In Memory of William A. Nice, MD <i>Indiana Chapter</i> | |
| 57 | Commendation for Raymond L. Fowler MD, FACEP, FAEMS <i>Angela Cornelius MD, MA, FACEP</i> <i>D. Mark Courtney, MD, FACEP</i> <i>Angela F. Gardner, MD, FACEP</i> <i>Jeffrey M. Goodloe MD, FACEP</i> <i>Andrew Hogan, MD</i> <i>S. Marshal Isaacs, MD, FACEP</i> <i>Jeff Jarvis MD, MS, FACEP</i> | |

Jeffery C. Metzger, MD, MBA, FACEP
Brian L. Miller MD, FACEP
Brandon Morshedi, MD, DPT, FACEP
Kathy Rinnert, MD, MPH, FACEP
John J. Rogers MD, FACEP
Gilberto A. Salazar, MD, FACEP
Robert E. Suter, DO, MHA, FACEP
Raymond E. Swienton, MD, FACEP
Dustin Williams, MD, FACEP
Georgia College of Emergency Physicians
Texas College of Emergency Physicians

58

In Memory of Bradley Middleton, MD
New York Chapter



RESOLUTION: 1(23)

SUBMITTED BY: Angela Cornelius, MD, MA, FACEP
Jeffrey Jarvis, MD, FACEP
Disaster Medicine Section
EMS-Prehospital Care Section
Tactical & Law Enforcement Medicine Section

SUBJECT: Commendation for Patrick Elmes, EMT-P

1 WHEREAS, Patrick Elmes, EMT-P, was a dedicated ACEP staff member from June 6, 2011, through
2 February 3, 2023; and
3

4 WHEREAS, Mr. Elmes was an exceptional staff liaison to the Disaster Preparedness & Response Committee,
5 Air Medical Transport Section, and the Disaster Medicine Section and also provided support to other committees and
6 sections, such as the EMS Committee, EMS Section, and Event Medicine Section over the years; and
7

8 WHEREAS, Mr. Elmes ensured that EMS Week was a successful educational opportunity for ACEP
9 members and the paramedics that they oversee; and
10

11 WHEREAS, Mr. Elmes, served a critical role in managing multiple federally funded EMS and disaster
12 medicine-related grant projects ACEP was awarded during his tenure with the College; and
13

14 WHEREAS, Mr. Elmes assisted College members in their quest for subspecialty certification in Disaster
15 Medicine: and
16

17 WHEREAS, Mr. Elmes represented the College with complete professionalism with other national EMS
18 organizations, including federal government agencies, which strengthened the College's position as a recognized
19 leader in the EMS and disaster medicine communities; and
20

21 WHEREAS, Mr. Elmes served his community as a paramedic, providing essential prehospital care; therefore
22 be it
23

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



RESOLUTION: 2(23)
SUBMITTED BY: Florida College of Emergency Physicians
SUBJECT: Commendation for Kelly Gray-Eurom, MD, MMM, FACEP

1 WHEREAS, Kelly Gray-Eurom, MD, MMM, FACEP, has served the American College of Emergency
2 Physicians with dignity, distinction, and dedication as Council Vice Speaker 2019-21 and Council Speaker 2021-23;
3 and

4
5 WHEREAS, Dr. Gray-Eurom represented the Council at Board of Directors' meetings during her term as
6 Vice Speaker and Speaker and provided thoughtful discourse and comments on a variety of issues; and

7
8 WHEREAS, Dr. Gray-Eurom gracefully led the Council during debate of contentious issues with respect and
9 courtesy; and

10
11 WHEREAS, Dr. Gray-Eurom diligently devoted significant amounts of time, creativity, humor, and
12 enthusiasm to her duties as a Council officer; and

13
14 WHEREAS, Dr. Gray-Eurom welcomed and encouraged the participation of new councillors and alternate
15 councillors on Council committees and is respected for her integrity, objectivity, and mentorship she provided to
16 numerous councillors across all chapters of the College; and

17
18 WHEREAS, Dr. Gray-Eurom has demonstrated a long history of service to the Council including serving as
19 councillor and alternate councillor and on various Council committees; and

20
21 WHEREAS, Dr. Gray-Eurom has maintained an active presence in the Florida Chapter and served on the
22 Board of Directors 2006-13 and as President 2012-13; and

23
24 WHEREAS, Dr. Gray-Eurom has shown exemplary leadership and outstanding service with her participation
25 on several committees and task forces of the College; and

26
27 WHEREAS; Dr. Gray-Eurom is a visionary and influential leader with a distinguished career in emergency
28 medicine as a clinician, educator, mentor, and advocate for the specialty; and

29
30 WHEREAS, Dr. Gray-Eurom will continue to be involved and committed to the cause and mission of ACEP
31 and the specialty of emergency medicine; therefore be it

32
33 RESOLVED, That the American College of Emergency Physicians commends Kelly Gray-Eurom, MD,
34 MMM, FACEP, for her service as Council Speaker, Council Vice Speaker, and for her enthusiasm and commitment
35 to the specialty of emergency medicine and to the patients we serve.



RESOLUTION: 3(23)
SUBMITTED BY: New Jersey Chapter
SUBJECT: Commendation for Russell H. Harris, MD, FACEP

1 WHEREAS, Russell H. Harris, MD, FACEP, has served the College and the specialty with skill and
2 dedication as a member of ACEP and the New Jersey Chapter for more than 40 years; and

3
4 WHEREAS, During his time with the chapter and ACEP, he ensured an ever rising level of professionalism
5 and dedication to the chapter and emergency medicine; and

6
7 WHEREAS, He served on the New Jersey Chapter Board of Directors 1994-2000 and as the chapter president
8 1998-99; and

9
10 WHEREAS, His dedication to the chapter included serving as councillor from 1997-06, 2008-09, 2011-13
11 and as alternate councillor in 2001, 2007, and 2010; and

12
13 WHEREAS, Dr. Harris' level of dedication to the New Jersey Chapter included but was not limited to hosting
14 a yearly membership dinner at his home in which he welcomed all 900+ chapter members with open arms; and

15
16 WHEREAS, At the national level, Dr. Harris served on the Public Relations Committee from 1998-01, State
17 Legislative/Regulatory Committee 2001-17, and the Education Committee 2005-07; and

18
19 WHEREAS, Dr. Harris has served as a selfless mentor to many emergency physicians throughout his career;
20 and

21
22 WHEREAS, Dr. Harris has been a full-time emergency physician at Our Lady of Lourdes Medical Center in
23 Camden, New Jersey for more than 35 years; and

24
25 WHEREAS, Dr. Harris is a retired Navy Captain and was awarded two Navy achievement medals during
26 Operation Desert Storm; and

27
28 WHEREAS, Dr. Harris has advocated on behalf of emergency medicine at both a local and national level;
29 therefore be it

30
31 RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting
32 impact of the contributions of Russell H. Harris, MD, FACEP, to the advancement of emergency medicine; and be it
33 further

34
35 RESOLVED, That the American College of Emergency Physicians commends Russell H. Harris, MD,
36 FACEP for his outstanding service, leadership, and commitment to the College and the specialty of emergency
37 medicine.



RESOLUTION: 4(23)

SUBMITTED BY: Angela Cornelius, MD, MA, FACEP
Richard C. Hunt, MD, FACEP
Jeffrey Jarvis, MD, FACEP
Jon Krohmer, MD, FACEP
Disaster Medicine Section
EMS-Prehospital Care Section
Event Medicine Section
Tactical & Law Enforcement Medicine Section

SUBJECT: Commendation for Rick Murray, EMT-P, FAEMS

1 WHEREAS, Rick Murray, EMT-P, FAEMS, began his distinguished career with ACEP on August 12, 1996,
2 and it ended on June 30, 2023, almost 27 years later; and
3

4 WHEREAS, Mr. Murray worked tirelessly to build ACEP's role in EMS and by serving our members who
5 oversee and work hand-in-hand in the daily life-saving work of EMTs and paramedics; and
6

7 WHEREAS, Mr. Murray has been an exceptional staff liaison to the EMS Committee, EMS-Prehospital Care
8 Section, Event Medicine Section, and Tactical & Law Enforcement Medicine Section, and also provided support to
9 other related committees and sections over the years including the Disaster Preparedness & Response Committee, Air
10 Medical Transport Section, and the Disaster Medicine Section; and
11

12 WHEREAS, Mr. Murray was instrumental in the formation of the Section of Tactical Emergency Medicine in
13 2003 and his leadership led to the embrace of expansive medical support for police and corrections, reflected in the
14 revised name of the section to Tactical & Law Enforcement Medicine; and
15

16 WHEREAS, EMS became a subspecialty of emergency medicine – the largest subspecialty – and his efforts
17 in assisting members to achieve this milestone are laudable; and
18

19 WHEREAS, Under his leadership, ACEP's EMS Department supported the work of members involved with
20 EMS through specialized courses, pre-conferences during ACEP's annual Scientific Assembly, and webinars; and
21

22 WHEREAS, Mr. Murray was instrumental in the success of EMS Week by leading the initiative and seeking
23 and securing vital funding to ensure the program continued as a successful educational opportunity for our members
24 and the paramedics they oversee; and
25

26 WHEREAS, Through his expertise, leadership, dedication, many work hours, and contacts, he helped ACEP
27 secure more than \$11 million dollars in federal, foundation, and corporate grants to support increased resources for
28 emergency physicians and EMS professionals to improve patient care, such as the CHDPA; Tale of Two Cities;
29 Terrorism Injuries Information Dissemination, and Exchange (TIIDE); and Until Help Arrives; and
30

31 WHEREAS, Mr. Murray's significant work on the Terrorism Injuries Information, Dissemination, and
32 Exchange (TIIDE) program grant from the Centers for Disease Control and Prevention, through coordination with
33 multiple professional organizations and those who led the medical response to terrorist injuries in other countries in
34 assimilating and disseminating new knowledge related to clinical care of bomb injuries, resulted in the U.S. and other
35 countries being far better prepared for a medical response to terrorist bombings and those materials remain some of
36 the most requested disaster-related materials from ACEP; and

37 WHEREAS, Mr. Murry was a true collaborator and had great relationships with many organizations and
38 agencies, including the Administration for Strategic Preparedness & Response, American College of Surgeons
39 Committee on Trauma, Centers for Disease Control and Prevention, Federal Emergency Management Agency,
40 National Association of EMS Physicians, National Highway Traffic Safety Administration, United States Department
41 of Health and Human Services, among many others, and he helped ACEP to develop and coordinate these beneficial
42 relationships; and

43
44 WHEREAS, Mr. Murray served his community as a paramedic, providing essential prehospital care, and as
45 an EMS educator and administrator; and

46
47 WHEREAS, Mr. Murray is widely respected in the emergency medicine, EMS, and trauma communities at
48 the local, state, national, and federal levels; and

49
50 WHEREAS, Mr. Murray is a titan in the EMS profession and in 2022 he was awarded the designation of
51 Fellow of the Academy of Emergency Medical Services (FAEMS) by the National Association of EMS Physicians;
52 therefore be it

53
54 RESOLVED, That the American College of Emergency Physicians commends Rick Murray, EMT-P,
55 FAEMS, for his outstanding service and commitment to the College, the specialty of emergency medicine, and the
56 subspecialty of emergency medical services.



RESOLUTION: 5(23)
SUBMITTED BY: Government Services Chapter
SUBJECT: Commendation for Gillian R. Schmitz, MD, FACEP

1 WHEREAS, Gillian R. Schmitz, MD, FACEP, has been an extraordinary and dedicated leader while serving
2 on the Board of Directors 2016-23 and in her roles as Vice President 2019-20, President-Elect 2020-21, President
3 2021-22, and Immediate Past President 2022-23; and

4
5 WHEREAS, During her term as President, Dr. Schmitz was committed to ACEP addressing ACGME
6 residency standards, private equity in emergency medicine, and workforce issues; and

7
8 WHEREAS, Dr. Schmitz maintained an active clinical schedule in a busy academic Level 1 Military
9 Treatment Facility while serving on the ACEP Board of Directors; and

10
11 WHEREAS, During her tenure on the ACEP Board of Directors and as President, she participated in
12 numerous visionary efforts, including Emergency Department Accreditation, and appointed many task forces to
13 address key issues affecting the practice of emergency physicians; and

14
15 WHEREAS, Dr. Schmitz has been a staunch advocate for preserving reimbursement for emergency
16 physicians and ensuring that the “No Surprises Act” protects both patients and physicians from surprise billing; and

17
18 WHEREAS, Dr. Schmitz has shown exemplary leadership and outstanding service with her tireless efforts
19 and expertise on various committees, task forces, sections, the Council, and Board of Directors; and

20
21 WHEREAS, Dr. Schmitz has exemplified her commitment to ACEP and its members by engaging virtually
22 with members during her informative town hall sessions and traveled around the country meeting members in person
23 and advocating for those on the frontlines; and

24
25 WHEREAS, In all of her meetings and travels, Dr. Schmitz represented the College and its members with
26 diplomacy, integrity, and honor and focused on unity and bringing members together; and

27
28 WHEREAS, Dr. Schmitz demonstrated leadership through chapter involvement and served on the
29 Government Services Chapter Board of Directors and as chapter President 2015-16 and has also been an active
30 member of the Texas College of Emergency Physicians; and

31
32 WHEREAS, Dr. Schmitz will continue to serve the College and be involved with the practice of emergency
33 medicine and dedicated to the mission of ACEP; therefore be it

34
35 RESOLVED, That the American College of Emergency Physicians commends Gillian R. Schmitz, MD,
36 FACEP, for her outstanding service, leadership, and commitment to the specialty of emergency medicine and to the
37 patients and communities we serve.



RESOLUTION: 6(23)
SUBMITTED BY: New York Chapter
SUBJECT: Commendation for JoAnne Tarantelli

1 WHEREAS, JoAnne Tarantelli has served as the Executive Director of New York ACEP (NY ACEP) for
2 nearly four decades; and

3
4 WHEREAS, She has been dedicated to the growth and development of emergency medicine in New York
5 State and across the country through her tenure; and

6
7 WHEREAS, Her unwavering leadership has guided New York ACEP through decades of challenges; and

8
9 WHEREAS, Her awareness and communication of important issues has allowed New York ACEP to weather
10 and address challenges before they impacted emergency medicine practice or patient care; and

11
12 WHEREAS, Her support of physicians and their practice have undoubtedly improved emergency care
13 throughout New York State; and

14
15 WHEREAS, She has supported and developed decades of emergency physicians and leaders as a confidant,
16 counselor, and friend; therefore be it

17
18 RESOLVED, That the American College of Emergency Physicians commends and thanks JoAnne Tarantelli
19 for her outstanding career and decades of dedicated service, leadership, commitment to the College, the emergency
20 physicians of New York, the specialty of emergency medicine, and the patients that we serve.



RESOLUTION: 7(23)
SUBMITTED BY: Florida College of Emergency Physicians
SUBJECT: In Memory of Clifford Findeiss, MD

1 WHEREAS, J. Clifford “Cliff” Findeiss, MD, obtained both an MS in Pharmacology and MD from
2 Northwestern University Feinberg School of Medicine in 1968, completed a surgical internship at Jackson Memorial
3 Hospital in Miami, and then proudly served as a Lieutenant in the US Navy Medical Corps; and
4

5 WHEREAS, Dr. Findeiss was an active member of the American College of Emergency Physicians since
6 1971, is recognized as an early national leader in the new specialty of emergency medicine, and served on the
7 American College of Emergency Physicians' original exploratory Committee on Board Establishment, ultimately
8 becoming board certified himself in 1983 and maintaining the certification until his death on April 1, 2023; and
9

10 WHEREAS, Dr. Findeiss possessed the intelligence, confidence, and stamina to turn possibilities into reality,
11 always seeking to put his philosophy of "doing well by doing right" into practice, combining his analytic and creative
12 skills to change emergency medical care delivery; and
13

14 WHEREAS, Dr. Findeiss co-founded Emergency Medical Services Associates (EMSA), which gradually
15 established a new system of 24/7/365 physician on-site care in south Florida emergency departments, during which
16 time Dr. Findeiss also served as the first Medical Director of Miami-Dade County Fire Rescue and the Hialeah Fire
17 Department, initiating field care protocols for first responders; and
18

19 WHEREAS, Dr. Findeiss is renowned as one of the first to recognize that care provided in emergency
20 departments should be provided by full-time physicians who dedicate their skills to the practice of acute, unscheduled
21 care; and
22

23 WHEREAS, Dr. Findeiss actively recruited other physicians to support the specialty’s development nationally
24 and in Florida traveling around the state, bringing emergency physicians together through the Florida Chapter of
25 ACEP; and
26

27 WHEREAS, Dr. Findeiss provided a lifetime of service to the Florida College of Emergency Physicians since
28 joining in 1973, having served as the sixth president in 1975-76, Chairman of the Florida Emergency Medicine
29 Foundation Board of Directors from 2011-15, and as a Foundation Board Member from 2007-21; and
30

31 WHEREAS, Dr. Findeiss’ entrepreneurial approach to the practice of emergency medicine expanded
32 opportunities for emergency physicians to choose a professional practice model congruent to the needs of individual
33 physicians and their families; and
34

35 WHEREAS, Dr. Findeiss’ visionary leadership, pioneering spirit, and tireless dedication to advancing the
36 specialty of emergency medicine over the last five decades have proven to be invaluable; and
37

38 WHEREAS; Dr. Findeiss was a role model and mentor leaving exponential and immeasurable impact among
39 his colleagues and future leaders in emergency medicine; and
40

41 WHEREAS; Dr. Findeiss was a dedicated and devoted husband, father, grandfather, colleague, mentor, and
42 friend who inspired all of those who knew him; therefore be it
43

44 RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the
45 contributions of a trailblazing pioneer, visionary leader, invaluable mentor, and outstanding emergency physician, J.
46 Clifford “Cliff” Findeiss, MD, and his selfless contributions to emergency medicine; and be it further
47

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 8(23)

SUBMITTED BY: Kansas Chapter
Missouri Chapter

SUBJECT: In Memory of Scott A. Hall, MD

1 WHEREAS, With the untimely death of Scott A. Hall, MD, on July 4, 2023, Missouri lost a devoted
2 emergency physician and EMS leader; and

3
4 WHEREAS, Dr. Hall was passionate about rural EMS, serving as an EMT then paramedic for NTA Ambulance
5 district for years before and throughout medical school; and

6
7 WHEREAS, Dr. Hall received his medical degree and completed a residency in emergency medicine at the
8 University of Kansas Medical Center and served as Chief Resident; and

9
10 WHEREAS, Dr. Hall was a community leader in Northwest Missouri, serving as EMS Medical director for
11 Buchanan County and NTA Ambulance district, and as Medical Director for Mosaic Life Care – St. Joseph Emergency
12 Department, and Harrison County Community Hospital Emergency Department; therefore be it

13
14 RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the
15 accomplishments of Scott A. Hall, MD, and offer our heartfelt condolence to his wife, daughter, and the entire Hall
16 family.



RESOLUTION: 9(23)

SUBMITTED BY: Alicia Mikolaycik Gonzalez, MD, FACEP
Susanne Spano, MD, FACEP
California Chapter

SUBJECT: In Memory of Gene W. Kallsen, MD

1 WHEREAS, The specialty of emergency medicine lost a longtime ACEP member, a beloved leader, and an
2 early pioneer of the specialty when Gene W. Kallsen, MD, passed away on March 4, 2023; and
3

4 WHEREAS, Dr. Kallsen started the University of Minnesota medical school in 1968, at the height of the
5 Vietnam War, and the same year that emergency medicine began with the formation of the American College of
6 Emergency Physicians; and
7

8 WHEREAS, After completing a transitional internship at the University of Washington, Dr. Kallsen joined
9 UCSF Fresno's emergency medicine program in 1977 – just three years after the founding of UCSF Fresno's
10 emergency medicine residency in 1974 – and at the time, emergency medicine had still not been officially recognized
11 as a specialty; and
12

13 WHEREAS, He completed his UCSF Fresno residency in 1979, the same year the American Board of
14 Emergency Medicine was approved, and that year, emergency medicine became the 23rd and youngest recognized
15 medical specialty; and
16

17 WHEREAS, Dr. Kallsen started on the ground floor of emergency medicine and quickly became an architect
18 and leader in the specialty and he was fondly known as the “father” of Emergency Medical Services in Fresno County
19 and served as the first EMS medical director in 1981; and
20

21 WHEREAS, He chaired the first statewide organization of EMS directors, serving as its representative on the
22 newly created EMS Commission, and helped develop the original EMS policies and protocols, many of which
23 continue to be used, and he fought to reform ambulance services in Fresno County, which resulted in faster response
24 times; and
25

26 WHEREAS, As chief of the UCSF Fresno Emergency Medicine Program for more than two decades, Dr.
27 Kallsen helped to establish the four-year ACGME-accredited residency into one of the most sought in the country and
28 it is estimated that he graduated between 200 and 300 emergency medicine residents; and
29

30 WHEREAS, Dr. Kallsen took great pride and joy in teaching young doctors, and to recognize his work and
31 service to UCSF, Dr. Kallsen was honored with professor emeritus title and his legacy lives on with the endowed
32 chair named in his honor; and
33

34 WHEREAS, Dr. Kallsen will be missed tremendously and his contributions to emergency medicine, EMS,
35 and his beloved UCSF Fresno community will always be remembered; therefore be it
36

37 RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to his
38 family gratitude for his tremendous service to emergency medicine.



RESOLUTION: 10(23)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Michael Kleinman, DO

1 WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Michael
2 Kleinman, DO, passed away on June 17, 2023, surrounded by his loving family, at the age of 68; and

3 WHEREAS, Dr. Kleinman completed medical school education at the Des Moines University College of
4 Osteopathic Medicine in 1979 and completed his internship and residency training in emergency medicine at
5 Memorial Hospital of York in 1984; and

6 WHEREAS, Dr. M. Kleinman was a founding faculty member for the emergency medicine residency at
7 WellSpan York Hospital in 1989 and he was a long-time emergency physician, faculty member, leader, and mentor;
8 and

9 WHEREAS, Dr. M. Kleinman served in a variety of leadership positions at WellSpan York Hospital including
10 Chair of the Department, member of the Medical Executive Committee, and Residency Program Director; and

11
12 WHEREAS, Dr. M. Kleinman was aptly known locally as “The Wizard” for his ability to always make the right
13 diagnosis at the right time and to orchestrate the complex actions needed to care for the many ill and injured patients
14 he helped over the years as he faithfully served as a staff emergency physician and faculty member until his passing;
15 and

16
17 WHEREAS, Dr. M. Kleinman’s kindness, caring, and wisdom were legendary among his colleagues and his
18 skill and compassion has helped to shape the careers of hundreds of emergency medicine students, residents, and
19 fellows over the years; therefore be it

20
21 RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of
22 Michael Kleinman, DO, who dedicated himself to his patients, his trainees, his profession, and his family; and be it
23 further

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



RESOLUTION: 11(23)
SUBMITTED BY: Michigan College of Emergency Physicians
SUBJECT: In Memory of Gloria J. Kuhn, DO, PhD

1 WHEREAS, Emergency medicine lost a pioneer in emergency medicine in Gloria J. Kuhn, DO, PhD,
2 a dedicated educator and mentor, and a staunch advocate for women leaders, who passed away on March 29, 2023;
3 and

4
5 WHEREAS, Dr. Kuhn was a member of the American College of Emergency Physicians 1977-2019; and

6
7 WHEREAS, Dr. Kuhn served on the Board of Directors of the Michigan College of Emergency Physicians;
8 and

9
10 WHEREAS, Dr. Kuhn founded the residency program at Mt. Carmel Hospital (now Sinai-Grace Hospital) in
11 Detroit in 1982 and served as its program director for 12 years; and

12
13 WHEREAS, Dr. Kuhn held the position of Professor and Vice-Chair of Academic Affairs, Department of
14 Emergency Medicine, Wayne State University, School of Medicine for 10 years; and

15
16 WHEREAS, Dr. Kuhn was recognized for her exemplary service to emergency medicine by receiving the
17 2013 Michigan College of Emergency Physicians John A. Rupke, MD, Lifetime Achievement Award; and

18
19 WHEREAS, Dr. Kuhn was committed to a lifetime of learning as demonstrated by obtaining her Doctorate in
20 Instructional Technology when she was 55; and

21
22 WHEREAS, Dr. Kuhn was recognized for her expertise in education by receiving the 2006 ACEP Award for
23 Outstanding Contribution in Education; and

24
25 WHEREAS, Dr. Kuhn firmly believed and was oft quoted: “*The decisions are made by those who show up to*
26 *the table; if you don’t show up, you won’t have a say.*”; and

27
28 WHEREAS, Dr. Kuhn was known for her commitment to the highest standards of resident education
29 balanced with a warm heart and willing ear if a patient case did not go well; and

30
31 WHEREAS, Dr. Kuhn embodied the idea that a residency program is a family, insisted on being called by her
32 first name, and hosted journal clubs at her home where spirited debate was only outdone by the excess of food and
33 dessert – always dessert; therefore be it

34
35 RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency
36 Physicians hereby expresses their enduring appreciation to Gloria J. Kuhn, DO, PhD, as a champion for emergency
37 medicine; and be it further

38
39 RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency
40 Physicians extends to the family of Gloria J. Kuhn, DO, PhD, her colleagues, and former residents, our condolences
41 along with our profound gratitude for her lifetime of service to the specialty of emergency medicine, Michigan
42 emergency physicians, and patients, who will never fully know her impact, across the United States of America and
43 likely beyond.



RESOLUTION: 12(23)
SUBMITTED BY: Michigan College of Emergency Physicians
SUBJECT: In Memory of Richard M. Nowak, MD, MBA, FACEP

1 WHEREAS, Emergency medicine lost a beloved physician leader in the passing of Richard M. Nowak, MD,
2 MBA, FACEP, who died January 26, 2023; and

3
4 WHEREAS, Dr. Nowak earned his medical degree from the University of Toronto School of Medicine,
5 completed residency at Montreal General Hospital, and a research fellowship at the University of Toronto prior to
6 joining the Henry Ford Medical Group, Detroit, MI, in 1975; and

7
8 WHEREAS, Dr. Nowak's legacy in emergency medicine is reflected by his almost 50-year relationship with
9 Henry Ford Hospital (HFH) where he provided innovative emergency care to innumerable patients in a highly
10 underserved population; and

11
12 WHEREAS, Dr. Nowak completed his MBA from Michigan State University and was a founding member
13 and Chairman of the HFH Department of Emergency Medicine and his contributions to the clinical and academic
14 mission of the department were immense; and

15
16 WHEREAS, Dr. Nowak founded the HFH emergency medicine residency program in 1976, prior to its
17 approval as a recognized specialty and when few emergency medicine residencies existed; and

18
19 WHEREAS, Dr. Nowak's commitment to teaching was boundless and he always demonstrated a sincere
20 interest in his patients and possessing an unbridled enthusiasm, he was renowned for his bedside teaching; and

21
22 WHEREAS, With an unparalleled sense of curiosity, humor, compassion, and collegiality, Dr. Nowak served
23 as a role model for students, residents, fellows, and colleagues, and his many life-long relationships with students are
24 a testament to his rare talent as an educator; and

25
26 WHEREAS, Dr. Nowak served as a representative in the Association of American Medical Colleges where he
27 assisted in the creation of our specialty in the house of medicine in 1979; and

28
29 WHEREAS, Dr. Nowak's commitment to leadership is further demonstrated by his commendable activity in
30 the Michigan College of Emergency Physicians (MCEP), including representing the College as a councillor and as
31 MCEP President in 1987; and

32
33 WHEREAS, Dr. Nowak was also enormously influential in education nationally, serving as an examiner for
34 the American Board of Emergency Medicine, on the Board of Directors of the Society of Teachers in Emergency
35 Medicine, and as President of the University Association for Emergency Medical Services, which is now the Society
36 for Academic Emergency Medicine (SAEM), and he later served on the SAEM Board of Directors; and

37
38 WHEREAS, Dr. Nowak was a nationally recognized presenter at countless local, national, and international
39 conferences and his lectures were always timely with just the right amount of history, humor, and personal anecdotes;
40 and

41
42 WHEREAS, Dr. Nowak's lifelong curiosity made him a staunch research advocate who established a world-
43 class research program, and by diversifying his areas of research activities he fostered interdisciplinary relationships

44 worldwide and pioneered advances in cardiopulmonary resuscitation, including the first use cardiopulmonary bypass
45 in the ED, cardiac biomarker development, and spirometry use for asthma that precipitated hand-held peak flow
46 meters; and

47

48 WHEREAS, Dr. Nowak embraced “bench to bedside” research decades before the term was coined and he
49 was a reviewer for numerous specialty journals; and

50

51 WHEREAS, He had more than 90 grant submissions, wrote numerous textbook chapters, more than 300
52 scientific papers, and 250 other publications, including a book on resuscitation, and he has served on numerous
53 international editorial boards in academic emergency medicine and cardiology and was recognized across the globe
54 with honors and awards; and

55

56 WHEREAS, In 1987, he received ACEP’s Award for Outstanding Contribution in Research; and

57

58 WHEREAS, Dr. Nowak devoted his entire professional career to emergency medicine and he always
59 promoted and took time for a life outside of medicine, evidenced by his love and involvement in sports, music,
60 automobiles, travel, hockey, and theater; however, his family, was the pride of his life and were always included in
61 lectures and on his travels and they were well known to his HFH family and to his colleagues around the world;
62 therefore be it

63

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

67

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



RESOLUTION: 13(23)

SUBMITTED BY: Valerie Norton, MD, FACEP
Lori Winston MD, FACEP
California Chapter

SUBJECT: In Memory of Barbara W. Trainor

1 WHEREAS, The specialty of emergency medicine lost a longtime champion and advocate when
2 Barbara Wallace Trainor passed away on December 23, 2022; and

3 WHEREAS, Mrs. Trainor was the California Chapter President Dr. Michael P. Trainor’s widow and
4 dedicated her time and talents to the chapter and the specialty both during his life and for many years after; and

5 WHEREAS, In recognition of Mrs. Trainor’s lifetime of dedication she received honorary membership in the
6 College in 2013; and

7 WHEREAS, Mrs. Trainor served on the Emergency Medical Research and Education Foundation Board of
8 Trustees and the California Medical Association Alliance Foundation Board, and as President of the Orange County
9 Medical Association Alliance, State President of the California Medical Associations Alliance, as president of the
10 Western Coalition of the American Medical Association Alliance, and tirelessly contributed to numerous other
11 organizations throughout her life; and

12 WHEREAS, Mrs. Trainor served as chair of the Trainor Lectureship given at the California Chapter’s
13 Scientific Assembly from 1993 to 2010; and

14 WHEREAS, Mrs. Trainor was committed to the specialty of emergency medicine and determinedly promoted
15 and improved the work of the College and the California Chapter; and

16 WHEREAS, Mrs. Trainor will be missed tremendously and her contributions to emergency medicine, both
17 while her husband was alive and after he passed away, will always be remembered; therefore be it
18

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



RESOLUTION: 14(23)

SUBMITTED BY: Alicia Mikolaycik Gonzalez, MD, FACEP
Susanne Spano, MD, FACEP
California Chapter
Wellness Section
Wilderness Medicine Section

SUBJECT: In Memory of Lori Weichenthal, MD, FACEP

1 WHEREAS, The specialty of emergency medicine lost a devoted ACEP member, a beloved trailblazer, and
2 leader in wilderness medicine and wellness when Lori Weichenthal, MD, FACEP, passed away; and
3

4 WHEREAS, Dr. Weichenthal attended the University of California, San Diego for her undergraduate
5 degree, completed her medical degree at the UCSF School of Medicine in San Francisco, and her emergency
6 medicine residency at UCSF Fresno; and
7

8 WHEREAS, Dr. Weichenthal was a pioneer in the field, one of only two women in the UCSF Fresno
9 Department of Emergency Medicine when she began her residency in 1995, serving as a guiding star for the
10 women who have followed, and in 1998 she joined the emergency medicine faculty as a clinical instructor,
11 quickly rising to UCSF assistant clinical professor, associate clinical professor, and in 2014 to UCSF
12 professor; and
13

14 WHEREAS, Her interest in wilderness medicine led her to create the Emergency Medicine Wilderness
15 Medicine Fellowship in 2008, serving as program director in its first years while developing the curriculum
16 and most recently working with other fellowships nationwide to create a standardized curriculum for
17 wilderness medicine; and
18

19 WHEREAS, Dr. Weichenthal started UCSF Fresno emergency medicine's role as Medical Director for
20 the Two Cities Marathon, which still occurs today, and about a decade ago, started the UCSF High Sierra
21 Wilderness Medicine CME Conference which is held annually; and
22

23 WHEREAS, In 2019, the Fresno-Madera Medical Society honored Dr. Weichenthal as one of three
24 Women Trailblazers and in the society's Winter 2019 "Central Valley Physicians" magazine, her colleagues
25 praised her achievements and the calm and caring way in which she solved problems and attained goals; and
26

27 WHEREAS, Her leadership included starting a Women in Academic Medicine group at UCSF Fresno
28 about five years ago to help address the disparities that exist between men and women in academic medicine;
29 and
30

31 WHEREAS, In 2018, to help better understand the culture at UCSF Fresno around diversity and
32 inclusion, Dr. Weichenthal founded a committee on Diversity, Equity, and Inclusion (DEI) and was
33 instrumental in the appointment of the first campus DEI director in 2021; and
34

35 WHEREAS, Dr. Weichenthal developed a wellness curriculum for residents and extensively
36 researched wellness in residency training, becoming a nationwide voice for the importance of physician
37 wellness programs; and
38

39 WHEEAS, She conducted research looking at burnout rates in emergency medicine residents and at

40 whether a wellness curriculum might decrease burnout and compassion fatigue; and recently completed a
41 study on the impact of a mindfulness meditation course on trainee and faculty wellness; and

42
43 WHEREAS, As part of her commitment to wellness, Dr. Weichenthal helped lead yoga sessions at
44 UCSF Fresno, and over the years she taught yoga to community classes and to youth with disabilities and
45 weight issues; and

46
47 WHEREAS, Dr. Weichenthal received numerous awards and honors throughout her career, including
48 being inducted into the UCSF Academy of Medical Educators, receiving an Excellence in Teaching Award in
49 Medical Education from the Haile T. Debas Academy of Medical Educators, a Kaiser Award nominee, faculty
50 and research awards, a Letter of Distinction from ACEP, mentoring distinctions from UCSF and Women in
51 Academic Emergency Medicine, a Lifetime Achievement Award from the Fresno-Madera Medical Society,
52 and a host of other honors and recognitions; and

53
54 WHEREAS, She was held in the highest esteem for her unwavering commitment to the teaching and
55 training of residents, fellows, and medical students – and to their wellness; and

56
57 WHEREAS, Dr. Weichenthal was a skilled clinician and expert academic instrumental in resident and
58 medical student education at UCSF Fresno, first being appointed as Assistant Dean for Graduate Medical
59 Education in 2016 to provide oversight to the residency and fellowship programs and in November 2021,
60 named Associate Dean for GME and Clinical Affairs, while also in 2020 having taken on the role of
61 Designated Institutional Officer (DIO) and at the same time she remained deeply involved in the emergency
62 medicine residency program as Associate Residency Director; and

63
64 WHEREAS, Dr. Weichenthal served on the ACEP Well-Being Committee, served as chair of the
65 ACEP Wellness Section, and as chair of the ACEP Wilderness Medicine Section; therefore be it

66
67 RESOLVED, That the American College of Emergency Physicians, the California Chapter, and the Wellness
68 and Wilderness Medicine Sections hereby acknowledge the many contributions made by Lori Weichenthal, MD,
69 FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

70
71 RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to her
72 family gratitude for her tremendous service to emergency medicine.



2023 Council Meeting Reference Committee Members

Reference Committee A – Governance, Membership, & Other Issues Resolutions 15-26

Scott H. Pasichow, MD, FACEP (IL) – Chair

William D. Falco, MD, FACEP (WI)

Gregory Gafni-Pappas, DO, FACEP (MI)

Catherine Marco, MD, FACEP (PA)

Laura Oh, MD, FACEP (GA)

Stephen C. Viel, MD, FACEP (FL)

Maude Surprenant Hancock, CAE

Laura Lang, JD



Bylaws Amendment

RESOLUTION: 15(23)
SUBMITTED BY: Board of Directors
SUBJECT: Additional Vice President Position on the ACEP Board of Directors

PURPOSE: Amends the Bylaws to add a second vice president officer position on the Board of Directors.

FISCAL IMPACT: Additional funds of \$24,682 annually pending recommendation of the Compensation Committee and approval by the Board of Directors.

1 WHEREAS, The Board of Directors continuously seeks to optimally and efficiently serve members of the
2 College, fostering ACEP becoming even stronger in advocacy for member emergency physicians and in fiscal ability,
3 to provide additional products and services for member emergency physicians; and
4

5 WHEREAS, The last change in Board of Directors composition occurred in 2005, with creation of the officer
6 position of Chair of the Board of Directors, at which time the College had only 23,559 members compared with
7 today's approximately 38,000 members, and at which time the College offered less products and services; and
8

9 WHEREAS, A multitude of communications technologies and formats continue to be created and to evolve,
10 thereby also creating choices and challenges in most effectively communicating ACEP advocacy, products, services,
11 and involvement opportunities for members, which then create increasing duty among the Board of Directors in
12 strategically directing resources and content; and
13

14 WHEREAS, Effectively maintaining and growing College membership is critical to the future successes of
15 ACEP for benefits for member emergency physicians, requiring additional focused strategy today, directed by the
16 Board of Directors, with ongoing leadership to effect that desired growth; and
17

18 WHEREAS, The Board of Directors believes the College leadership costs are best conserved by focusing
19 Board of Directors duties among the current number of members on the Board of Directors; therefore be it
20

21 RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 1 – Officers, Section 2
22 – Election of Officers, and Section 7 – Vice President, and Article XI – Committees, Section 2 – Executive
23 Committee, be revised to read:
24

25 **ARTICLE X – OFFICERS/EXECUTIVE DIRECTOR**

26 **Section 1 – Officers**
27
28

29 The officers of the Board of Directors shall be president, president-elect, chair, immediate past president, vice
30 presidents, and secretary-treasurer. The officers of the Council shall be the speaker and vice speaker. The Board of
31 Directors may appoint other officers as described in these Bylaws.
32

33 **Section 2 — Election of Officers**
34

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

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Section 7 — Vice Presidents

There shall be two vice president positions. The vice presidents shall be a members 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 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.

Background

This resolution seeks to amend the Bylaws to add a second vice president officer position on the Board of Directors.

A subcommittee of the Board was appointed in January 2023 with the following objectives:

- Review the Board member and officer roles, including the current election process, and whether they continue to best serve the Board, individual Board members, and the College as a whole.
- Review the activities that Board members should be doing that would be most valuable to the College and to the individual Board members.

The subcommittee reviewed the current vice president position description and recommended submitting a Bylaws amendment to create a second vice president position to better align the work of the Board with the needs of the membership and to create an additional officer leadership opportunity on the Board. The addition of another formal leadership role (vice president) will help enable the Board to be more facile in addressing member needs based on the expanding complexity of the healthcare landscape. The subcommittee recommended that one vice president position have a primary focus on membership and the second vice president position have a primary focus on internal and external communications. The Board reviewed the subcommittee’s recommendation at their June 28-29, 2023, meeting and approved submitting a Bylaws amendment to the 2023 Council and approved the position descriptions (see Attachment A) of the two vice president positions contingent on the resolution being adopted by the Council.

The Board also discussed the need for the Compensation Committee to determine the stipend for both vice president positions if the Bylaws amendment is adopted. The Compensation Committee has been informed about the Bylaws amendment and the potential need to develop a stipend recommendation. The stipend for the second vice president is not included in the current fiscal year budget and would require a budget modification.

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 (2) 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 councilors 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."

If the resolution is adopted by the Council, and the Board adopts the resolution at their October 12, 2023, meeting, the Bylaws amendment would be effective on that date and the two vice president positions would be eligible for election at that meeting.

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.

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

The current annual stipend for the vice president is \$35,736 and \$11,054 for a non-officer Board member. The Compensation Committee has the responsibility, as delineated in the Bylaws, to determine the stipends for the Board of Directors and officers and would need to determine the stipend amount for both vice president positions. The total fiscal impact for FY 2023-24, if the Compensation Committee recommends the same stipend amount for the second vice president position, would be \$16,455 for November 1, 2023 – June 30, 2024. ($\$35,756$ current vice president stipend, less $\$11,054$ current non-officer Board member stipend = $\$24,682$ divided by 12 = $\$2056.83$ x 8 months = $\$16,454.64$).

Prior Council Action

None that is specific to adding a second vice president officer position.

Prior Board Action

June 2023, approved submitting a Bylaws amendment to the 2023 Council and approved the position descriptions of the two vice president positions contingent on the resolutions being adopted by the Council.

September 2022, approved the revised position description of the vice president.

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

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

VICE PRESIDENT – MEMBERSHIP POSITION DESCRIPTION

Basic Functions: Represent the College at chapter meetings, emergency medicine residencies, media briefings, legislative hearings, and meetings of other organizations, as requested by the president. Support and defend policies and programs adopted by the Board of Directors.

Characteristic Duties and Responsibilities:

1. Serve as Board liaison to the Membership Committee, Emergency Medicine Residents' Association, Young Physicians Section, and other committees and sections as appointed by the president.
2. Serve as Board representative to staff in membership issues, with specific focus on recruitment and retention of members.
3. Update the Board of Directors on issues pertaining to membership in coordination with staff.
4. Complete special assignments upon request of the president.
5. Serve as a member of the Executive Committee.

VICE PRESIDENT – COMMUNICATIONS POSITION DESCRIPTION

Basic Functions: Represent the College at chapter meetings, emergency medicine residencies, media briefings, legislative hearings, and meetings of other organizations, as requested by the president. Support and defend policies and programs adopted by the Board of Directors.

Characteristic Duties and Responsibilities:

1. Serve as Board liaison to College communications including, but not limited to, *ACEPNow*, *EM Today*, and the ACEP Annual Report and excluding *Annals of Emergency Medicine* and *JACEP Open* unless appointed to such by the president.
2. Serve as Board representative to the ACEP Rapid Response Team to College social media monitoring and strategy and to staff regarding communication issues, with specific focus on methods that effectively communicate College products, services, advocacy, and leadership actions with present and potential College members.
3. Serve as Board liaison to the Communications Committee and other committees and sections as appointed by the president.
4. Update the Board of Directors on issues pertaining to College communications in coordination with staff.
5. Complete special assignments upon request of the president.
6. Serve as a member of the Executive Committee.



Bylaws Amendment

RESOLUTION: 16(23)

SUBMITTED BY: Bylaws Committee
Board of Directors

SUBJECT: Council Quorum – Defining “Present” – Housekeeping Bylaws Amendment

PURPOSE: Amends the Bylaws to define the term “present” to determine a quorum whether voting in person or by remote communication technology.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

1 WHEREAS, The term “present” in the American College of Emergency Physicians (ACEP) Bylaws is not
2 clearly defined; and

3 WHEREAS, The term “present” in the ACEP Bylaws, should be defined as either “in person” or
4 “participating by approved remote communication technology” to determine a quorum present; and

5 WHEREAS, A quorum always refers to the number of members present, not to the number voting¹; therefore
6 be it

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

9 Article VIII - COUNCIL

10 Section 4 — Quorum

11
12
13 A majority of the number of councillors credentialed by the Tellers, Credentials, and Elections Committee
14 during each session of the Council meeting shall constitute a quorum for that session. The vote of a majority of
15 councillors voting in person or represented by proxy (if applicable) shall decide any question brought before such
16 meeting, unless the question is one upon which a different vote is required by law, the Articles of Incorporation, or
17 these Bylaws.

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

Background

This resolution amends the Bylaws to define the term “present” to determine a quorum whether voting in person or by remote communication technology.

The 2020 Council meeting was conducted virtually and the 2021 Council meeting was a hybrid meeting including in-person and remote participation. Temporary Council Standing Rules were adopted in 2020 and 2021 to allow for remote participation. During their January 24, 2022, meeting, the Council Steering Committee discussed the Council’s use of remote voting technology for the past two years and potential changes that may be needed in the Council

¹ Sturgis, Alice. *The Standard Code of Parliamentary Procedure, 4th Edition* (p. 112). McGraw Hill LLC. Kindle Edition.

Standing Rules if the Council meeting is held virtually or as a hybrid meeting in future years. The Steering Committee supported continuing to use online voting technology instead of keypads so that the same voting system would be used whether the Council meeting is held in person, hybrid, or fully virtual. The Steering Committee submitted a resolution to the 2022 Council to amend the Council Standing Rules to specify that voting electronically includes remote communication and voting technology .

The Bylaws Committee was assigned an objective for the 2022-23 committee year to review the national ACEP Bylaws and identify any areas where revision may be appropriate and submit recommendations to the Board of Directors. The Bylaws Committee was specifically directed to review Article VIII – Council, Section 4 – Quorum to address voting by remote participation and potential clarifications regarding “present and voting” language throughout the Bylaws to address remote participation. The Bylaws Committee prepared the Bylaws amendment to define “present” to determine a quorum present with respect to councillor voting and to address “present and voting” throughout the College Bylaws regarding councillor participation by remote communication technology. The Board of Directors approved cosponsoring the resolution with the Bylaws Committee.

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 15(22) Electronic Voting During the Council Meeting adopted. The resolution amended the Council Standing Rules to specify that voting electronically includes remote communication and voting technology; stipulates that individual connectivity issues or individual disruption of remote communication technology will not be the basis for a point of order or other challenge to any voting; points of order related to perceived or potential mass discrepancies in voting are in order; and that the chair of the Tellers, Credentials, & Elections Committee will monitor the voting to ensure there are no large discrepancies between votes.

October 2021, adopted Temporary Council Standing Rules to accommodate a hybrid meeting for in-person and virtual participation, including using an online voting platform.

October 2020, adopted Temporary Council Standing Rules to accommodate the virtual meeting, including utilizing an online platform for electronic voting.

Resolution 12(96) Quorum adopted. The resolution amended the Bylaws with a revised definition of a Council quorum.

Resolution 3(80) Council Meeting. The resolution amended the Bylaws to redefine a Council quorum as a majority of councillors present.

Prior Board Action

June 2023, approved cosponsoring a Bylaws Amendment with the Bylaws Committee to define the term “present” to determine a quorum whether voting in person or by remote communication technology.

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

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



Bylaws Amendment

RESOLUTION: 17(23)

SUBMITTED BY: Marco Coppola, DO FACEP
Melissa Costello, MD, MS, FACEP
Gary Katz, MD, MBA, FACEP
Arlo Weltge, MD, MPH, FACEP

SUBJECT: Establishing the Position and Succession of a Speaker-Elect for the Council

PURPOSE: Amends the Bylaws to create the position of “speaker-elect” to replace the current position of vice speaker, establishes an automatic transition from speaker-elect to speaker with each term being two years, and clarifies the procedures for filling a vacancy and automatic succession.

FISCAL IMPACT: Negligible use of budgeted staff resources to update the Bylaws and other administrative documents.

1 WHEREAS, The Council Speaker plays a critical role in the leadership and governance of ACEP, serving as
2 the presiding officer of the Council; and

3
4 WHEREAS, The ACEP Council elects a new Speaker every two years and the election introduces uncertainty
5 and potential disruption to the continuity of leadership within ACEP; and

6
7 WHEREAS, A seamless transition to the role of Speaker from without an additional election after a fixed
8 period of time enhances stability, efficiency, and effectiveness of leadership within the organization; and

9
10 WHEREAS, The naming convention within the College for elected positions that move automatically into the
11 next office at the end of a previous term is “-elect”; and

12
13 WHEREAS, An automatic transition to the role Speaker after two years would allow the incoming Speaker to
14 build upon the experience and knowledge gained during the preceding term without restrictions on activities created
15 by nomination for election; therefore be it

16
17 RESOLVED, That the ACEP Bylaws be amended to read:

18
19 ARTICLE VIII — COUNCIL

20
21 Section 8 — Board of Directors Action on Resolutions (paragraph 3)

22
23 The ACEP Council Speaker and ~~Vice Speaker~~ **Speaker-Elect** or their designee shall provide to the College a
24 written summary of the Council meeting within 45 calendar days of the adjournment of the Council meeting. This
25 summary shall include:

- 26
27 1. An executive summary of the Council meeting.
28 2. A summary and final text of each passed and referred resolution.

29
30 ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

31
32 Section 1 – Officers

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

36
37 Section 2 — Election of Officers
38

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

43 Section 4.2 — President-Elect
44

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

53
54 Section 4.4 — Council Officers
55

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

62
63 In the event of a vacancy in the office of speaker, the ~~vice-speaker~~ speaker-elect shall succeed to the office of
64 speaker for the remainder of the unexpired term, and an interim ~~vice-speaker~~ speaker-elect shall then be elected as
65 described above. Any time remaining in the unexpired term of the previous speaker will not abbreviate the term
66 that the new speaker would have originally served prior to the occurrence of the vacancy.

67
68 In the event that the offices of both speaker and ~~vice-speaker~~ speaker-elect become vacant, the Steering
69 Committee shall elect a speaker, as outlined in paragraph one of Section 4.4, to serve until the election of a new
70 speaker and ~~vice-speaker~~ speaker-elect at the next meeting of the Council. This individual, having served as
71 speaker following election by the Steering Committee, shall be eligible for nomination to serve the full terms of
72 speaker or speaker-elect, provided that all other candidate eligibility criteria are met.

73
74 Section 4.6 — Vacancy by Removal of a Council Officer
75

76 In the event of removal of ~~a Council officer, nominations for replacement shall be accepted from the floor of~~
77 ~~the Council, and election shall be by majority vote of the councillors present and voting at the Council meeting at~~
78 ~~which the removal occurs. In the event that~~ the speaker, ~~is removed and the vice-speaker~~ speaker-elect ~~is elected~~
79 shall succeed to the office of speaker. Any time remaining in the unexpired term of the previous speaker will not
80 abbreviate the term that the new speaker would have originally served prior to the removal.

81
82 In the event of removal of the speaker-elect, the office of vice-speaker nominations for replacement shall
83 be accepted from the floor of the Council, and election shall be by majority vote of the councillors present and
84 voting at the Council meeting at which the removal occurs ~~shall then be filled by majority vote at that same~~
85 ~~meeting, from nominees from the floor of the Council.~~ The new speaker-elect will succeed to the office of speaker
86 at the end of the unexpired term.

Section 11 — Speaker

87
88
89 The term of office of the speaker of the Council shall be two years. The speaker shall attend meetings of the
90 Board of Directors and may address any matter under discussion. The speaker shall preside at all meetings of the
91 Council, except that the ~~vice-speaker~~ speaker-elect may preside at the discretion of the speaker. The speaker shall
92 prepare, or cause to be prepared, the agendas for the Council. The speaker may appoint committees of the Council and
93 shall inform the councillors of the activities of the College. The speaker's term of office shall begin immediately
94 following the conclusion of the annual meeting at which the election of a new speaker-elect has occurred and shall
95 conclude at such time as a successor takes office. The speaker shall not have the right to vote in the Council except in
96 the event of a tie vote of the councillors. During the term of office, the speaker is ineligible to accept nomination to
97 the Board of Directors of the College. No speaker may serve consecutive terms except in fulfillment of a partial
98 unexpired term.
99

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

101
102 The term of office of the ~~vice-speaker~~ speaker-elect of the Council shall be two years. The ~~vice-speaker~~
103 speaker-elect shall attend meetings of the Board of Directors and may address any matter under discussion. The ~~vice~~
104 ~~speaker~~ speaker-elect shall assume the duties and responsibilities of the speaker if the speaker so requests or if the
105 speaker is unable to perform such duties. The term of the office of the ~~vice-speaker~~ speaker-elect shall begin
106 immediately following the conclusion of the annual meeting at which the election occurred and shall conclude at such
107 time as a successor takes office. During the term of office, the ~~vice-speaker~~ speaker-elect is ineligible to accept
108 nomination to the Board of Directors of the College. No ~~vice-speaker~~ speaker-elect may serve consecutive terms.

Background

This resolution amends the Bylaws to create the position of “speaker-elect” to replace the current position of vice speaker, establishes an automatic transition from speaker-elect to speaker with each term being two years, and clarifies the procedures for filling a vacancy and automatic succession. The resolution eliminates the need for a speaker election every two years and essentially codifies in the Bylaws what has occurred since 2001. Since 1983, all vice speakers nominated for speaker have been elected and since 2001 the current vice speaker has been unopposed as the candidate for speaker.

The speaker and vice speaker served one-year terms from 1974-76. The Bylaws were amended in 1976 to change the term to two years. Until 1991, the Bylaws were silent on the issue of multiple terms for the Council officers and the Bylaws were amended in 1991 to limit the speaker and vice speaker to two consecutive terms of two years each. Only two speakers and two vice speakers have served two consecutive terms (1989-1997). The Bylaws were amended in 2003 to limit the speaker and vice speaker to a single two-year term of office.

The Council has considered automatic succession of the vice speaker to speaker in the past. A Bylaws amendment was considered in 1984 to allow the vice speaker to succeed to the office of speaker at the conclusion of the speaker's two-year term and the resolution was not adopted. In 2001 a Council Issues Governance Task Force was appointed composed of members of the Board of Directors and the Council Steering Committee. The task force recommended that the term of the vice speaker and speaker be limited to a single two-year term with automatic progression from vice speaker to speaker. During the Leadership & Legislative Issues Conference, a roundtable discussion on governance was held. Several members participating in that discussion were not in agreement with the automatic progression. The Steering Committee discussed the issue again and agreed that the Council may prefer to have separate elections for each office. The Bylaws amendment submitted in 2003 focused solely on the single two-year term for the Council officers.

Eliminating the election of the speaker would allow the speaker-elect to assist the speaker in the annual elections process, including serving on the Nominating Committee and Candidate Forum Subcommittee, addressing questions from candidates regarding the Candidate Campaign Rules, and assisting the speaker in evaluating and addressing alleged Candidate Campaign Rule violations. Currently, as a candidate the vice speaker is excluded from participating

in these activities in the election year for speaker. However, if adopted, the resolution would also eliminate the possibility of a floor nominee for speaker and removes the ability for the Council to have a choice in the speaker election if the speaker-elect has real or perceived performance issues.

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.

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

Negligible use of budgeted staff resources to update the Bylaws and other administrative documents.

Prior Council Action

Resolution 2(03) Council Officer Terms adopted. Amended the Bylaws to limit the speaker and vice speaker to a single two-year term of office.

Resolution 7(02) Council Officer Terms referred to the Council Steering Committee. The resolution sought to amend the Bylaws to limit the speaker and vice speaker to a single two-year term of office.

Resolution 4(91) Council Officer Terms adopted. Limited the speaker and vice speaker terms to no more than two consecutive terms.

Resolution 15(84) Councillor Officer Terms not adopted. The resolution sought to amend the Bylaws to allow the vice speaker to succeed to the office of speaker at the expiration of the speaker's two-year term.

Resolution 15(80) Election of Officers not adopted. The resolution sought to amend the Bylaws to limit the speaker and vice speaker to no more than three consecutive two-year terms.

Resolution 9(76) Speaker and Vice Speaker adopted. Amended the Bylaws to elect the speaker and vice speaker for two-year terms.

Amended Resolution 6(73) Speaker and Vice Speaker Elections adopted. Amended the Bylaws to allow the Council to elect the speaker and vice speaker.

Prior Board Action

Resolution 2(03) Council Officer Terms adopted.

June 2002, approved cosponsoring a resolution with the Council Issues Governance Task Force to amend the Bylaws to limit the speaker and vice speaker to a single two-year term of office.

April 2002, accepted the reports of the Council Issues Governance Task Force and the Steering Committee Governance Task Force.

Amended Resolution 4(91) Council Officer Terms adopted.

Resolution 9(76) Speaker and Vice Speaker adopted.

Amended Resolution 6(73) Speaker and Vice Speaker Elections adopted.

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

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



RESOLUTION: 18(23)
SUBMITTED BY: Emergency Medicine Workforce Section
SUBJECT: Referred Resolutions

PURPOSE: Create two separate “refer to the Board” options: “refer to the Board for decision” and “refer to the Board for report” and return the resolution to the Council for final decision.

FISCAL IMPACT: Budgeted committee and staff resources to develop Bylaws and Council Standing Rules amendments to be considered at the 2024 Council meeting.

1 WHEREAS, The Council currently has the options to decide on resolutions: Approve, Not Approve, or Refer
2 to the Board; and

3
4 WHEREAS, The Council may want a resolution to have further discussion and information by the Board, but
5 then to be returned to the Council for a final decision; therefore be it

6
7 RESOLVED, That ACEP create two separate “Refer to Board” options: “Refer to Board for Decision” and
8 “Refer to Board for Report” then return the resolution back to the Council for final decision.

Background

This resolution requests that ACEP create two separate “refer to the Board” options: 1) “refer to the Board for decision” and 2) “refer to the Board for report” and return the resolution to the Council for final decision. Adoption of this resolution would require amendments to the Bylaws and the Council Standing Rules to be submitted to the 2024 Council for consideration.

The options available to the Council regarding resolutions are: adopt, adopt as amended, not adopt, or refer. Resolutions can be referred to the Board of Directors, the Council Steering Committee, or the Bylaws Interpretation Committee (for certain provisions of the Bylaws). A resolution may be referred to the Board of Directors for a variety of reasons, including but not limited to:

- additional information is needed to inform a decision
- additional expertise, study, or data collection is required
- additional discussion is needed to consider potential unintended consequences regarding controversial or complex issues
- consider the impact of the resolution to the organization
- obtain a legal opinion
- a significant financial investment may be required that is not available in the current budget
- further analysis of fiscal impact is needed (this is particularly true regarding late or emergency resolutions when background information has not been prepared)
- the resolution asks the College to consider a decision that is contrary to current policy or creates new policy
- pending legislative or regulatory matters
- the Council was not able to reach consensus

ACEP’s Board of Directors has the authority to take action on referred resolutions as they deem appropriate. The ACEP president, on behalf of the Board of Directors, may assign the referred resolution to a committee, task force,

section, workgroup of the Board, or staff to review the referred resolution and provide recommendations to the Board regarding proposed action on the resolution.

The Board of Directors is currently required, per the Bylaws Article VIII – Council, Section 8 – Board of Directors Actions on Resolutions, to provide “written and comprehensive communication regarding the actions taken and status of each adopted and referred resolution” including “a summary of the Board of Directors’ intent, discussion, and decision for each referred resolution.” Written reports on the prior year’s resolutions, as well as reports from the two previous years, are provided in the Council meeting materials. Additionally, information on the disposition of each resolution is available on the ACEP website, [Actions on Council Resolutions](#). The resolutions are listed by year and title and include the original resolution, background information, testimony in the Reference Committee, Council action, Board action, and implementation action. The search function includes a global search across all resolutions and a search capability within each year. All resolutions since 1989 are now available. Staff are continuing to work on adding all resolutions since 1972.

Each year the Council Steering Committee reviews the implementation actions on adopted and referred resolutions to ensure that the will of the Council is followed in implementing the resolutions. Their review includes actions on all resolutions adopted and referred from the most recent Council meeting and the resolutions from the two prior years. This requirement is codified in the Council Standing Rules, “Policy Review” section:

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

The Steering Committee has the authority to represent the Council between annual meetings as defined in the Bylaws Article XI – Committees, Section 3 – Steering Committee:

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

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

As previously stated, adoption of this resolution would require amendments to the Bylaws and the Council Standing Rules to be submitted to the 2024 Council for consideration. It is unclear from the resolution as written whether the Board’s decision on a referred resolution or the Board’s report on a referred resolution would need to be assigned to a Reference Committee for deliberation or if the intent is for the Council to deliberate directly on the Board’s decision or the Board’s report. Subsequently, there is the potential for re-debate/re-vote/re-referral for each referred resolution from the prior year's Council meeting.

A resolution was submitted to the Council in 2022 to amend the Bylaws to: 1) require a report on each resolution referred to the Board will become a matter of business at the subsequent Council meeting; 2) the report will include a summary of the Board’s discussion and their recommendations regarding the referred resolution; and 3) the Board’s recommendations on referred resolutions will be subject to approval by the Council. The resolution was not adopted. Testimony regarding the proposed resolution reflected that there is an existing process for such actions to be taken and a referred resolution could be resubmitted if there is dissatisfaction with the Board’s actions on a referred resolution.

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

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 Bylaws and Council Standing Rules amendments to be considered at the 2024 Council meeting.

Prior Council Action

Resolution 12 (22) Council Approval of Board Actions on Referred Resolutions not adopted. The resolution sought to amend the Bylaws to: 1) require a report on each resolution referred to the Board will become a matter of business at the subsequent Council meeting; 2) the report will include a summary of the Board’s discussion and their recommendations regarding the referred resolution; and 3) the Board’s recommendations on referred resolutions will be subject to approval by the Council.

Amended Resolution 10(21) Board of Directors Action on Council Resolutions adopted. Amended the Bylaws to include reporting requirements to the Council regarding the disposition of all resolutions considered by the Council and reporting requirements for all resolutions adopted and referred by the Council.

Amended Resolution 12(15) Searchable Council Resolution Database adopted. Directed ACEP to create a web-based searchable database for Council resolutions.

Substitute Resolution 30(90) Resolution Review adopted. Revised the Council Standing Rules to include a periodic review of previous resolutions adopted by the Council and the Board of Directors and provide an annual report to the Council.

Prior Board Action

Amended Resolution 10(21) Board of Directors Action on Council Resolutions adopted.

Amended Resolution 12(15) Searchable Council Resolution Database adopted.

Substitute Resolution 30(90) Resolution Review adopted.

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

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



RESOLUTION: 19(23)
SUBMITTED BY: Emergency Medicine Workforce Section
SUBJECT: Scientific Assembly Vendor Transparency

PURPOSE: Require staffing and recruitment companies exhibiting at Scientific Assembly to bring sample contracts for physicians to review and the contracts must include information regarding non-compete clauses, due process and policies on transparency in billing and collections.

FISCAL IMPACT: Potential reduction in outside funding support should groups be denied access to exhibit at Scientific Assembly as well as possible legal expenses to respond to complaints against ACEP for such actions.

1 WHEREAS, ACEP allows vendors to advertise and recruit members for potential employment during
2 Scientific Assembly; and

3
4 WHEREAS, ACEP members seeking employment deserve transparency in the recruitment and contract
5 process; therefore be it

6
7 RESOLVED, For transparency as part of the vendor contract, vendors recruiting emergency physicians for
8 employment be required to bring sample contracts for physicians to review during Scientific Assembly exhibits and
9 the sample contracts must include stipulations relating to non-compete clauses, due process, and policies on
10 transparency in billing/collections.

Background

This resolution calls for ACEP to require staffing and recruitment companies exhibiting at Scientific Assembly to bring sample contracts for physicians to review and the contracts must include information regarding non-compete clauses, due process and policies on transparency in billing and collections.

As part of the exhibitor application process, ACEP includes an [employer profile survey for](#) staffing and recruitment companies to complete. The survey, developed in consultation with outside counsel and approved by the ACEP Board of Directors, requests information regarding the group’s governance structure, transparency of their billing practices, ownership model, attestation to ACEP’s policies, as well as other non-competitive information. While companies are required to complete the survey, no questions are mandatory and no answers will prohibit a company from exhibiting.

Contracting and [employment resources](#) are available on the ACEP website to assist members. An employer database is being enhanced to improve transparency between members and entities that employ emergency physicians regarding adherence to ACEP policy statements. There are dozens of pages of resources on the ACEP website dedicated to the topics of Employment Contracts and other practice and legal issues. In an effort to better support all members as they face unprecedented challenges in employment, ACEP staff embarked on a process to update, curate and develop educational and other assets into a complete set of resources designed to educate and empower physicians, at any point in their career, to more knowledgeably [evaluate contract terms](#) and push back on unfair business practices, regardless of employment model or practice type. The Medical-Legal Committee developed a checklist of “[Key Considerations in an Emergency Medicine Employment Contract](#).” The checklist is available on the EMRA website and the ACEP website in the [Medical-Legal Resources](#). ACEP members also receive a [20 percent discount on services from Resolve, a partner who offers contract review](#), compensation data and more. Members have exclusive access to a [contract toolkit](#) that includes an extensive list of frequently asked questions about the nuances of employment agreements.

ACEP's policy statement "[Emergency Physician Contractual Relationships](#)" includes the following provisions:

Contractual Rights:

- ACEP supports the emergency physician receiving early notice of a problem with his or her performance and an opportunity to correct any perceived deficiency before disciplinary action or termination is contemplated.
- All entities contracting with or employing emergency physicians to provide clinical services, either indirectly or directly, should ensure an adequate and fair discovery process prior to deciding whether or not to terminate or restrict an emergency physician's contract or employment to provide clinical services.
- Emergency physicians employed or contracted should be informed of any provisions in the employment contract or the contracting vendor's contract with the hospital concerning termination of a physician's ability to practice at that site. This includes any knowledge by the contracting vendor of substantial risk of hospital contract instability.
- Emergency physician contracts should explicitly state the conditions and terms under which the physician's contract can be reassigned to another contracting vendor or hospital with the express consent of the individual contracting physician.
- The emergency physician should have the right to review the parts of the contracting entities' contract with the hospital that deal with the term and termination of the emergency physician contract.

Billing Rights:

- The emergency physician is entitled to detailed itemized reports on what is billed and collected for his or her service on at least a semi-annual basis regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law. The emergency physician shall not be asked to waive access to this information.
- Hospitals should disclose to physicians and/or the contracting vendor which networks, plans, etc. the hospital is contracting with, ie, which networks consider the hospital to be "in-network."
- It is the right of an emergency physician contracting entity to make an independent decision regarding all contractual arrangements that involve insurers and to be represented by legal counsel.
- Health care facilities should provide confidential complete transparency to the emergency physician of all facility charges that are billed as part of an emergency visit.

The Nature of the Contract:

- Business relationships that include emergency physicians are best defined within a written contract.
- The contracting parties should be ethically bound to honor the terms of any contractual agreement to which it is a party and to relate to one another in an ethical manner. This applies even if prior to the initiation of employment or in the case of deferred/delayed employment such as that of a graduating resident or fellow.
- Physician disciplinary, quality of care or credentialing issues pertaining to medical care must be reviewed and affirmed by a licensed emergency physician.
- The emergency physician is individually responsible for the ethical provision of medical care within the physician-patient relationship, regardless of financial or contractual relationships.

Quality medical care is provided by emergency physicians organized under a wide variety of group configurations and with varying methods of compensation. ACEP does not endorse any single type of contractual arrangement between emergency physicians and the contracting vendor.

The resolution requires that language be added to the contracts of the vendors recruiting emergency physicians requiring them to provide sample employee contracts at their booth(s) in the exhibit hall and further specifies what elements must be in those employment contracts. Enforcement of the resolution could be an antitrust violation.

Like many professional associations, ACEP provides venues for competitors to communicate with its members such as exhibiting at meetings, sponsoring events, and advertising in publications. While some court decisions allow associations to offer or deny access to these venues based on certain criteria, there is also case law holding that a denial of essential means of competition may be made the basis for antitrust challenges against associations. Since ACEP is the oldest and largest association of emergency physicians and its *Scientific Assembly* is the largest emergency medicine meeting in the world, excluding certain competitors from these venues could have a significant, adverse impact on those competitors' ability to compete and could result in antitrust litigation filed against ACEP.

ACEP's "[Antitrust](#)" policy statement states: "The College is not organized to and may not play any role in the competitive decisions of its member or their employees, nor in any way restrict competition among members or potential members. Rather it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice." The policy further specifies:

- There will be no discussions discouraging or withholding patronage or services from, or encouraging exclusive dealing with any health care provider or group of health care providers...
- There will be no discussions about restricting, limiting, prohibiting, or sanctioning advertising or solicitation that is not false, misleading, deceptive, or directly competitive with College products or services.
- There will be no discussions about discouraging entry into or competition in any segment of the health care market.
- There will be no discussions about whether the practices of any member, actual or potential competitor, or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the College's Bylaws.

ACEP's General Counsel has engaged outside counsel previously to provide legal opinion on the antitrust risk to ACEP to implement Referred Amended Resolution 44(20) Due Process in Emergency Medicine that called for ACEP to exclude or limit certain competitors from participating in the ACEP Scientific Assembly. The opinion was presented to the Board of Directors in June 2021 with available case law and previous legal opinions shared on this matter. It was the recommendation of outside counsel that the findings of all four available legal opinions were consistent and clearly demonstrated a substantial risk to carrying out the resolution as written. However, suggestions were made by general counsel and outside counsel that meet the intent of the resolution. Specifically, ACEP could seek to obtain non-competitive information from all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products with the intent to increase transparency and demonstrate an employer's adherence to key ACEP policy statements.

ACEP 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

Potential reduction in outside funding support should groups be denied access to exhibit at Scientific Assembly as well as possible legal expenses to respond to complaints against ACEP for such actions.

Prior Council Action

Amended Resolution 19(22) Due Process and Interactions with ACEP adopted (second resolved). Directed ACEP to create a method for members to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying such that are of concern. The first resolved was not adopted. It requested that ACEP adopt this policy: "Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support, or otherwise be associated with the ACEP, as of January 1, 2023, shall remove all contractual restrictions on or waivers of due process for emergency physicians. Physicians cannot be asked to waive this right as it can be detrimental to the quality and safety of patient care. The entities affected include but are not limited to physician group practices, hospitals, and staffing companies."

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at

entities that deny an emergency physician this right; 2) revise the policy statement “Emergency Physician Rights and Responsibilities;” 3) adopt a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.

Resolution 17(03) Certificate of Compliance referred to the Board of Directors. The resolution called for ACEP to require emergency physician staffing groups to comply with terms of a certificate as a prerequisite for being an exhibitor or sponsor for any ACEP activity. The certificate included multiple provisions that groups must attest to including “With the provisional period not to exceed one year, our physician group provides our emergency physicians access to predefined due process.”

Resolution 14(02) Emergency Physician Rights and Self-Disclosure not adopted. The resolution would have required any exhibitor, advertiser, grant provider, and sponsor who employs emergency physicians as medical care providers to disclose their level of compliance with College policies on compensation and contractual relationships.

Prior Board Action

Amended Resolution 19(22) Due Process and Interactions with ACEP adopted (second resolved).

June 2021, approved developing and distributing a questionnaire to all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products in which they are asked to voluntarily provide non-competitive information about their organizations.

April 2021, approved the revised policy statement “[Compensation Arrangements for Emergency Physicians](#);” revised and approved April 2015; reaffirmed October 2008, revised and approved April 2002 and June 1997; reaffirmed April 1992; originally approved June 1988.

April 2021, approved the revised policy statement “[Emergency Physician Contractual Relationships](#);” revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title. Originally approved October 1984 titled “Contractual Relationships between Emergency Physicians and Hospitals.”

April 2021, approved the revised policy statement “[Emergency Physician Rights and Responsibilities](#);” revised and approved October 2021, April 2008 and July 2001; originally approved September 2000.

October 2020, approved the policy statement “[Emergency Physician Compensation Transparency](#).”

July 2019, reviewed the updated information paper “[Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships](#);” revised June 1997, originally reviewed July 1996.

July 2018, reviewed the PREP “[Emergency Physician Contractual Relationships](#)” as an adjunct to the policy statement “Emergency Physician Contractual Relationships.”

September 2004, approved a report to the Council with a letter from the Federal Trade Commission regarding issues raised in Resolution 17(03) Certificate of Compliance and Resolution 18(03) Intention to Bid for Group Contract and agreed to take no further action on the resolutions.

Background Information Prepared by: Leslie Moore, JD
Senior Vice President, General Counsel

Jana Nelson
Senior Vice President, Marketing and Communications

Jodi Talia
Senior Vice President, Development

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



RESOLUTION: 20(23)

SUBMITTED BY: Kalev Freeman, MD, FACEP
Antony Hsu, MD, FACEP
James Paxton, MD, MBA, FACEP
Nicholas Vasquez, MD, FACEP

SUBJECT: Emergency Medicine Research Mentorship Network

PURPOSE: 1) 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; 2) not be limited to either virtually only or in-person only; 3) develop multiple emergency medicine research mentorship models with support by ACEP staff with an ACEP.org-based and aligned online structure; 4) 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.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other projects and an additional staff member dedicated to the project. Unbudgeted costs of approximately \$150,000 for salary and benefits and additional estimated costs of \$50,000 to create and track the mentorship network.

1 WHEREAS, ACEP has a significant investment in promoting emergency medicine research; and

2

3 WHEREAS, Many emergency medicine residents and fellows of ACEP present a broad range of research
4 projects and findings at ACEP Scientific Assembly every year; and

5

6 WHEREAS, ACEP has many emergency physician-researchers who pursue clinical research around the
7 world at early points in their training and career looking for mentors; and

8

9 WHEREAS, The emergency physician-researchers pipeline drops off dramatically during their careers; and

10

11 WHEREAS, The number of emergency physician-researchers who are minorities in race, gender-identity and
12 nonacademic—based practice sites comprise a significant proportion of ACEP membership; and

13

14 WHEREAS, The Society of Academic Emergency Medicine does not support a research mentorship program
15 at this time; and

16

17 WHEREAS, Emergency medicine researchers do not yet have an organization-supported ongoing program
18 for research mentorship; therefore be it

19

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

24

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

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

29
30 RESOLVED, That ACEP’s emergency medicine research mentorship resources include, but are not limited
31 to, constructive surveys and ACEP-staff curated anonymized feedback with an ongoing mentor development track
32 replete with recognition of contributions and standardized mentorship training opportunities.

Background

This resolution requests ACEP to establish a formal emergency medicine research mentorship program of ACEP-staffed networks focused on diverse academic and non-academic topics; that the research mentorship program not be limited to either virtually only or in-person only; develop multiple emergency medicine research mentorship models with support by ACEP staff including an aligned online structure; and provide resources including, but not limited to, constructive surveys, ACEP-staff curated anonymized feedback, ongoing mentor development track. and recognition of contributions and standardized mentorship training opportunities.

The creation of a research mentorship network would require recruiting both mentors and mentees and supporting those interactions. New resources, materials, and tools to support researchers would need to be curated and adapted from existing sources or created de novo including IT support and software.

ACEP, together with the Emergency Medicine Foundation, is a leading supporter of emergency medicine research through: educational activities and nearly \$1 million dollars in grants annually; hosting of the annual Research Forum; facilitation of the longest-running emergency medicine research training course, Emergency Medicine Basic Research Skills (EMBRs); ownership and support of two of the field’s most preeminent emergency medicine journals (*Annals of Emergency Medicine* and *JACEP Open*); federal and state advocacy for research funding; training and application of research-to-practice; direct pursuit of and collaboration on research (encompassing millions of dollars annually in federal and foundation funding); support for the Research, Scholarly Activity, and Innovation (RSI) Section; and more. More recently, ACEP has also created one of the largest and most detailed registries of emergency care and related infrastructure through the Emergency Medicine Data Institute (EMDI), which will serve as an unparalleled data resource for the field. Currently, ACEP staff includes a Senior Research Fellow who is a doctoral and fellowship research-trained emergency physician to help guide and support the research mission of ACEP.

ACEP has directly supported formal and informal research mentorship for more than 20 years. EMBRS is a year-long, research training program including didactics and practical workshops on research study design, protocol development, statistical analysis, grant writing, manuscript publication, research management, and research career advancement. Participants are also eligible to receive an EMF/EMBRs grant based on their research grant application as a key deliverable of the training program. Informal mentorship opportunities are supported through the RSI Section, Research Committee, and through research related events, such as the Research Forum.

ACEP recognizes that increasing the number, longevity, and diversity of emergency medicine researchers is critical to advancing emergency medicine research and in turn has dedicated resources towards this purpose. The ultimate purpose of emergency medicine research is to increase the prominence of the field and pursue the quintuple aim (i.e., improved population health, decreased health care costs, improved care experience, well workforce, promotion of equity).

Develop an evidence-based strategy and resources to promote interest in emergency medicine research among students, residents, and faculty with the goal of increasing research training, emergency medicine research fellows, and physician-scientists, for women and individuals of racial and ethnic minority backgrounds.

Promoting research-related mentorship and mentored exposure to research is foundational. Such experiences and relationships can begin and continue throughout a prospective researcher’s career from secondary education through mid or late in independent practice. Additionally, while all those who receive such mentorship may not pursue research-oriented careers, it is likely that they decide to enter the field of emergency medicine at a higher rate; suggesting a secondary benefit that is relevant given recent recruitment challenges to the field. Furthermore,

developing more emergency physician researchers offers a path to expand career options in the context of workforce concerns and may provide for greater career longevity and job satisfaction. Most major academic institutions provide numerous resources, support, and infrastructure to develop researchers locally. This investment in developing and supporting researchers can benefit the institutions directly when the investigators receive federal funding since part of the award goes to the institution.

The NIH funds more than 60 academic medical centers around the country through a program called the Clinical and Translational Science Award (CTSA) administered by the National Center for Advancing Translational Sciences (NCATS).³ The goal of the CTSA is to help institutions create an integrated academic home for clinical and translational science with the resources to support researchers and research teams working to apply new knowledge and techniques to patient care. This funding specifically focuses on providing the infrastructure and resources to support research separate from any research an institution/investigator might receive. The total budget for FY 2023 is over \$800 million dollars.

The Society for Academic Emergency Medicine (SAEM) offers numerous research mentorship opportunities and resources for investigators. SAEM maintains and tracks lists of federal funding in emergency medicine and has a variety of educational offerings throughout the year and at their annual meeting. SAEM has developed extensive online resources for emergency medicine researchers, including a tool to help connect researchers with similar areas of focus called the [SAEM Collaborator Connection](#). Collaboration between ACEP and SAEM would build complimentary resources and avoid duplication of effort.

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

Background References

¹<https://brimr.org/brimr-rankings-of-nih-funding-in-2022/>

²Brown J. National Institutes of Health support for individual mentored career development grants in emergency medicine. *Acad Emerg Med.* 2014;21(11):1269–73 and Bessman SC, Agada NO, Ding R, et al. Comparing National Institutes of Health funding of emergency medicine to four medical specialties. *Acad Emerg Med.* 2011;18(9):1001–4.

³Brown J. National Institutes of Health support for individual mentored career development grants in emergency medicine. *Acad Emerg Med.* 2014;21(11):1269–73 and Bessman SC, Agada NO, Ding R, et al. Comparing National Institutes of Health funding of emergency medicine to four medical specialties. *Acad Emerg Med.* 2011;18(9):1001–4.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other projects and an additional staff member dedicated to the project. Unbudgeted costs of approximately \$150,000 for salary and benefits and additional estimated costs of \$50,000 to create and track the mentorship network.

Prior Council Action

None

Prior Board Action

January 2021, approved endorsing the 2030 National Institutes of Health Funding Goals for Emergency Medicine.

Background Information Prepared by: Martin Wegman, MD, PhD
Senior Research Fellow

Jonathan Fisher, MD, MPH, FACEP
Senior Director, Workforce and EM Practice

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



RESOLUTION: 21(23)

SUBMITTED BY: Emergency Medicine Residents' Association

SUBJECT: Mitigation of Competition for Procedures Between Emergency Medicine Resident Physicians and Other Learners

PURPOSE: Support EM residents right of first refusal over non-physicians, such as PAs and NPs, in performing ACGME-required procedures that are deemed medically necessary in EDs.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement.

1 WHEREAS, There are physicians, physician assistants, nurse practitioners, and other learners in emergency
2 departments; and

3
4 WHEREAS, Residency is an important time for resident training and procedural practice¹; and

5
6 WHEREAS, Mastery of skills in residency is integral to developing clinical acumen²; and

7
8 WHEREAS, Residency training requires mastery of various procedures including airway management,
9 vascular access, laceration repair, invasive diagnostic procedures, among others³; and

10
11 WHEREAS, Emergency medicine residents are expected to perform a minimum required number of
12 procedures prior to graduation to be considered competent by the Accreditation Council for Graduate Medicine
13 Education (ACGME)⁴; and

14
15 WHEREAS, These procedural skills have and should continue to prioritize patient safety and be performed
16 with appropriate attending supervision; and

17
18 WHEREAS, There are an increasing number of non-physician professionals in the emergency department⁵;
19 and

20
21 WHEREAS, There is a developing trend of fewer medically necessary procedures required in the emergency
22 department due to improvements in medical care and novel treatment options⁵; therefore be it

23
24 RESOLVED, That ACEP support emergency medicine resident physicians' right of first refusal over non-
25 physicians, such as physician assistants and nurse practitioners, in performing ACGME-required procedures that are
26 deemed medically necessary in emergency departments.

Resolution References

¹Husted A, Rölfing JD, Ingeman ML, Paltved C, Ludwig M, Konge L, Nayahangan L, Jensen RD. Identifying technical skills and clinical procedures for simulation-based training in emergency medicine: A nationwide needs assessment. *Am J Emerg Med.* 2022 Dec;62:140-143. doi: 10.1016/j.ajem.2022.09.014. Epub 2022 Sep 15. PMID: 36167748.

²Tran V, Cobbett J, Brichko L. Procedural competency in emergency medicine training. *Emerg Med Australas.* 2018 Feb;30(1):103-106. doi: 10.1111/1742-6723.12925. Epub 2018 Jan 16. PMID: 29341458.

³Williams AL, Blomkalns AL, Gibler WB. Residency training in emergency medicine: the challenges of the 21st century. *Keio J Med.* 2004 Dec;53(4):203-9. doi: 10.2302/kjm.53.203. PMID: 15647626.

⁴Bucher, J.T., Bryczkowski, C., Wei, G. et al. Procedure rates performed by emergency medicine residents: a retrospective review. *Int J Emerg Med* 11, 7 (2018). <https://doi.org/10.1186/s12245-018-0167-x>

⁵Gisondi, Michael A. MD; Regan, Linda MD; Branzetti, Jeremy MD; Hopson, Laura R. MD. More Learners, Finite Resources, and the Changing Landscape of Procedural Training at the Bedside. *Academic Medicine*: May 2018 - Volume 93 - Issue 5 - p 699-704 doi: 10.1097/ACM.0000000000002062

EMRA Policy

EM resident physicians should be given priority, preference, and right of first refusal for medically necessary procedures over non-physician providers, to preserve the integrity of resident physician training.

Background

This resolution asks ACEP to adopt a position that emergency medicine residents have right of first refusal over non-physicians, such as physician assistants (PAs) and nurse practitioners (NPs) in performing ACGME-required procedures that are deemed medically necessary in emergency departments. Adopting such a position would align with EMRA's policy and current ACGME common program requirements.

The ACGME is an independent not-for-profit organization that sets and monitors educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans. The ACGME oversees the accreditation of residency and fellowship programs in the US. In the 2022-23 academic year, there are 13,066 accredited residency and fellowship programs in 182 specialties and subspecialties with 158,079 resident and fellows. Specialty-specific Review Committees create a uniform set of high standards for each accredited specialty and subspecialty applied across all accredited U.S. residency and fellowship programs educating and training physicians in those fields to ensure the highest quality physicians and patient care.¹ The ACGME does not have oversight of non-physician learners except as related to physician trainees. According to the ACGME Emergency Medicine Program Requirements²:

- I.E. The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)
 - I.E.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC). (Core)

Background and Intent:

The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.

- IV.B.1.b).(2) Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)
 - IV.B.1.b).(2).(a) Residents must demonstrate competence in:
 - IV.B.1.b).(2).(a).(i) performing diagnostic and therapeutic procedures and emergency stabilization;
 - IV.B.1.b).(2).(a).(ii) managing critically-ill and injured patients who present to the emergency department, prioritizing critical initial stabilization action, mobilizing hospital support services in the resuscitation of critically-ill or injured patients and reassessing after a stabilizing intervention; (Core)
 - IV.B.1.b).(2).(a).(iii) properly sequencing critical actions for patient care and generating a differential diagnosis for an undifferentiated patient; (Core)

- IV.B.1.b).(2).(a).(iv) mobilizing and managing necessary personnel and other hospital resources to meet critical needs of multiple patients; and, ^(Core)
- IV.B.1.b).(2).(a).(v) performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types on all age groups. ^(Core)
- IV.B.1.b).(2).(b) Residents must perform indicated procedures on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation, take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. ^(Core)
- IV.B.1.b).(2).(c) Residents must demonstrate competence in performing the following key index procedures:
 - IV.B.1.b).(2).(c).(i) adult medical resuscitation; ^(Core)
 - IV.B.1.b).(2).(c).(ii) adult trauma resuscitation; ^(Core)
 - IV.B.1.b).(2).(c).(iii) anesthesia and pain management; ^(Core)
 - IV.B.1.b).(2).(c).(iv) cardiac pacing; ^(Core)
 - IV.B.1.b).(2).(c).(v) chest tubes; ^(Core)
 - IV.B.1.b).(2).(c).(vi) cricothyrotomy; ^(Core)
 - V.B.1.b).(2).(c).(vii) dislocation reduction; ^(Core)
 - IV.B.1.b).(2).(c).(viii) emergency department bedside ultrasound; ^(Core)
 - IV.B.1.b).(2).(c).(ix) intubations; ^(Core)
 - IV.B.1.b).(2).(c).(x) lumbar puncture; ^(Core)
 - IV.B.1.b).(2).(c).(xi) pediatric medical resuscitation; ^(Core)
 - IV.B.1.b).(2).(c).(xii) pediatric trauma resuscitation; ^(Core)
 - V.B.1.b).(2).(c).(xiii) pericardiocentesis; ^(Core)
 - IV.B.1.b).(2).(c).(xiv) procedural sedation; ^(Core)
 - IV.B.1.b).(2).(c).(xv) vaginal delivery; ^(Core)
 - IV.B.1.b).(2).(c).(xvi) vascular access; and ^(Core)
 - IV.B.1.b).(2).(c).(xvii) wound management. ^(Core)

Over the past few years there is increasing number of learners in EDs, including emergency medicine residents, off service residents, PAs, and NPs. Another development has been the creation of post graduate training programs in emergency medicine for both PAs and NPs. These programs are varied in location and format and often co-exist with emergency medicine residencies. Some of these programs have even referred to themselves as “residencies.” While there may be abundance of certain procedures, other more critical procedures may be rarer. Additionally, some procedures such as transvenous pacing or pericardiocentesis have become rarer in the ED as the location they are being performed has shifted to the cardiac catheterization lab in some centers. All of these factors have led to increase competition for procedures among learners.³

A recent study published in the Western Journal of Emergency Medicine by Phillips et al. report the results of a survey of EM residents on the effects of Non-physician Practitioners (NPP) on emergency medicine physician resident education. The survey was distributed to 1,168 emergency medicine residents across the country and received 393 responses. 66.9% residents reported a detracting or greatly detracting impact on their education caused by NPP presence in training facilities. The survey also identified a significant loss of procedure opportunities, which was greatest at facilities that included postgraduate training programs for NPPs, where emergency physician residents reported a 14x increased loss of procedure opportunities. Even more concerning was the finding that, 33.5% residents reported feeling “not confident at all” in their ability to report concerns about NPPs to local leadership without retribution, and 65.2% reported feeling “not confident at all” regarding confidence in the Accreditation Council for Graduate Medical Education to satisfactorily address concerns about NPPs raised in the end-of-year survey.⁴

Background References

¹ <https://www.acgme.org/about-us/overview/>

² https://www.acgme.org/globalassets/pfassets/programrequirements/110_emergencymedicine_2022.pdf

³ Gisondi MA, Regan L, Branzetti J, Hopson LR. More Learners, Finite Resources, and the Changing Landscape of Procedural Training at the Bedside. *Acad Med.* 2018 May;93(5):699-704. doi: 10.1097/ACM.0000000000002062. PMID: 29166352.

⁴ Phillips AW, Sites JP, Quenzer FC, Lercher DM. Effects of Non-physician Practitioners on Emergency Medicine Physician Resident Education. *West J Emerg Med.* 2023 May 3;24(3):588-596. doi: 10.5811/westjem.58759. PMID: 37278773; PMCID: PMC10284528.

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 for development of a policy statement.

Prior Council Action

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistant adopted. The resolution called for ACEP to revise the current policy statement “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.

Substitute Resolution 43(91) Development of New Residency Programs adopted. The resolution directed ACEP to strongly encourage the Residency Review Committee for Emergency Medicine to consistently apply existing special

requirements used in reviewing prospective emergency medicine residency programs and meet with the ACGME to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted. Directed ACEP to promote the expansion of existing and the development of additional emergency medicine programs, particularly in those areas of emergency physician shortage.

Prior Board Action

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; revised and approved June 2020 with the current title; revised and approved June 2013 titled “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;” originally approved January 2007 titled “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” replacing two policy statements “Guidelines on the Role of Physician Assistants in the Emergency Department” and “Guidelines on the Role of Nurse Practitioners in the Emergency Department.”

June 2023 approved the revised policy statement “[Guidelines for Undergraduate Education in Emergency Medicine](#);” revised March 2022, June 2021, June 2015 and April 2008; reaffirmed October 2001; revised January 1997; originally approved September 1986.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistant 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.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

January 2019, reaffirmed the policy statement “[Providers of Unsupervised Emergency Department Care](#);” revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers in the ED.

June 2012, reviewed the information paper “Physician Assistants and Nurse Practitioners in Emergency Medicine.”

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted.

Amended Substitute Resolution 43(91) Development of New Residency Programs. The Board amended the substitute resolution adopted by the Council. The amended substitute resolution directed ACEP to meet with the Residency Review Committee for Emergency Medicine (RRC-EM) to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce & Emergency Medicine Practice

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



RESOLUTION: 22(23)

SUBMITTED BY: Emergency Medicine Residents' Association

SUBJECT: Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation

PURPOSE: Support continued accreditation of both three-year and four-year residency program training formats.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement.

1 WHEREAS, Emergency Medicine residencies have included three-year and four-year programs since the
2 1980s¹; and
3

4 WHEREAS, A 2023 ABEM study published in *JACEP Open* compared ACGME Milestones data and ABEM
5 test performance of emergency physicians completing three- and four-year residencies concluded the “results do not
6 provide sufficient evidence to make a confident determination of the superiority of one training duration compared
7 with the other”²; and
8

9 WHEREAS, A 2023 study in the *American Journal of Emergency Medicine* utilized data from over one
10 million patient encounters by three-year graduates, four-year graduates, and experienced new hires found similar
11 performance on “measures of clinical care and practice patterns related to efficiency, safety, and flow” among the
12 three groups; ultimately concluded the results did not support recommending one length of training over the other³;
13 and
14

15 WHEREAS, There is no clear evidence from existing literature that either three- or four-year programs are
16 superior or noninferior to the other; and
17

18 WHEREAS, Any change to length of training requirements in emergency medicine should be evidence-
19 based; therefore be it
20

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

References

1. Sloan EP, Strange GR, Jayne HA. United States emergency medicine residency length in 1986-87 and 1987-88. *Ann Emerg Med* 1987;16:862–6.
2. Beeson, MS, Barton, MA, Reisdorff, EJ, et al. Comparison of performance data between emergency medicine 1-3 and 1-4 program formats. *JACEP Open*. 2023; 4:e12991. <https://doi.org/10.1002/emp2.12991>
3. Nikolla DA, Zocchi MS, Pines JM, et al. Four- and three-year emergency medicine residency graduates perform similarly in their first year of practice compared to experienced physicians. *Am J Emerg Med*. Apr 15 2023;69:100-107.

EMRA Policy

EMRA recognizes the value of choice in emergency medicine residency training formats. EMRA urges the continued accreditation of three-year and four-year formats.

Background

This resolution calls for ACEP to support continued accreditation of three-year and four-year residency training program formats.

Currently, the Accreditation Council for Graduate Medical Education (ACGME), which accredits emergency medicine residency programs, has standards¹ that state:

“Residency programs in emergency medicine are configured in 36-month and 48-month formats and must include a minimum of 36 months of clinical education.”

The requirements additionally specify that:

“Programs utilizing the 48-month format must ensure that all of the clinical, educational, and milestone elements contained in these Program Requirements are met and must provide additional in-depth experience in areas related to emergency medicine, such as medical education, clinical- or laboratory-based research, or global health. An educational justification describing the additional educational goals and outcomes to be achieved by residents in the incremental 12 months of education must be submitted to the Review Committee prior to implementation, and at each subsequent accreditation review of residency programs of 48 months’ duration.”

As of the academic year 2021-22 there were 276 programs and 80% of programs were three years in length. A review of the ACGME program requirements of the 27 primary specialties demonstrates that emergency medicine is one of the few specialties that has two different length of training formats. The ACGME is currently in the process of a major revision to the program requirements for Emergency Medicine which is a process that occurs every 10 years.²

A 2016 study surveyed emergency medicine program directors on their opinion of the ideal length of training for emergency medicine programs. The mean length of training was 41.5 months (SD = 5.5, range = 36 to 60 months).³ A 2023 study by the American Board of Emergency Medicine (ABEM) examined performance of three-year versus four-year residents. ACGME Milestones and ABEM In-training Examination (ITE), Qualifying Examination (QE), Oral Certification Examination (OCE), and program extensions from three-year and four-year residency programs showed slight differences of uncertain significance.⁴

| Measure | 3-year Graduate | 4-year graduate | P value |
|-------------------|-----------------|-----------------|---------|
| Milestones | 3.51 | 3.67 | <0.001 |
| ITE Score | 79.7 | 80.3 | 0.01 |
| QE Score | 83.5 | 83.0 | <0.001 |
| QE Pass Rate | 93.1 | 90/8 | <0.001 |
| OE Score | 5.65 | 5.67 | 0.03 |
| OE Pass Rate | 95.5 | 96.9 | 0.06 |
| Program Extension | 91.9 | 90.4 | 0.05 |

Another study examined more than one million encounters by 70 three-year graduates, 39 four-year graduates, and 476 experienced attendings found that measures of clinical care and practice patterns related to efficiency, safety, and flow. Length of stay, patients per hour, RVUs, and 72-hour returns were similar for all three groups although slight variations were found.⁵

In 2021, ACEP convened a workgroup of representatives from eight Emergency Medicine organizations (ACEP, AACEM, ACOEP, SAEM, CORD-EM, AAEM, EMRA, RAMS) to consider the optimal training and skills needed to prepare medical students entering the field of emergency medicine for future practice in the field. This was done in advance of the scheduled review and major revision of the emergency medicine program requirements according to ACGME timeline. Individuals reviewed the available formal and gray literature on selected topics both within and beyond emergency medicine, as appropriate as selected by the group. A detailed analysis was presented at biweekly virtual meetings over a six month period. At these sessions, each topic was thoroughly vetted by the entire group before a final consensus recommendation was developed. The individual recommendations were compiled and provided to the ACGME. Discussion of 3 year versus 4 year versus competency-based duration of training was robust and the committee did not reach a consensus recommendation for the optimal length of training. Instead, it was recommended that future length of training should be based on curriculum requirements for the future and time needed to achieve

competency in them. Passage of this resolution to support continuation of both 3 and 4 year formats would align with the multiorganizational report.

Emergency medicine has seen a dramatic rise in emergency medicine residencies in the past 10 years. The 2023 match also saw an unprecedented number of unfilled spots, with 554 of 3,010 (18.4%) PGY-1 positions at 131 of 276 (47%) emergency medicine programs going unfilled.⁶ There has been speculation by some that moving to an all 4-year format will help address the rapid growth of emergency medicine residencies and workforce issues. Others speculate that an all 4-year format will tip the financial incentives in favor of further expansion of residencies. In an all 4-year model, CMS would be obligated to provide additional funding to cover the additional year of training. It is unclear whether programs would keep the same total number residents and spread them out over 4 years, meaning a smaller class size, or whether programs would add an additional year with the same class size. As such, the workforce impact of moving to an all 4-year format is unknown.

Background References

1. ACGME Program Requirements for Graduate Medical Education in Emergency Medicine https://www.acgme.org/globalassets/pfassets/programrequirements/110_emergencymedicine_2023.pdf accessed 8/14/2023
2. Shaping GME: The Future of Emergency Medicine <https://www.acgme.org/globalassets/pfassets/reviewandcomment/emergencymedicinethemesinsights.pdf> accessed 8/14/2023
3. Hopson L, Regan L, Gisondi MA, Cranford JA, Branzetti J. Program Director Opinion on the Ideal Length of Residency Training in Emergency Medicine. *Acad Emerg Med*. 2016 Jul;23(7):823-7. doi: 10.1111/acem.12968. Epub 2016 Jun 20. PMID: 26999762.
4. Beeson MS, Barton MA, Reisdorff EJ, et al. Comparison of performance data between emergency medicine 1-3 and 1-4 program formats. *J Am Coll Emerg Physicians Open*. Jun 2023;4(3):e12991.
5. Nikolla DA, Zocchi MS, Pines JM, et al. Four- and three-year emergency medicine residency graduates perform similarly in their first year of practice compared to experienced physicians. *Am J Emerg Med*. Apr 15 2023;69:100-107.
6. Preiksaitis C, Krzyzaniak S, Bowers K, Little A, Gottlieb M, Mannix A, Gisondi MA, Chan TM, Lin M. Characteristics of Emergency Medicine Residency Programs With Unfilled Positions in the 2023 Match. *Ann Emerg Med*. 2023 Jul 11:S0196-0644(23)00429-8. doi: 10.1016/j.annemergmed.2023.06.002. Epub ahead of print. PMID: 37436344.

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 for development of a policy statement.

Prior Council Action

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

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

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

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted. Directed ACEP to continue long-range planning for projecting emergency physician needs based on patient visits and physician attrition and continue to

work toward preservation of adequate numbers of residency positions in emergency medicine, and to continue intensive lobbying efforts to preserve funding for adequate numbers of residency positions in emergency medicine.

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

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

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted. Directed ACEP to promote the expansion of existing and the development of additional emergency medicine programs, particularly in those areas of emergency physician shortage.

Prior Board Action

January 2021, appointed a multi-organization ACGME Emergency Medicine Requirements Consensus Task Force appointed to develop recommendations in response to Referred Resolution 48(20) Residency Program Expansion.

June 2018, reaffirmed the policy statement “[Emergency Medicine Training, Competency, and Professional Practice Principles](#);” reaffirmed April 2012; revised and approved January 2006; originally approved November 2001.

Amended Resolution 15(09) Emergency Medicine Workforce Solution adopted.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted.

Amended Substitute Resolution 43(91) Development of New Residency Programs adopted. The Board amended the substitute resolution to meet with the Residency Review Committee for Emergency Medicine (RRC-EM) to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce & Emergency Medicine Practice

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



RESOLUTION: 23(23)
SUBMITTED BY: Pennsylvania College of Emergency Physicians
SUBJECT: Opposing Sale-Leaseback Transactions by Health Systems

PURPOSE: 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.

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, Health systems are increasingly engaging in sale-leaseback transactions, wherein they sell their
2 owned properties to third-party investors and then lease them back for continued use; and
3

4 WHEREAS, Sale-leaseback transactions by health systems are primarily driven by the desire to raise capital
5 quickly, resulting in a short-term financial gain for the health system while potentially compromising the long-term
6 stability and accessibility of health care services; and
7

8 WHEREAS, The sale-leaseback model often leads to increased operational costs for health care providers due
9 to the need to pay lease fees, potentially diverting resources away from patient care and other critical health care
10 investments; and
11

12 WHEREAS, Sale-leaseback transactions can limit the control and flexibility of health systems over their
13 facilities, as decisions regarding facility management and improvements are subject to the terms and conditions set by
14 the third-party investors; and
15

16 WHEREAS, The prioritization of financial gains through sale-leaseback transactions may incentivize health
17 systems to make decisions that are not aligned with the best interests of patients, potentially compromising the quality
18 and continuity of care provided; and
19

20 WHEREAS, The sale-leaseback model can negatively impact the stability and accessibility of health care
21 services, particularly in underserved communities where the closure or downsizing of health care facilities could
22 result in limited access to essential medical services; and
23

24 WHEREAS, The sale-leaseback of Hahnemann University Hospital, located within steps of this Council
25 meeting, was instrumental in the collapse of a health care institution that spanned three centuries; therefore be it
26

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

Background

This resolution directs 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.

[The sale and subsequent closing of Hahnemann University Hospital in Philadelphia, PA in 2019](#) resulted in the loss of a critical safety net hospital and created significant disruption in the training of more than 570 residents and fellows, including emergency physicians. Considered the “largest displacement of medical residents in a single event ever”¹, residency program slots and their associated funding was subsequently used by the hospital system and its debtors as an asset that could be traded or sold. Despite the Affordable Care Act (ACA) laying out the process for redistributing medical residency slots when a hospital closes, the disruption to current residents was unavoidable and significant.

The company that acquired Hahnemann, “[Medical Properties Trust, Inc.\(MPT\)](#), is a self-advised real estate investment trust formed in 2003 to acquire and develop net-leased hospital facilities. From its inception in Birmingham, AL, the company has grown to become one of the world’s largest owners of hospitals with 444 facilities and roughly 47,000 licensed beds in nine countries and across four continents on a pro forma basis. MPT’s financing model facilitates acquisitions and recapitalizations and allows operators of hospitals to unlock the value of their real estate assets to fund facility improvements, technology upgrades and other investments in operations.” This worrisome trend puts innumerable health care facilities at risk for insolvency.

As a result of the closing of Hahnemann and other local hospitals with sale-leasebacks, [Pennsylvania lawmakers plan to introduce legislation](#) that would place a moratorium on private equity and other firms from buying hospitals in the state. Lawmakers would also prohibit owners from taking out dividends within two years of an acquisition and limit sale-leaseback transactions.

Several states have taken unprecedented legal actions to prevent hospital closure due to ownership changes. [Rhode Island’s attorney general was one of the first to conditionally approve a transaction](#) that would allow a change in ownership of two safety net hospitals in 2021. [Illinois introduced legislation](#) to enforce monetary penalties for any critical access hospital that closes due to a failed sale-leaseback transaction by a health system.

Persistent labor shortages and inflation concerns over the past three years [have left the majority of the 5,000+ hospitals in the U.S. unprofitable](#). As a result, leaseback of hospital buildings and infrastructure has been on the rise. Concerns about the potential diversion of resources away from patient care and limitations on the flexibility of for-profit health systems to make sustainable long-term financial decisions, still need to be addressed at the state and federal level.

This resolution asks for investment of ACEP resources in advocating for outside agencies to monitor and discourage and oppose hospital sale-leaseback transactions. There is not a specific ask related to emergency medicine specifically or even physicians in general. Additionally, this is an issue where many of ACEP’s advocacy partners, including the American Medical Association (AMA) in collaboration with the Association of American Medical Colleges (AAMC)¹, American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council for Graduate Medical Education (ACGME), have existing policy and advocacy efforts that are ongoing and specific to their physician members and trainees.²

Background References

¹ <https://www.aamc.org/news/what-residents-need-know-about-hahnemann-university-hospital-closure>

² <https://www.ama-assn.org/press-center/press-releases/ama-statement-hahnemann-university-hospital-closure-settlement>

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

None

Prior Board Action

None

Background Information Prepared by: Adam Krushinskie
Director, State Government Relations

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



RESOLUTION: 24(23)
SUBMITTED BY: Pennsylvania College of Emergency Physicians
SUBJECT: Addressing the Growing Epidemic of Pediatric Cannabis Exposure

PURPOSE: Advocate for changes in cannabis product packaging to prevent resemblance to non-cannabis products marketed towards children, while also appealing to regulatory bodies for labeling regulations to reduce accidental ingestion by young children and ensure clear dosing information and risk communication for cannabis products consumed by children.

FISCAL IMPACT: Cannabis labeling is not a current advocacy initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources for federal or state advocacy initiatives to support this effort.

1 WHEREAS, Recent studies have shown a rapid increase in unintentional cannabis exposures among young
2 children, posing significant toxicity risks and leading to a rising number of hospitalizations; and
3

4 WHEREAS, Pediatric cannabis exposure can have serious consequences for the health and well-being of
5 young children, necessitating proactive measures to prevent and mitigate such exposures; and
6

7 WHEREAS, Prioritizing prevention strategies is essential in reducing pediatric cannabis exposures; and
8

9 WHEREAS, ACEP plays a crucial role in promoting patient safety, public health, and advancing emergency
10 medicine; therefore be it
11

12 RESOLVED That ACEP advocate for changes in product packaging so as not to resemble non-cannabis
13 containing products, i.e., candy commonly marketed towards children; and be it further
14

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

Background

This resolution calls for the College to push for changes in cannabis product packaging to avoid any resemblance to non-cannabis products, particularly those marketed towards children. Additionally, the resolution directs the College to appeal to regulatory bodies and public health agencies to implement labeling regulations to reduce the likelihood of accidental ingestion of cannabis products by young children and clearly communicate dosing information as well as the potential risks associated with cannabis products.

[According to the National Conference of State Legislatures](#), as of April 24, 2023, medical use of cannabis is legalized in 38 states, three territories, and the District of Columbia. Twelve other states have laws that limit THC content for the purpose of allowing access to products that are rich in cannabidiol (CBD). As of June 1, 2023, recreational use of cannabis is legal in [23 states](#), the District of Columbia, the Northern Mariana Islands, and Guam; 27 states and D.C. have decriminalized small amounts of marijuana.

Although the use of cannabis remains illegal federally, some of its derivative compounds have been approved by the Food and Drug Administration (FDA) for prescription use. Cannabidiol derived from industrial hemp is legal at the federal level for non-prescription use, but legality and enforcement vary by state. A systematic review of the literature

shows that as cannabis legalization, availability, and potency increase so does the possibility of increasing unintentional pediatric cannabis intoxication and associated hospitalization.¹

As cannabis continues to be prevalent in the United States, addressing the rise in pediatric cannabis exposure effectively remains a critical public health challenge. Recent studies have revealed increases in pediatric cannabis exposure incidents, resulting in significant toxicity risks and a subsequent rise in hospitalizations among this population.² Among various forms of marijuana, edible products containing cannabis extracts pose a unique risk to youth due to their attractive appearance, often closely resembling candies, cookies, and drinks. This resemblance to regular food items and lack the typical smell and visible smoke associated with inhaled marijuana makes them inconspicuous and appealing to adolescents. Greater accessibility and palatability have contributed to their growing popularity among young individuals. Moreover, manufacturers often design the packaging of edible products to closely resemble mainstream foods, further increasing the likelihood of accidental ingestion.

The effects of edible marijuana products take longer to manifest compared to inhaled forms. The cannabis compounds must be digested before entering the bloodstream, resulting in a delayed onset of effects. This delay can lead to unintentional overconsumption, as users may consume more, believing the product to be ineffective. The psychoactive compound in cannabis, delta-9-tetrahydrocannabinol (THC), can cause adverse effects, such as impaired motor function, respiratory distress, and even seizures in young children who accidentally consume these products.³ In the first half of 2021, poison control centers have managed 2,158 cases related to cannabidiol. Some of these were related to additional drugs, or adulteration with a synthetic cannabinoid.⁴ Between 2017 and 2018, Utah reported 52 cases of poisoning from ingestion of CBD oil that produced symptoms that included hallucinations, nausea, vomiting, seizures, and loss of consciousness.⁵

The increasing prevalence of cannabis use in the United States has brought attention to potential adverse effects, especially in children and adolescents. In 2023, the Centers for Disease Control and Prevention (CDC) conducted a study examining trends in cannabis-involved emergency department (ED) visits among individuals aged 25 years and younger, comparing the period before and during the COVID-19 pandemic.⁶ The study analyzed data from the CDC's National Syndromic Surveillance Program covering the period from December 30, 2018, to January 1, 2023. The findings revealed a significant total of 539,106 cannabis-involved ED visits among individuals aged <25 years, highlighting an average rate of 64.9 visits per 10,000 ED visits. During the COVID-19 pandemic,⁶ the study observed a spike in weekly cannabis-involved ED visits, particularly among children aged ≤10 years. The numbers ranged from 30.4 to 71.5 in the years 2020, 2021, and 2022, compared to 18.7 to 23.2 during the pre-pandemic period. This notable increase in visits points to a trend of heightened cannabis-related incidents among younger children during the pandemic, potentially influenced by changes in home environments and easier accessibility to cannabis products.

The study also uncovered patterns among youths aged 11-14 years, where cannabis-involved ED visits showed an upward trend starting in 2020. The peak of these visits (209.3) occurred during the second half of the 2021-22 school year. Another significant finding from the study was the sharp increase in cannabis-related ED visits among children under the age of 11, with a striking 214% rise on average from 2019 to 2022. This rise was primarily associated with accidental poisoning due to the ingestion of cannabis-infused edibles.

Some have suggested that strengthening labeling policies could play a role in reducing unintended ingestion incidents. Several states already require specific labeling and packaging requirements. These regulations vary substantially by state but generally involve specific warnings about potential harmful effects of cannabis and may include nutritional information. All states require THC content and manufacturer information, but common practices in more than 80 percent of states include providing a list of ingredients, batch number, production tracking, health warnings, and other information.⁷ For instance, in Colorado, Washington, and Alaska, warning labels or accompanying material must indicate that cannabis has intoxicating effects (1 Colo. Code Regs. § 212-2, 2016; Wash. Admin. Code § 314-55-105, 2016; Alaska Admin. Code tit. 3, § 306.345, 2016).⁹ Additionally, Colorado and Oregon mandate the inclusion of the state-designated universal symbol for cannabis on edibles labels (1 Colo. Code Regs. § 212-2; Or. Admin. R. 333-007-0070, 2016) and require a statement that intoxicating effects may not be felt for up to two hours after consumption (1 Colo. Code Regs. § 212-2; Or. Admin. R. 333-007-0070). Furthermore, Washington and Oregon either currently or will soon require that extra informational material be provided to buyers of edibles with each sale or displayed on posters in dispensaries (Wash. Admin. Code § 314-55-105; Or. Admin. R. 333-008-1500, 2016). In Washington State, this accompanying material must include warning statements about health risks, the importance of

keeping edibles out of reach of children, potential impaired judgment, delayed activation of effects, as well as disclosures of pesticides and extraction methods (Wash. Admin. Code § 314-55-105). Some packaging requirements include mandatory child-resistance measures (Alaska, Arizona, Colorado, Connecticut, Guam, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, the Northern Mariana Islands, Oregon, and Washington). Alaska, Colorado, Hawaii, Maryland, Massachusetts, New Mexico, the Northern Mariana Islands, and Oregon, require that containers housing cannabis must be opaque. Some states also require products to be labeled as "medical use only" if they are intended for medical patients (California, Delaware, the District of Columbia, Hawaii, Illinois, Minnesota, New Jersey, and Rhode Island).⁸

Additional standards and specifications are on the horizon as well. In July 2023, the National Conference on Weights and Measures (NCWM) met to finalize basic labeling requirements for cannabis products. State and federal regulators will use these guidelines set by the NCWM and created in coordination with the American Trade Association of Cannabis and Hemp (ATACH) as model standards for definitions, packaging and labeling requirements, and storage best practices. Under the guidelines, cannabis products must indicate whether the product "Contains 0.3% or less Total Delta-9 THC" or "Contains more than 0.3% Total Delta-9 THC." Additionally, the back or side panel of cannabis packaging must feature "a declaration of the labeled cannabinoid per serving or application," with the stipulation that "the cannabinoid quantity declaration must be in milligrams." This policy will become effective January 1, 2024.⁷

In 2021, the Council adopted Amended Resolution 50(21) Complications of Marijuana Use directing ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED, provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis-related ED diagnoses, and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department. In response to the resolution, the Clinical Policies Committee is in the process of developing practice guidelines and the Public Health & Injury Prevention Committee has developed [patient information](#) on the risks and potential effects of marijuana use and physician information on the management of THC presentations in the ED.

ACEP members have published multiple articles and editorials:

- [The perils of recreational marijuana use: relationships with mental health among emergency department patients](#) (JACEP Open; March 8, 2020)
- [Indications and preference considerations for using medical Cannabis in an emergency department: A National Survey](#) (The American Journal of Emergency Medicine; July 10, 2020)
- [Letter to Editor: A National Survey of US Medicine Physicians on their Knowledge Regarding State and Federal Cannabis Laws](#) (Cannabis & Cannabinoid Research; December 2020)
- [The emergency department care of the cannabis and synthetic cannabinoid patient: a narrative review](#) (International Journal of Emergency Medicine; February 2021)

ACEP has developed education and resources available on demand regarding ED presentations related to marijuana:

- [Deadly Spice: A CME Now Case Study](#)
- [Legal and Legit? Vices of the Young:](#)
- [Still Dope: New on the Scene 2020:](#)
- [Marijuana Risks](#) – patient handout
- [THC Management](#) – physician handout

Background References

¹<https://pubmed.ncbi.nlm.nih.gov/28370228/>

²<https://www.nytimes.com/2023/01/04/health/children-eating-edibles-weed.html>

³<https://www.acep.org/siteassets/sites/acep/media/by-medical-focus/mental-health/marijuana-risk-handouts---patient-1.pdf>

⁴<https://aapcc.org/national-poisondata-system>

⁵HorthRZ, CrouchB, HorowitzBZ, et al. Notes from the field: acute poisonings from a synthetic cannabinoid sold as cannabidiol—Utah, 2017–2018. *MMWR Morb Mortal Wkly Rep*. 2018;67(20):587–588.

⁶https://www.cdc.gov/mmwr/volumes/72/wr/mm7228a1.htm?s_cid=mm7228a1_e&ACSTrackingID=USCDC_921-

[DM108851&ACSTrackingLabel=This%20Week%20in%20MMWR%3A%20Vol.%2072%2C%20July%2014%2C%202023&deliveryName=USCDC_921-DM108851#suggestedcitation](https://www.liebertpub.com/doi/10.1089/can.2020.0079)

⁷<https://www.liebertpub.com/doi/10.1089/can.2020.0079>

⁸<https://www.marijuanamoment.net/federal-standards-handbook-is-getting-new-sections-on-cannabis-packaging-labeling-and-storage/>

⁹[https://cannacon.org/cannabis-packaging-regulations-across-](https://cannacon.org/cannabis-packaging-regulations-across-states/#:~:text=The%20most%20universal%20cannabis%20regulations,Oregon%20and%20Washington%20require%20this)

[states/#:~:text=The%20most%20universal%20cannabis%20regulations,Oregon%20and%20Washington%20require%20this](https://cannacon.org/cannabis-packaging-regulations-across-states/#:~:text=The%20most%20universal%20cannabis%20regulations,Oregon%20and%20Washington%20require%20this)

¹⁰<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5260817/>

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

Cannabis labeling is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources for federal or state advocacy initiatives to support this effort.

Prior Council Action

The Council has discussed and adopted many resolutions about cannabis, although none have focused solely on pediatric cannabis exposure.

Amended Resolution 50 (21) Complications of Marijuana Use amended and adopted. Directed ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in emergency department presentations; provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses; and, develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department.

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted. Directed ACEP to support rescheduling of cannabis to facilitate well-controlled studies of cannabis and related cannabinoids for medical use.

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Directed ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board of Directors. Directed ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Prior Board Action

Amended Resolution 50 (21) Complications of Marijuana Use adopted.

June 2019, approved the policy statement: [Medical Cannabis](#)

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted.

June 2017, approved the Emergency Medicine Practice Committee's recommendations regarding Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED and take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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



RESOLUTION: 25(23)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, DO, FACEP

SUBJECT: Compassionate Access to Medical Cannabis Act – “Ryan’s Law”

PURPOSE: Support allowing patients access to medical cannabis; endorse and support passage of Ryan’s Law across the U.S.; and, endorse, support, and assist chapters in the passage of Ryan’s Law legislation in their states.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources for federal and state advocacy initiatives to support these efforts and potentially additional unbudgeted costs associated with assisting chapters.

1 WHEREAS, In 1996 California became the first state to legalize the use of medical cannabis when citizens
2 passed the Compassionate Use Act; and

3
4 WHEREAS, 38 states, the District of Columbia, and four U.S. territories allow medical cannabis use; and

5
6 WHEREAS, The fastest growing demography of people using medical cannabis is people 65 and older; and

7
8 WHEREAS Medical organizations that have issued statements in support of allowing access to medical
9 cannabis include the [American Nurses Association](#), [American Public Health Association](#), [American Medical Student](#)
10 [Association](#), [National Multiple Sclerosis Society](#), [Epilepsy Foundation](#), and [Leukemia & Lymphoma Society](#); and

11
12 WHEREAS, On January 12, 2017 the National Academies of Science, Engineering & Medicine released a
13 report entitled “Health Effects of Cannabis and Cannabinoids: Current State of Evidence and Recommendations for
14 Research”, which concluded there was conclusive or substantial scientific evidence that medical cannabis was an
15 effective treatment for chronic pain in adults, anti-emetics in chemotherapy-induced nausea and spasticity symptoms
16 in MS and moderate scientific evidence that medical cannabis was an effective treatment for obstructive sleep apnea
17 and

18
19 WHEREAS, Many terminally ill patients are admitted to acute care hospitals with chronic pain and nausea
20 due to chemotherapy; and

21
22 WHEREAS, According to a survey from Morse Life Health System Hospice and Palliative Care 87% of
23 Americans support medical cannabis as an option for treatment in cases where the patient has received a terminal
24 diagnosis; and

25
26 WHEREAS, Hospitals in Israel, Germany, Canada, and other countries have developed policy and procedures
27 for inpatient use of medicinal cannabis; and

28
29 WHEREAS, The AMA Code of Ethics, Opinion 10.01 - Fundamental Elements of the Patient- Physician
30 Relationship that states “The patient has the right to receive information from physicians and to discuss the benefits,
31 risks, and costs of appropriate treatment alternatives.” should apply to inpatients; and

32
33 WHEREAS, Ryan’s Law allows terminal ill patients to use medical cannabis in hospitals; and

34
35 WHEREAS, Ryan’s Law specifically prohibit the smoking or vaping of medical cannabis for hospitalized
36 terminally ill patients; and

37 WHEREAS, Ryan’s Law allows any hospital investigated by the federal government for using a scheduled 1
38 drug to immediately prohibit the use of medical cannabis in the hospital; and

39
40 WHEREAS, Ryan’s Law was signed into law in California by Governor Newsom on September 28, 2021,
41 becoming effective January 1, 2022 (Ryan’s Law applies to all CA health care facilities including acute care hospitals,
42 special hospitals, skilled nursing facilities, congregate living health facilities, or hospice providers, excluding
43 chemical dependency recovery hospitals, and state hospitals); and

44
45 WHEREAS, Marin Health Medical Center became one of the first hospitals in California to implement
46 Ryan’s law; and

47
48 WHEREAS, The Ryan’s Law team is advocating for a version of Ryan’s Law in 14 other states and the
49 United States Congress and if approved these laws will also require health care facilities and hospitals to allow
50 terminally ill patients use of some types of medical cannabis; therefore be it

51
52 RESOLVED, That ACEP support allowing patients access to medical cannabis; and be it further

53
54 RESOLVED, That ACEP endorse and support the passage of Ryan’s Law across the entire United States; and
55 be it further

56
57 RESOLVED, That ACEP endorse, support, and assist ACEP chapters in the passage of Ryan’s Law
58 legislation in their states.

Background

The resolution calls for ACEP to support allowing patients access to medical cannabis; endorse and support the passage of Ryan’s Law across the U.S.; and, endorse, support, and assist ACEP chapters in the passage of Ryan’s Law legislation in their states. A similar resolution was submitted to the Council last year with the same three resolveds.

The Compassionate Access to Medical Cannabis Act, or “Ryan’s Law,” is a [California law](#) requiring health care facilities to allow the use of medical cannabis on their premises for terminally ill patients with a valid medical cannabis card or recommendation from their physician. The law requires health care facilities to not interfere with or prohibit eligible patients from consuming medical cannabis on-site (smoked or vaped cannabis products are excluded); list medical cannabis use in a patient’s record; obtain a copy of the patient’s valid medical cannabis license or physician recommendation before allowing any consumption; write and distribute guidelines detailing the new protocols; and, ensure that the patient’s cannabis is stored and secured in a locked container when not being consumed.

However, recognizing the current legal disparities between state laws and federal law, a provision was added to the law to ensure that hospitals and facilities are not forced to choose between complying with state law and not federal law (or vice versa), thus ensuring they do not face the threat of potentially losing access to federal funds for operating in accordance with state law. Hospitals may comply with federal demands in the case of a federal agency ordering a facility to stop allowing a patient to consume medical cannabis.

The legalization of both recreational and medicinal use of cannabis continues to be highly controversial, enhanced by conflicting studies demonstrating various effects experienced in states where marijuana use has been legalized. [According to the National Conference of State Legislatures](#), as of April 24, 2023, medical use of cannabis is legalized in 38 states, three territories, and the District of Columbia. Twelve other states have laws that limit THC content for the purpose of allowing access to products that are rich in cannabidiol (CBD). As of June 1, 2023, recreational use of cannabis is legal in [23 states](#), the District of Columbia, the Northern Mariana Islands, and Guam; 27 states and D.C. have decriminalized small amounts of marijuana.

Despite legalization in several states, marijuana remains a Schedule I drug under the federal Controlled Substances Act, along with drugs like cocaine, LSD, heroin, MDMA (ecstasy), and psilocybin, among others. Schedule I drugs

are those with a high potential for abuse, no current accepted medical treatment use within the U.S., and a lack of accepted safety for use under medical supervision. Although the use of cannabis remains illegal federally, some of its derivative compounds have been approved by the Food and Drug Administration (FDA) for prescription use. Cannabidiol derived from industrial hemp is legal at the federal level for non-prescription use, but legality and enforcement vary by state.

In October 2022, President Joe Biden [announced](#) three initiatives his Administration was taking to address federal marijuana policy: 1) pardoning all prior federal offenses of simple marijuana possession; urging all state governors to do the same with regard to state offenses; and, 3) directing the Secretary of Health and Human Services and the Attorney General to initiate the administrative review process to review expeditiously how marijuana is scheduled under federal law. The Administration aims to finish that review before the end of 2023.

The 2021 Council adopted Amended Resolution 50(21) Complications of Marijuana Use directing ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED, provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis-related ED diagnoses, and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department. In response to the resolution, the Clinical Policies Committee began reviewing information on the conditions where there is evidence for an association between marijuana use and ED presentations: hyperemesis, psychosis, trauma, and, possibly, dysrhythmias. An initial literature search was performed to gain understanding of the scope of existing literature on the topic and found there was limited published data. The committee was also informed that the Society for Academic Emergency Medicine’s “Guidelines for Reasonable and Appropriate Care” (GRACE) program is currently working on a practice guideline for cannabis-induced hyperemesis. ACEP’s Clinical Policies Committee shifted its focus to developing a systematic review of the evidence for an association between marijuana use and specific ED presentations. The committee continues to work on developing a scientific article accompanied by a best practice document.

ACEP’s policy statement “[Medical Cannabis](#)” states:

The American College of Emergency Physicians (ACEP) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including cannabis and cannabis derivative products, for medical use. Currently, in many states, cannabis and related cannabinoids are being recommended for patient use by physicians when little evidence has been provided regarding appropriate indications, efficacy, dosages, and precautions of these drugs. ACEP supports the rescheduling of cannabis and encourages the Food & Drug Administration (FDA), Drug Enforcement Administration (DEA), and other appropriate organizations to facilitate scientifically valid, well-controlled studies of the use of cannabis and cannabis derivative products for treatment of disease and of its impact on societal health.

ACEP members have published multiple articles and editorials:

- [The perils of recreational marijuana use: relationships with mental health among emergency department patients](#) (JACEP Open; March 8, 2020)
- [Indications and preference considerations for using medical Cannabis in an emergency department: A National Survey](#) (The American Journal of Emergency Medicine; July 10, 2020)
- [Letter to Editor: A National Survey of US Medicine Physicians on their Knowledge Regarding State and Federal Cannabis Laws](#) (Cannabis & Cannabinoid Research; December 2020)
- [The emergency department care of the cannabis and synthetic cannabinoid patient: a narrative review](#) (International Journal of Emergency Medicine; February 2021)

ACEP has developed education and resources available on demand regarding ED presentations related to marijuana:

- [Deadly Spice: A CME Now Case Study](#)
- [Legal and Legit? Vices of the Young:](#)
- [Still Dope: New on the Scene 2020:](#)
- [Marijuana Risks](#) – patient handout

- [THC Management](#) – physician handout

Based on direction in Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis and recommendation from the Federal Government Affairs Committee, ACEP Supported H.R. 3797, the “Medical Marijuana Research Act of 2019.” This legislation is consistent with ACEP policy, amending the Controlled Substances Act to establish a less burdensome registration process specifically for marijuana research, and providing approved researchers with the ability to acquire cannabis needed for their studies. This legislation is also intended to ensure a supply of marijuana for research purposes through the National Institute on Drug Abuse Drug Supply Program, directed the FDA to issue guidelines on the production of marijuana, and encouraged authorized researchers and manufacturers to produce marijuana. In the 117th Congress, ACEP advocated for the “Medical Marijuana and Cannabidiol Research Expansion Act,” an updated version of the legislation that was successfully passed by both chambers of Congress and signed into law on December 2, 2022. The law removes the aforementioned barriers for research, ensures an adequate supply of research-grade marijuana, and promotes the development of FDA-approved drugs derived from CBD and marijuana.

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources for federal and state advocacy initiatives to support these efforts and potentially additional unbudgeted costs associated with assisting chapters.

Prior Council Action

Resolution 30(22) Compassionate Access to Medical Cannabis Act – “Ryan’s Law” not adopted. The resolution requested that ACEP support allowing patients access to medical cannabis; endorse and support passage of Ryan’s Law across the U.S.; and, endorse, support, and assist chapters in the passage of Ryan’s Law legislation in their states.

Amended Resolution 50(21) Complications of Marijuana Use adopted. Directed ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED; provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses; and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department.

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted. Directed ACEP to support rescheduling of cannabis to facilitate well-controlled studies of cannabis and related cannabinoids for medical use.

Resolution 37(18) ACEP Policy Related to “Recreational” Cannabis not adopted. Called for ACEP to align ACEP policy on recreational use of cannabis with current AMA policy on the issue.

Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency not adopted. Called for ACEP to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Directed ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana,

cannabis, synthetic cannabinoids and similar substances.

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board of Directors. Directed ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. The resolution directed ACEP to adopt and support a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 15(15) CARERS Act of 2015 not adopted. Directed ACEP to endorse S. 683 and require the AMA Section Council on Emergency Medicine to submit a resolution directing the AMA to endorse this legislation.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25(11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16(10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

Prior Board Action

Amended Resolution 50(21) Complications of Marijuana Use adopted.

June 2019, approved the policy statement “[Medical Cannabis.](#)”

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted.

June 2017, approved the Emergency Medicine Practice Committee’s recommendations regarding Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED and take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 26(23)
SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, DO, FACEP
SUBJECT: Decriminalization of All Illicit Drugs

PURPOSE: Endorse and support decriminalization of personal possession and use of small amounts of all illicit drugs in the U.S. and endorse and support chapters to develop and introduce state legislation decriminalizing personal possession and use of small amounts of all illicit drugs.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources for federal and state advocacy initiatives to support these efforts and additional unbudgeted costs of approximately \$10,000 for legislative drafting or consulting for development of model legislation.

1 WHEREAS, In 2001 Portugal became the first country to decriminalize the personal possession and use of
2 small amounts of all illicit drugs; and
3

4 WHEREAS, Since it decriminalized all illicit drugs, Portugal has seen a dramatic drops in drops in
5 problematic drug use, HIV and hepatitis infection rates, overdose deaths, drug-related crime, and incarceration rates;
6 and
7

8 WHEREAS, The following countries have decriminalized drug use: Antigua + Barbuda, Argentina, Armenia,
9 Australian States: South Australia, Australian Capital Territory, Northern Australia, Belize, Bolivia, Chile, Colombia,
10 Costa Rica, Croatia, Czech Republic, Estonia, Germany, Italy, Jamaica, Mexico, Netherlands, Paraguay, Peru, Poland,
11 Portugal, Russian Federation, South Africa, Spain, Switzerland, Uruguay, U.S. Virgin Islands; and
12

13 WHEREAS, On Election Day 2020, Oregonians overwhelmingly passed Measure 110 that made the
14 possession of small amounts of cocaine, heroin, LSD, and methamphetamine, among other drugs, punishable by a
15 civil citation – akin to a parking ticket – and a \$100 fine; and
16

17 WHEREAS, Alaska, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland,
18 Massachusetts, Nevada, New Hampshire, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington
19 DC have decriminalized to some degree the personal possession and use of illicit drugs; therefore be it
20

21 RESOLVED, That ACEP endorse and support the decriminalization of the personal possession and use of
22 small amounts of all illicit drugs in the United States; and be it further
23

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

Background

The resolution directs the College to endorse and support the decriminalization of the personal possession and use of small amounts of all illicit drugs in the United States and also directs the College to endorse and support ACEP chapters to develop and introduce state legislation that decriminalizes the personal possession and use of small amounts of all illicit drugs. A similar resolution was submitted to the Council last year that was not adopted, however, that resolution included language in both resolveds to instead make personal possession and use of small amounts of

all illicit drugs in the U.S. a civil penalty with referral to treatment.

Decriminalization of drugs typically refers to the elimination of criminal penalties for the possession and use of illicit drugs, possession and use of paraphernalia and related equipment used to introduce drugs into the body, and low-level drug sales (i.e., not large-scale trafficking). To date, twenty-six states in the U.S. and the District of Columbia (D.C.) have decriminalized the possession of small amounts of marijuana, and in November 2020, Oregon became the first state in the country to decriminalize possession of all drugs and increase access to support services. Since the passage of this ballot measure (the “Drug Addiction Treatment and Recovery Act,” Measure 110), similar efforts have been either introduced or initiatives have been launched in several states and the U.S. Congress. Such efforts include bills aimed specifically at decriminalization of marijuana and others, like the “Drug Policy Reform Act” (H.R. 4020 in the 117th Congress), that would decriminalize drug possession at the federal level, promote evidence-based treatment- and recovery-focused health approaches, and expunge criminal records and provide resentencing opportunities.

Worldwide, Portugal is considered the primary case study for decriminalization, having decriminalized the personal use and possession of all illicit drugs in 2001. Portugal’s law did not make illicit drugs legal, nor did it decriminalize drug trafficking. Instead of incarceration or criminal penalties, law enforcement officers encountering individuals in possession of drugs may confiscate the drug and refers the individual to substance use disorder (SUD) services, managed under regional networks of “dissuasion commissions” operated through the Portugal Ministry of Health. These commissions consist of health, social, and legal services workers who connect individuals directly with SUD treatment, harm reduction services, and therapy, depending on an individual’s needs or desires. While there are no longer any criminal penalties, individuals may be served with fines or required to provide community service or attend required therapy interventions.

The success or failure of Portugal’s decriminalization example is still a matter of debate more than two decades later, with disagreement among proponents and opponents on what lessons can be learned from the country’s experience given the available data. Some, like the [U.S. Office of National Drug Control Policy](#), suggest that “[i]t is difficult, however, to draw any clear, reliable conclusions...regarding the impact of Portugal’s drug policy changes.” A more recent review of the available scientific literature published in the [Current Opinion in Psychiatry](#) journal (July 2018) concluded that:

“[s]cientific evidence supporting drug addiction as a health disorder and the endorsement by the [United Nations] strengthen the case for decriminalization. However, studies reporting the positive outcomes of decriminalization remain scarce. The evidence needs to be more widespread in order to support the case for decriminalization.”

According to the [Drug Policy Alliance](#), while Portugal’s rate of drug use has stayed about the same, arrests, incarceration, disease, overdoses, and other associated harms with drug use and SUD are all down. Additionally, Portugal’s drug use rates are below the average in Europe and far lower than drug use rates in the U.S. Within the first decade after the law was enacted, three-quarters of individuals with opioid use disorder (OUD) were in medication-assisted treatment (MAT) programs, the number of people in drug treatment programs increased by more than 60 percent, overdose fatalities dropped significantly, incarceration rates and prison overcrowding were dramatically reduced, and bloodborne disease diagnoses like HIV also fell.

However, there were also [negative effects](#) in the years following decriminalization. One study found that after the law was enacted, drug experimentation increased even though it did not lead to regular drug use. Murders increased by 41 percent in the first five years following passage, but began to fall again after, and large-scale drug trafficking increased. Further complicating efforts to analyze the full effects of the law is the fact that even prior to enactment, drug consumption and possession convictions typically resulted in fines, not incarceration, and the country already had low rates of incarceration for drug use.

Most recently, an [article](#) published in the *Washington Post* on July 7, 2023, suggests that the country’s initial progress may have stalled, and that decriminalization model may need to be reexamined in the wake of rising crime rates, significant increases in visible drug use in urban areas, long delays in access to state-funded rehabilitation treatment, lack of law enforcement engagement in registration of individuals with SUD, among others. The article further notes that, “[o]verdose rates have hit 12-year highs and almost doubled in Lisbon from 2019 to 2023.” Some of these

challenges also appear to have been exacerbated by the effects of the COVID-19 pandemic. Overall, these issues have led even some pro-decriminalization advocates to push for some targeted reforms to address some of the more pressing public impacts, such as limited recriminalization in urban areas, or near schools and hospitals, though other decriminalization advocates oppose such changes. The piece also quotes João Goulão, Portugal’s current national drug coordinator and the architect of the country’s decriminalization and drug policy, who ...”admitted to the local press in December that ‘what we have today no longer serves as an example to anyone.’ Rather than fault the policy, however, he blames a lack of funding.”

Proponents of drug decriminalization focus on the relatively recent shift in understanding substance use disorder as a health issue, rather than a criminal justice issue or as a personal failing. Supporters also note that drug arrests are the most commonly arrested offense in the U.S. with [one drug arrest every 23 seconds](#), and that there are significant long-term consequences that may limit an individual’s ability to secure public benefits, employment, housing, child welfare services, immigration, and others, if they have a criminal drug offense on their record. Supporters argue that removing criminal penalties would reduce incarceration and the associated public costs, allow law enforcement to reprioritize resources for other purposes, promote health care, treatment, and safety efforts rather than criminal punishment, reduce stigma for both drug use and treatment, and would reduce or eliminate barriers to evidence-based harm reduction strategies. Additionally, with more accessible community services, such as safe use/injection facilities, needle exchange programs/services, and more, proponents suggest there will be a significant public health impact in reduced bloodborne pathogen and disease transmission, lower rates of overdose and overdose deaths, and higher rates of successful long-term recovery given access to treatment and recovery programs.

Opponents of decriminalization note that there remains limited data on the effects of decriminalization, including a lack of reporting of adverse trends such as increases in drug-related deaths and overall safety of the drug supply. With respect to the safety of the drug supply, many communities throughout the U.S. have witnessed increases in fentanyl contamination in heroin, opioids, benzodiazepines, cocaine, and other stimulants (along with other effects of the COVID-19 pandemic, the volatility of the illicit drug supply is presumed to be a likely contributing factor in the estimated [107,622 overdose deaths](#) recorded in 2021, a 15 percent increase compared to 2020). Additionally, some (particularly law enforcement) are concerned about the potential for increased rates of violent crime and drug trafficking, especially given the substantial influx of illicit fentanyl and other synthetic opioids in the U.S. drug supply. Some have recently pointed to Portugal’s recent experience, suggesting that decriminalization may lead to “normalization,” and that the initial benefits of decriminalization may reverse course as time goes on.

Others note concerns about the current lack of health care, SUD/OD treatment, and social service infrastructure needed to support decriminalization laws – a challenge noted in Oregon even by supporters of the state’s decriminalization effort. These concerns appear to have manifested [in practice](#), with civil fines or penalties ineffective, low engagement with available community support resources and limited voluntary treatment, a lack of grant funding, with Portland experiencing a [46 percent increase in overdoses this year](#). Other persistent challenges remain as well, including continued stigma and bias among health care providers who may have received little or no training on providing SUD/OD treatment.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources for federal and state advocacy initiatives to support these efforts and additional unbudgeted costs of approximately \$10,000 for legislative drafting or consulting for development of model legislation.

Prior Council Action

Resolution 31(22) Decriminalization of All Illicit Drugs not adopted. The resolution called for ACEP to endorse and support decriminalization of personal possession and use of small amounts of all illicit drugs in the U.S. and endorse and support chapters to develop and introduce state legislation decriminalizing personal possession and use of small amounts of all illicit drugs

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted. Directed ACEP to support rescheduling of cannabis to facilitate well-controlled studies of cannabis and related cannabinoids for medical use.

Resolution 37(18) ACEP Policy Related to “Recreational” Cannabis not adopted. Called for ACEP to align ACEP policy on recreational use of cannabis with current AMA policy on the issue.

Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency not adopted. Called for ACEP to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. The resolution directed ACEP to adopt and support a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25(11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16(10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

Prior Board Action

June 2019, approved the policy statement “[Medical Cannabis.](#)”

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted.

June 2017, approved the Emergency Medicine Practice Committee’s recommendation to take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: Ryan McBride, MPP
ACEP Congressional Affairs Director

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



2023 Council Meeting Reference Committee Members

Reference Committee B – Advocacy & Public Policy Resolutions 27-42

Diana Nordlund, DO, JD, FACEP (MI) – Chair
Lisa M. Bundy, MD, FACEP (MS)
Puneet Gupta, MD, FACEP (CA)
Joshua S. da Silva, MD (GS)
Torree M. McGowan, MD, FACEP (GS)
Michael Ruzek, DO, FACEP (NJ)

Erin Grossman
Ryan McBride, MPP



RESOLUTION: 27(23)

SUBMITTED BY: Rural Emergency Medicine Section
Social Emergency Medicine Section
Arizona Chapter
California Chapter
Colorado Chapter
New Mexico Chapter
Oklahoma Chapter
Vermont Chapter
Washington Chapter

SUBJECT: Addressing Interhospital Transfer Challenges for Rural EDs

PURPOSE: 1) Work with state and federal agencies to create state and regional transfer coordination centers; 2) advocate for state and federal requirements for tertiary centers to have a regional process for the rapid acceptance of patients from rural hospitals; 3) advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities; 4) support research to strengthen evidence-based rural hospital transfer processes; and 5) create a task force to examine current models and existing research yielding detailed recommendations for ACEP advocacy efforts.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources for federal and state advocacy initiatives to support these efforts. Additionally, it would require unbudgeted costs of \$50,000 – \$100,000 to collect and analyze data and conduct a comprehensive study, unbudgeted staff resources for supporting a task force, and unbudgeted funds of a minimum of \$10,000 for convening an in-person task force meeting.

1 WHEREAS, Rural hospitals bear a great burden of transferring complex or critically ill patients, with up to
2 15% of Emergency Department (ED) visits to rural hospitals resulting in transfer; and

3 WHEREAS, Crowding and boarding at tertiary and academic EDs is an impediment to transfer of patients to
4 these hospitals which provide critical treatments and interventions for patients with time-sensitive conditions; and
5

6 WHEREAS, The current process of finding an accepting hospital for these patients is uncoordinated,
7 inefficient, and time-consuming, taking physicians away from their roles caring for other emergent patients; and
8

9 WHEREAS, Delays or failure to transfer rural patients can harm patients with time-sensitive conditions
10 because delay in access to life-saving interventions, which would otherwise reduce rural patient morbidity and
11 mortality, can violate the principle of justice; and
12

13 WHEREAS, There is no systematic data collected on transfers, which are critical to inform national and
14 regional policy on transfers and bed capacity, particularly during surges; and
15

16 WHEREAS, Several models exist to address this problem, which can be scaled regionally and nationally, in
17 particular, the [Arizona REACH](#), [Washington Medical Coordination Center](#), and the Office of the Administration for
18 Preparedness and Response (ASPR) [Medical Operations Coordination Centers](#); therefore be it
19

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

23 RESOLVED, That ACEP advocate for state and federal requirements that tertiary centers have a regional
24 process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not
25 available at the referring hospital, even when capacity is limited at the tertiary center; and be it further
26

27 RESOLVED, That ACEP advocate for regional dashboards with updated information on hospital specialty
28 service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis,
29 STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined
30 as patient catchment areas rather than jurisdictional boundaries; and be it further
31

32 RESOLVED, That ACEP support research to strengthen the evidence base regarding rural hospital transfer
33 processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes
34 and experience and include investigation of common challenges experienced by all small, non-networked hospitals;
35 and be it further
36

37 RESOLVED, That ACEP create a task force to examine current models and existing research yielding
38 detailed recommendations for ACEP advocacy efforts regarding interhospital transfer challenges for rural EDs and the
39 task force should:
40

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

Background

This resolution directs ACEP to work with state and federal agencies to create state and regional transfer coordination centers; advocate for state and federal requirements for tertiary centers to have a regional process for the rapid acceptance of patients from rural hospitals; advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities; support research to strengthen evidence-based rural hospital transfer processes; and create a task force to examine current models and existing research yielding detailed recommendations for ACEP advocacy efforts.

ACEP has had several rural health task forces over the past 20 years; however none specifically address rural hospital transfer processes to identify best practices. Furthermore, ACEP does not have comprehensive evidence-based data about rural EDs and has not conducted research as requested in the resolution. Since no such research has been previously conducted, and ACEP lacks access to this data, a third-party academic researcher would be required to collect this information on current and theoretical transfer models.

ACEP has advocated at the state and federal level for better coordination when transferring patients between facilities, however, the three models referenced in the resolution exist to address transfers (Arizona REACH, Washington Medical Coordination Center, and the ASPR Medical Operations Coordination Center).

ACEP's policy statement "[Appropriate Interfacility Patient Transfer](#)" addresses regional transfer policies:

“When transfer of patients is part of a regional plan to provide optimal care at a specialized medical facility, written transfer protocols and interfacility agreements should be in place.”

The policy statement does not examine existing and theoretical transfer models and does not identify best practices, including coordination of transfers across state lines.

ACEP's current legislative and regulatory priorities for the First Session of the 118th Congress include several rural emergency care initiatives although none that are specific to interhospital transfer challenges for rural EDs.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources for federal and state advocacy initiatives to support these efforts. Additionally it would require unbudgeted costs of \$50,000 – \$100,000 to collect and analyze data and conduct a comprehensive study, unbudgeted staff resources for supporting a task force, and unbudgeted funds of a minimum of \$10,000 for convening an in-person task force meeting.

Prior Council Action

Amended Resolution 65(21) Rural Provider Support and a Call for Data adopted. Directed ACEP to: 1) recognize that patients presenting to rural emergency departments are a vulnerable ED patient population in the U.S. and deserve increased support; 2) support the Rural Section in collecting survey data from rural emergency departments to investigate volumes, clinician staffing patterns, and common barriers of care and staffing based on defined volumes; 3) recognize that ABEM/AOBEM-certified or eligible physicians are underrepresented in rural emergency departments and that very low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; 4) encourage rural emergency departments to retain ABEM/AOBEM-certified physicians to serve as emergency department medical directors so there will be physician-led teams in all U.S. EDs; and 5) support and endorse rural-specific tools including telemedicine initiatives, the development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools.

Substitute Resolution 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; and 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.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Prior Board Action

February 2023, approved the legislative and regulatory priorities for the First Session of the 118th Congress that

include several initiatives related to rural emergency care.

June 2022, approved the revised policy statement "[Rural Emergency Medical Care](#)" with the current title; originally approved June 2017 titled "Definition of Rural Emergency Medicine."

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 65(21) Rural Provider Support and a Call for Data 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.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

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 on legislation that impacts rural communities; and to seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Committee.

August 2017, reviewed the information paper "[Delivery of Emergency Care in Rural Settings](#)."

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2014, discussed the proposal from the Rural Emergency Medicine Section to support the Rural Emergency Medicine Education (REME) Program and appointed a Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks

September 2003, approved the recommendations by the Rural Emergency Summit

February 2003, approved the development of a Rural Emergency Summit

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Background Information Prepared by: Adam Krushinskie
Director, State Government Relations

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



RESOLUTION: 28(23)

SUBMITTED BY: Andrew Fenton, MD, FACEP
Roneet Lev, MD, FACEP
Aimee Moulin, MD, FACEP
California Chapter

SUBJECT: Facilitating EMTALA Interhospital Transfers

PURPOSE: 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.

FISCAL IMPACT: No additional staff resources are required as the proposed action fits within currently budgeted and ongoing federal and state advocacy initiatives.

1 WHEREAS, ACEP recently wrote a letter to the White House ringing the alarm that emergency departments
2 (EDs) are in crisis: *“Our nation’s safety net is on the verge of breaking beyond repair; EDs are gridlocked and
3 overwhelmed with patients waiting – waiting to be seen; waiting for admission to an inpatient bed in the hospital;
4 waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities; or, waiting simply to return to
5 their nursing home,”*; and

6
7 WHEREAS, Contributing to the crisis is limited capacity at tertiary care centers and the lack of access to
8 specialist care leading to patients requiring transfer being boarded for hours or days in EDs who are unable to provide
9 definitive care; and

10
11 WHEREAS, EMTALA regulations require: *“A Medicare participating hospital that has specialized
12 capabilities or facilities...may not refuse to accept from a referring hospital within the boundaries of the United
13 States an appropriate transfer of an individual who requires such specialize capabilities or facilities if the receiving
14 hospital has the capacity to treat the individual.”* (42 CFR 489.24 (f)),”; and

15
16 WHEREAS, ACEP’s policy statement [“Appropriate Interfacility Patient Transfer”](#) states: *“When a patient
17 requires a higher level of care other than that provided or available at the transferring facility, a receiving facility
18 with the capability and capacity to provide a higher level of care may not refuse any request for transfer.”*; and

19
20 WHEREAS, ACEP’s policy statement [“EMTALA and On-Call Responsibility for Emergency Department
21 Patients”](#) states: *“All hospitals with specialized capabilities have a responsibility to accept transfer of patients when
22 such transfer is necessary to stabilize an emergency medical condition. Hospitals should have a means to
23 ensure medical staff responsibility for transfer acceptance and provision of specialized care.”*; and

24
25 WHEREAS, Because of financial and logistical issues, it is not uncommon that it is difficult to determine the
26 contact information and number for hospitals that may be able to provide higher level of care; and

27
28 WHEREAS, The California Chapter of ACEP wrote a letter to the state Department of Health Care Services
29 requesting the Department create and maintain a central list of transfer coordinator numbers for each Medicare
30 participating hospital bound by EMTALA; therefore be it

31
32 RESOLVED, That ACEP work with the American Hospital Association and appropriate agencies to compel

33 hospitals to make available to other hospitals transfer coordinator information, including contact numbers for
34 accepting transfers, for each Medicare participating hospital bound by EMTALA; and be it further

35

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

Background

The resolution calls for the College 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. It also directs the College to 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.

The resolution highlights the difficulties of determining appropriate contact information for hospitals that may be able to provide a higher, more specialized level of care based on financial and/or logistical issues. This is a particularly acute problem given the ongoing emergency department (ED) boarding crisis affecting EDs throughout the country, as well as one exacerbated throughout the COVID-19 pandemic response. The resolution cites a January 2023 letter sent by California ACEP to the California Department of Public Health, which notes:

“...our members report difficulty determining who to contact at a given hospital to coordinate transfers. This opacity creates delays in care for the patient in need of transfer and sucks countless hours of emergency physician time into endless phone mazes diverting precious time from patients in the emergency department and stacked up waiting rooms.”

The letter goes on to offer a suggested solution, proposing that the California Department of Public Health create and maintain a central list of transfer coordinator numbers for each Medicare participating hospital bound by EMTALA, ideally updated on a semi-annual basis.

Delays and inefficiencies in the transfer process may negatively affect patient outcomes and contribute to growing frustration and burnout for physicians and health care providers. A Becker’s Hospital Review [white paper](#) (sponsored by Conduit Health Partners, an outsource organization whose services include patient transfer coordination) notes that, “[p]hysician frustration during the referral process can contribute to a poor patient experience, slower time to transfer, or patients leaving the organization...” Some hospitals employ dedicated call centers or patient transfer coordination partners to facilitate transfers and coordinate communications between physicians. Overall, there is limited information on interhospital transfers broadly and varying levels of effectiveness of dedicated call centers or related services.

Over the course of the past year, ACEP’s 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. Improving coordination between hospitals and health systems is a key component of this effort. One of the policy suggestions ACEP has proposed as an operational modification is a new Centers for Medicare & Medicaid Services (CMS) condition of participation (COP) that would require hospitals to develop contingency plans when inpatient occupancy exceeds 85 percent (or similar threshold as appropriate), 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. As part of this continued initiative, ACEP is hosting an ED Boarding Summit on September 27, 2023, and stakeholder invitees include the American Hospital Association, America’s Essential Hospitals, federal health care entities, and many others,

Additionally, similar efforts have been central to ACEP federal advocacy in response to the COVID-19 pandemic and related work to prepare for future pandemics, natural disasters, manmade disasters, and other mass casualty events

(such as the reauthorization of the Pandemic and All Hazards Preparedness Act, or PAHPA). ACEP has partnered with the American College of Surgeons Committee on Trauma (ACS-COT) in the development of a blueprint for a coordinated National Trauma and Emergency Preparedness System (NTEPS) that can provide 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 would be operationalized on a framework of 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. While this effort is designed around bolstering emergency/trauma response systems, the fundamental structures and improved coordination would also serve to strengthen everyday “normal” coordination and communication between hospitals and health systems in a given region.

ACEP has developed [Emergency Department Boarding and Crowding](#) resources on the website, including [policy solutions to ED boarding](#), that include links to relevant information papers, policy statements, resources regarding state approaches, and other resources. ACEP’s current legislative and regulatory priorities include:

- Develop and promote legislative efforts to address ED boarding and crowding crisis.
- Continue to advocate to CMS and other agencies for measures, reimbursement changes, and other regulatory strategies to help address the boarding and crowding crisis.
- Seek expansion of outpatient and inpatient psychiatric bed availability and services to reduce psychiatric boarding in the ED, improve coordination of care between EDs and mental health services within communities, and promote establishment of new and innovative models of care for acute psychiatric emergencies.
- Support innovative initiatives and models to reduce psychiatric boarding in the ED

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

No additional staff resources are required as the proposed action fits within currently budgeted and ongoing federal and state advocacy initiatives.

Prior Council Action

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.

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.

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.

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 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

June 2016, reviewed the updated information paper “[Emergency Department Crowding High-Impact Solutions](#)”

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper “Crowding and Surge Capacity Resources for EDs.”

October 2006, reviewed the information paper “Approaching Full Capacity in the Emergency Department.”

Substitute Resolution 18(04) Caring for Emergency Department ‘Boarders’ adopted

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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



RESOLUTION: 29(23)

SUBMITTED BY: Pennsylvania College of Emergency Physicians
Pediatric Emergency Medicine Section

SUBJECT: Addressing Pediatric Mental Health Boarding in Emergency Departments

PURPOSE: Advocate for federal support to decrease ED boarding of pediatric mental health patients, and 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.

FISCAL IMPACT: Budgeted resources for federal advocacy initiatives.

1 WHEREAS, Pediatric mental health boarding refers to the practice of keeping children and adolescents with
2 mental health conditions in emergency departments for extended periods due to the lack of appropriate mental health
3 care resources; and
4

5 WHEREAS, Pediatric mental health boarding is a systemic issue arising from the limited availability of
6 community-based mental health services, insufficient pediatric psychiatric beds, and inadequate coordination between
7 emergency departments, mental health providers, and other relevant stakeholders; and
8

9 WHEREAS, Pediatric mental health boarding can have detrimental effects on the well-being and
10 development of children, leading to increased anxiety, worsening of mental health symptoms, disruption of academic
11 progress, and potential escalation of crisis situations; and
12

13 WHEREAS, Emergency departments are ill-equipped to provide comprehensive mental health care, as they
14 primarily focus on acute medical conditions and lack the necessary staff, training, and resources to address the
15 specialized needs of pediatric mental health patients; and
16

17 WHEREAS, Current national legislative efforts, such as the “Improving Mental Health Access from the
18 Emergency Department Act” (S. 1346), offer workable solutions for emergency departments, these efforts do not
19 allocate specific resources/funds for pediatric patients; and
20

21 WHEREAS, The State of Massachusetts has successfully implemented a tiered payment structure for
22 pediatric mental health beds and other states (Delaware, Pennsylvania) are currently advocating for similar payment
23 structures to support current open pediatric mental health beds and encourage facilities to maintain these beds;
24 therefore, be it
25

26 RESOLVED, That ACEP advocate for federal support to decrease ED boarding of pediatric mental health
27 patients; and be it further
28

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

Background

This resolution calls for the College to advocate for federal support to decrease ED boarding of pediatric mental health patients, and 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.

Pediatric mental health boarding is an issue that arises when children and adolescents experiencing mental health crises are held in emergency departments (EDs) while awaiting appropriate psychiatric care or placement in a mental health facility. Psychiatric boarding has become a significant challenge in many emergency departments and health care systems, with detrimental effects on the overall mental health and well-being of young patients.

During the last decade, pediatric ED visits for mental health conditions have risen dramatically.¹ The COVID-19 pandemic led to a further acceleration of these visits, causing several pediatric health organizations to issue a national emergency for children's mental health in 2021 and the U.S. Surgeon General to release an advisory on mental health among youth. According to the CDC, one in five children and adolescents experience a mental health condition each year², with a staggering 50% of mental illnesses beginning by age 14 and 75% by age 24.³ Another study revealed that during March–October 2020, among all ED visits, the proportion of mental health-related visits increased by 24 percent among U.S. children aged 5–11 years, compared to 2019 figures. That proportion also increased to 31 percent among adolescents aged 12–17 years, compared with 2019.⁴ The problem of pediatric mental health is underscored by a [2021 CDC survey](#) of American youth, which found:

- 42% of high school students felt sad or hopeless almost every day for at least two weeks.
- 29% of high school students reported experiencing poor mental health in the past 30 days.
- 1 in 5 high school students seriously contemplated suicide, and 1 in 10 made an attempt.

In the U.S. the growing demand for mental health services exceeds the available resources. Multiple studies show that pediatric patients with mental health conditions who are boarded are more likely to leave without being treated, and less likely to receive counseling or psychiatric medications.⁵ The lack of specialized care during this critical period can also lead to an increased risk of self-harm, violence, and suicide attempts. Another study revealed that the primary barrier to disposition for mental health patients with prolonged ED stays was the lack of patient acceptance to inpatient psychiatric hospitals, community settings, or other housing.⁶

According to data from the 2013 National Pediatric Readiness Assessment, which was made available by the Health Resources & Services Administration (HRSA)-funded National Emergency Medical Services for Children (EMSC) Data Analysis Resource Center, only 47.2 percent of hospital emergency departments (EDs) reported having a policy specifically for children's mental health, and this percentage drops significantly to 33 percent in rural areas. Furthermore, although over half of all EDs have designated transfer guidelines for children with mental health issues, the figure decreases to 38 percent for rural and remote EDs.⁷

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. As part of this continued initiative, ACEP is hosting an ED Boarding Summit on September 27, 2023, and stakeholder invitees include the American Hospital Association, America's Essential Hospitals, federal health care entities, and many others. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue.

Addressing mental health boarding and crowding have also been included as key priorities in communications with Congress during the 118th Congress as legislators in both the House and Senate develop legislative efforts to address the nation's mental health crisis. 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. ACEP staff continue to discuss potential solutions with legislators in both chambers and inform additional legislative efforts in development. 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 also available on the ACEP website, including [Policy Solutions to Emergency Department Boarding](#).

Background References

¹<https://pubmed.ncbi.nlm.nih.gov/31175994/>

²<https://www.cdc.gov/childrensmentalhealth/features/kf-childrens-mental-health-report.html>

³https://www.samhsa.gov/data/sites/default/files/report_1973/ShortReport-1973.html

⁴<https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm#:~:text=During%20weeks%2012%E2%80%9342%2C%202020%2C%20the%20proportion%20of%20mental,years%20remained%20similar%20in%202020.>

⁵<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8762987/>

⁶<https://pubmed.ncbi.nlm.nih.gov/33279330/>

⁷<https://www.hrsa.gov/sites/default/files/hrsa/critical-crossroads/critical-crossroads-tool.pdf>

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 for federal advocacy initiatives.

Prior Council Action

Amended Resolution 38 (22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted. Directed the College, through legislative venues and lobbying efforts, to focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; publish best practice action plans for hospitals to improve emergency department capacity; and, work to define criteria to determine when an emergency department 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.

Prior Board Action

June 2023, filed the report of the ED Boarding Summit Task Force and approved convening an ED Boarding Summit within the next 12 months.

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.

Resolution 29(23) Addressing Pediatric Mental Health Boarding in Emergency Departments
Page 5

Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue

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.

September 2018, approved the revised policy statement “[Boarding of Pediatric Patients in the Emergency Department](#);” originally approved January 2012.

September 2018, approved the revised policy statement “[Definition of Boarded Patient](#);” reaffirmed October 2017; originally approved January 2011.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

June 2016, reviewed the updated information paper “[Emergency Department Crowding High-Impact Solutions](#)”

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper “Crowding and Surge Capacity Resources for EDs.”

October 2006, reviewed the information paper “Approaching Full Capacity in the Emergency Department.”

Substitute Resolution 18(04) Caring for Emergency Department ‘Boarders’ adopted

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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



RESOLUTION: 30(23)
SUBMITTED BY: Pennsylvania College of Emergency Physicians
SUBJECT: Advocating for Increased Funding for EMS

PURPOSE: 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

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives.

1 WHEREAS, EMS providers play a critical role in providing life-saving services to individuals covered by
2 Medicaid and Medicare; and

3
4 WHEREAS, EMS reimbursements for transporting Medicaid patients have received only two increases in the
5 last two decades, with the last increase occurring in 2018; and

6
7 WHEREAS, The current reimbursement rates for Advanced Life Support (ALS) and Basic Life Support
8 (BLS) services in Pennsylvania are significantly below Medicare and commercial insurance reimbursements; and

9
10 WHEREAS, There are often additional costs associated with providing EMS services in rural areas;

11
12 WHEREAS, Future reimbursement rates for services and mileage should increase in line with Medicare rates
13 based on changes to the CPI, ensuring that EMS agencies can keep pace with the increased cost of providing these
14 vital services; and

15
16 WHEREAS, EMS is reimbursed at a flat rate based on the level of care provided and on miles transported,
17 rather than the value of the care provided; and

18
19 WHEREAS, EMS is unable to collect financial reimbursement for valuable healthcare services provided to
20 Medicaid and Medicare patients that do not involve transport of a patient to an Emergency Department setting,
21 including, but not limited to, emergent scenarios such as cardiac arrest care involving field termination, non-emergent
22 mobile integrated health services and other “treatment-in-place” healthcare delivery models that allow for reduced
23 reliance on Emergency Departments; and

24
25 WHEREAS, Agencies throughout the nation are reporting that EMS units are facing financial collapse, a
26 crisis accelerated by COVID-19 and inflation; therefore be it

27
28 RESOLVED, That ACEP advocate for increased funding for EMS services to address the inadequacies in
29 reimbursement rates for EMS services and advocate for increased funding for EMS services recognizing the
30 importance of fair and adequate reimbursements to ensure the provision of high-quality emergency medical care for
31 patients and the sustainability of EMS services and be it further

32
33 RESOLVED, That ACEP advocate for a premium rate for EMS reimbursement in rural areas; and be it
34 further

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

38
39 RESOLVED, That ACEP advocate for reimbursement of EMS based on the value of the care provided; and
40 be it further

41
42 RESOLVED, That ACEP actively advocate for reimbursement models for EMS that allow for “treatment-in-
43 place” health care delivery.

Background

This resolution calls on ACEP to advocate for: increased funding for EMS services to address inadequacies in reimbursement rates; increased funding for EMS services; a premium rate for EMS reimbursement in rural areas; EMS reimbursement rates for services and mileage to increase in line with Medicare rates based on changes to the consumer price index (CPI); reimbursement of EMS based on the value of the care provided; and reimbursement models that allow for “treatment-in-place” health care delivery.

EMS provides a critical role in providing life-saving services for Medicare and Medicaid recipients around the US. Despite this, EMS is reimbursed at a flat rate rather than based on the value, quality or efficiency of the care delivered. As such, EMS is unable to collect financial reimbursement for any healthcare services provided to Medicaid and Medicare patients that do not involve transport of a patient to an Emergency Department. This includes emergent scenarios such as cardiac arrest care terminated in the field, mobile integrated health services, patient navigation services, alternate destination programs, co-response with law enforcement and other “treatment-in-place” delivery models that reduce reliance on transport to Emergency Departments. Further complicating this issue is that EMS is deemed an essential service in only 11 states and not deemed an essential service at the federal level. The result is that EMS funding has been left to states and local governments, leading to a lack of national coordination and inconsistencies in EMS system design, training, qualifications, personnel requirements, and pay. For years, EMS agencies have struggled with these issues and increasing difficulty in retaining and supporting both volunteer and paid staff. The stresses of the COVID-19 pandemic only exacerbated these problems. As a result, the challenges of already-strained state and local budgets coupled with extreme surges in EMS demand without additional capacity (and in some cases, reduced capacity) have pushed many EMS systems to the breaking point.

ACEP’s policy statement “[Definition of an Emergency Service](#)” codifies that an emergency service is any health care service provided to evaluate and/or treat any medical condition for which a prudent layperson possessing an average knowledge of medicine and health, believes that immediate unscheduled medical care is required. Thus, advocacy for EMS falls under any ACEP policy that support reimbursement and fair payment for emergency services. In the “[Fair Reimbursement when Services are Mandated](#)” policy, any government agency, legislative body, insurance carrier, third party payer, or any other entity that mandates that a service or product be provided by emergency physicians or other health care professionals is called on to also mandate an adequate source of funding to ensure fair coverage for those services or products. Further, the “[Emergency Medical Services Interfaces with Health Care Systems](#)” asserts ACEP’s belief that EMS plays an essential role in the clinically effective, fiscally responsible regionalization of healthcare and therefore EMS systems must have significant involvement, funding, and leadership decision-making authority to best provide necessary out-of-hospital acute assessment and safe, timely care to patients. Current reimbursement and payment policies for EMS are not sufficient to keep EMS systems afloat. More and more patients will lose access to emergency services as systems fail.

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.

Prior Council Action

Amended Resolution 36(22) Emergency Medical Services are Essential Services adopted. Directed the College to advocate for EMS to be considered and funded as an essential service and work with 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 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 "[Fair Reimbursement When Services are Mandated](#)" with the current title; revised and approved April 2017 titled "Fair Coverage when Services are Mandated;" reaffirmed April 2011 and September 2005; originally approved June 1999 titled "Compensation when Services are Mandated."

Resolution 36(22) Emergency Medical Services are Essential Services adopted.

January 2021, reaffirmed the policy statement "[Definition of an Emergency Service](#);" reaffirmed June 2015; revised and approved April 2009; reaffirmed October 2002, October 1998; revised January 1994 with the current title; originally approved October 1982 titled "Bona Fide Emergency Defined."

February 2018, approved the policy statement "[Emergency Medical Services Interfaces with Health Care Systems](#)" replacing 4 separate policy statements on EMS and ambulance care.

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Background Information Prepared by: Erin Grossmann
Regulatory & External Affairs Manager

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



RESOLUTION: 31(23)
SUBMITTED BY: New York Chapter
SUBJECT: Combating Mental Health Stigma in Insurance Policies

PURPOSE: 1) Advocate and commit resources for the elimination of discrimination against individuals with treated mental health conditions in insurance policies; and 2) work with other organizations to promote equitable access to insurance for all emergency physicians, regardless of their mental health status.

FISCAL IMPACT: Budgeted resources for federal advocacy initiatives. Unbudgeted staff and resources may be required for actions beyond federal advocacy.

1 WHEREAS, Mental health conditions such as depression and post-partum depression are common among
2 emergency physicians and can significantly impact their ability to work and perpetuate burn out; and
3

4 WHEREAS, Disability insurance can provide financial protection for emergency physicians in the event of a
5 disability that prevents them from working; and
6

7 WHEREAS, Some insurance companies may decline a disability insurance policy for an emergency physician
8 due to a previously diagnosed and treated mental health condition, such as depression and post-partum depression;
9 and
10

11 WHEREAS, The American College of Emergency Physicians (ACEP) has a responsibility to advocate for the
12 well-being and fair treatment of its members; therefore be it
13

14 RESOLVED, That ACEP advocate and commit resources for the elimination of discrimination against
15 individuals with treated mental health conditions in insurance policies; and be it further
16

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

Background

This resolution directs the College to advocate and commit resources for the elimination of discrimination against individuals with treated mental health conditions in insurance policies and work with other organizations to promote equitable access to insurance for all emergency physicians, regardless of their mental health status.

The resolution notes that some insurance companies may decline a disability insurance policy for an emergency physician due to a previously diagnosed and treated mental health condition, such as depression and post-partum depression. The resolution also notes that disability insurance may provide financial protection for emergency physicians in the event of a disability, such as a mental health condition, that prevents them from working.

Upwards of 65 percent of emergency physicians and emergency medicine resident physicians report [experiencing burnout](#) during their careers.¹ Approximately 15 to 17 percent of emergency physicians, and upwards of 20 percent of emergency medicine residents met the [diagnostic criteria for PTSD](#) in 2019. Other data indicates that, in the last year, as many as 6,000 emergency physicians have [contemplated suicide](#) and up to 400 have attempted to take their own life.

ACEP’s current legislative and regulatory priorities include “Advocate for continued and increased funding for short, medium, and long-term efforts to improve mental health, reduce burnout, and prevent suicide for emergency physicians and other health care workers, and continue to develop new policy solutions.”

ACEP helped inform, develop, and secure successful passage and enactment of the [Dr. Lorna Breen Health Care Provider Protection Act](#) (P.L. 117-105), which promotes mental and behavioral health support for physicians and health care providers, increases awareness and education about mental and behavioral health challenges for health care workers, and has funded dozens of grants totaling more than \$100 million for organizations to develop programs and resources for frontline health care workers.

ACEP has advocated and continues to advocate at the federal level for both elimination of pre-existing conditions exclusions and for mental health parity in insurance plans, supporting legislative efforts that would provide the Department of Labor the ability to issue civil monetary penalties for violations of the Mental Health Parity and Addiction Equity Act. However, these laws and efforts focus on traditional health insurance – pre-existing conditions exclusions may still apply to certain types of life insurance or disability insurance.

ACEP’s policy statement “[Physician Impairment](#)” states: “The existence of a health problem in a physician is NOT synonymous with occupational impairment...” and that most physicians with “appropriately managed personal health problems and other stressors are able to function safely and effectively in the workplace.

Background Reference

¹Carbajal E. 29 physician specialties ranked by 2022 burnout rates. Becker’s Hospital Review website.

<https://www.beckershospitalreview.com/hospital-physician-relationships/29-physician-specialties-ranked-by-2022-burnout-rates.html>. Published February 1, 2023. Accessed August 31, 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.

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Fiscal Impact

Budgeted resources for federal advocacy initiatives. Unbudgeted staff and resources may be required for actions beyond federal advocacy.

Prior Council Action

Amended Resolution 41(22) Addressing Stigma in the Emergency Department adopted. Directed ACEP to develop an educational resource on identifying and addressing stigma in the emergency department that can be provided to emergency physicians and residency programs, highlighting the role of important practices such as person-first language.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders adopted. It called for ACEP to promote awareness of ACEP policy statements that oppose barriers to physicians seeking treatment for mental health and substance use issues, work with the AMA and state medical societies to advocate for changes by state medical boards for protections for licensure for physicians that seek help and treatment, and partner with other stakeholders to investigate the effectiveness and quality of Physician Health Programs.

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted. Directed ACEP to work with stakeholders to advocate for changes in state medical board licensing application questions about physician’s mental health.

Resolution 16(18) No More Emergency Physician Suicides adopted. Directed ACEP to study the unique specialty-specific factors leading to depression and suicide in emergency physician and develop an action plan to address them.

Substitute Resolution 41(05) Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

Amended Resolution 32(04) Disability in Emergency Physicians adopted. Directed ACEP to evaluate and communicate issues related to disability and impairment in the practice of emergency medicine to members and address barriers to participation for members with disabilities. Also directed ACEP to request that ABEM include information on disability in their Longitudinal Study of Emergency Physicians.

Substitute Resolution 9(99) Federation of State Medical Board Recommendations adopted. Directed ACEP to consider establishing a formal relationship with the FSMB and to develop strategies and tools for members to respond to the FSMB's recommendations in "Maintaining State-Based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession."

Prior Board Action

Amended Resolution 41(22) Addressing Stigma in the Emergency Department adopted.

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

October 2020, reviewed the information paper [Stigma in the Emergency Department](#).

February 2020, "[Physician Impairment](#);" revised and approved October 2013 and October 2006; reaffirmed September 1999; revised and approved April 1994; originally approved September 1990.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders was adopted.

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted.

Resolution 16(18) No More Emergency Physician Suicides adopted.

Substitute Resolution 41(05) Non-Discrimination adopted.

Amended Resolution 32(04) Disability in Emergency Physicians adopted.

Substitute Resolution 9(99) Federation of State Medical Boards adopted.

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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



RESOLUTION: 32(23)

SUBMITTED BY: Gary Gaddis, MD, PhD, FACEP
David Schriger, MD, MPH, FACEP

SUBJECT: Health Care Insurers Waive Network Considerations During Declarations of Emergency

PURPOSE: 1) Advocate at the federal level and provide assistance to chapters for state lobbying efforts, urging the enactment of legislation and/or regulations that require 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, regardless of whether that state of emergency is the result of a natural disaster, an act of war, a pandemic, or other causative forces; and 2) Submit a resolution to the American Medical Association, requesting its House of Delegates to consider joining ACEP in seeking legislative or regulatory changes designed to compel health insurers to waive "network" considerations under the same circumstances.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Efforts pertaining to this issue would be prioritized with current committee and staff resources for federal and state advocacy initiatives.

1 WHEREAS, Because of the COVID-19 pandemic, a public health emergency was declared by the Trump
2 Administration on March 13, 2020¹; and
3

4 WHEREAS, During that time of emergency, numerous hospitals quickly became overcrowded and
5 oversubscribed, leading to an over-capacity inpatient census, which caused their health personnel and their systems of
6 care to become compromised regarding their ability to meet patient care needs; and
7

8 WHEREAS, Elsewhere, other area hospitals’ capacities were simultaneously undersubscribed; and
9

10 WHEREAS, This uneven distribution of patients and the local over-crowding that subsequently occurred at
11 oversubscribed hospitals is widely believed to have led to avoidable morbidity and mortality, as a direct consequence
12 of this patient maldistribution; and
13

14 WHEREAS, In a scholarly article by Ioannides et al.², which appeared in the *Annals of Emergency Medicine*
15 in October of 2022, it was demonstrated that sufficient ambulance capacity existed throughout the early months of the
16 pandemic to have enabled extensive inter-hospital patient transfers to mitigate the effects of sporadic overcrowding, if
17 only local inter-hospital transfer protocols had been enacted and then followed by local health authorities; and
18

19 WHEREAS, In their manuscript, Ioannides et al. specifically advocated that regional Emergency Medical
20 Services (EMS) leaders should develop policies and procedures to facilitate a more even distribution of patients in
21 during future episodes of high hospital demand, toward employing EMS resources to facilitate inter-hospital transfers
22 of patients, and thus mitigate the sporadic over-subscribing of hospital capacities that demonstrably harmed patients;
23 and
24

25 WHEREAS, The existence of adequate EMS capacity to effect inter-hospital patients alone can be expected
26 to be insufficient to effect sufficiently numerous, voluntary patient transfers between hospitals (making this EMS
27 capacity be of questionable relevance), because offers for inter-hospital transfers would be likely to be resisted or
28 refused by many patients, if those patients were asked to transfer to a hospital that their health insurer considered to be
29 “out of network”; and
30

31 WHEREAS, The reason patients would be unlikely to agree to be transferred to an “out of network” facility
32 lies in the higher “out of pocket” “co-payments” that these patients would encounter when billed for care at “out of

33 network” locations; and

34
35 WHEREAS, This complicating factor of insurers “networks,” which would blunt the salutatory effect of
36 updated inter-hospital transfer protocols, was spotlighted in a Letter to the Editor of the *Annals of Emergency*
37 *Medicine*³ written by the author of this resolution (GM Gaddis), with that letter appearing in the May 2023 *Annals of*
38 *Emergency Medicine*; and

39
40 WHEREAS, The authors of the manuscript which precipitated that Letter to the Editor documented agreement
41 with the key points raised in Gaddis’ Letter³ in their reply⁴; and

42
43 WHEREAS, The senior author of the Ioannides manuscript, David Schriger, MD, FACEP, an Associate
44 Editor of the *Annals of Emergency Medicine*, has indicated that such advocacy for waiver of insurance networks was
45 exactly what the authorship team of Ioannides et al. hoped would happen in response to their manuscript⁵ because
46 they did not believe it to be appropriate to engage in political advocacy within the text of a scientific article in a
47 scientific journal and thus, they did not take the opportunity to raise this point in their manuscript²; and

48
49 WHEREAS, These insurer “network” concerns are human-made barriers that could be eradicated by human
50 actions; and

51
52 WHEREAS, The logical and salutatory human action to eliminate these “network” considerations and barriers
53 during times of emergencies could be voluntarily undertaken by health care insurance companies; and

54
55 WHEREAS, Such health insurers may be unlikely to voluntarily waive “network” considerations for their
56 insureds, even during times of declared national emergencies, as can be judged from their failure to extend this
57 courtesy to their insured patients during the COVID-19 emergency; and

58
59 WHEREAS, In the absence of voluntary network suspensions, new governmental legislation or regulatory
60 mandates are likely to be needed to compel such actions on the part of health care insurance companies; and

61
62 WHEREAS, ACEP maintains a presence in our nation’s capital to “lobby” for legislative and regulatory
63 changes desired by ACEP leaders, as does the American Medical Association (AMA); therefore be it

64
65 RESOLVED, That ACEP lobby at the federal level and provide assistance to chapters for state lobbying
66 efforts, for the enactment of legislation and/or regulations requiring health insurers to waive “network” rules and
67 considerations for their insured patients during times at which a Declaration of Emergency has been declared and
68 placed in force by a state governor or by the President of the United States, whether that state of emergency is the
69 result of a natural disaster, an act of war, a pandemic, or other causative forces; and be it further

70
71 RESOLVED, That ACEP submit a resolution to the American Medical Association for consideration by its
72 House of Delegates at its upcoming Interim Meeting, asking the AMA to join ACEP in the seeking of legislative or
73 regulatory change designed to compel health insurers to waive “network” considerations during times at which a
74 Declaration of Emergency has been declared and placed in force by a state governor or by the President of the United
75 States, whether that state of emergency is the result of a natural disaster, an act of war, a pandemic, or other causative
76 forces.

Resolution References

1. Centers for Disease Control. COVID-19 Timeline. <https://www.cdc.gov/museum/timeline> Accessed July 9, 2023
2. Ioannides KLH, Dekker A, Shin M, Schriger DL. Ambulances required to relieve overcapacity hospitals: A novel measure of hospital strain during the COVID-19 pandemic in the United States. *Ann Emerg Med.* 2022;80:301-13.
3. Gaddis GM. Response to “Ambulances Required to Relieve Overcapacity Hospitals: A Novel Measure of Hospital Strain during the COVID-19 Pandemic in the United States. *Ann Emerg Med.* 2023; 81:644-45.
4. Ioannides KLH et al. Reply to Response to “Ambulances Required to Relieve Overcapacity Hospitals: A Novel Measure of Hospital Strain during the COVID-19 Pandemic in the United States. *Ann Emerg Med.* 2023;81:645-6.
5. Schriger, D. Personal email communication; November, 2022.

Background

This resolution calls for the College to lobby at the federal level and provide assistance to chapters for state lobbying efforts, urging the enactment of legislation and/or regulations that require 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. It further directs the College to submit a resolution to the American Medical Association asking them 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.

The resolution posits that insurer network considerations could serve as barriers to optimal patient care and out-of-network costs may deter inter-hospital patient transfers that could be beneficial in alleviating hospital capacity and crowding issues. The resolution suggests that waivers of insurer network requirements during emergencies could help eliminate these concerns by enabling overburdened/over-capacity facilities to transfer patients. During the COVID-19 pandemic, constraints on hospital resources became increasingly severe, leading to an increase in admitted patients remaining in the ED for prolonged periods of time. The resolution cites a study that suggests using only a modest portion of existing ambulance infrastructure would have significant impacts in load-balancing community resources and alleviating strain on over-capacity facilities.

The COVID-19 public health emergency provides some precedent for requiring health insurers to waive certain rules and considerations for their covered consumers. Group health plans and individual health insurance plans were obligated to cover COVID-19 tests and related services without requiring cost sharing, prior authorization, or other medical management requirements during the COVID-19 state of emergency. A coverage requirement was extended to over-the-counter (OTC) COVID-19 tests and health plans ensured coverage for up to 8 OTC at-home tests per covered individual each month. Alternatively, plans could establish a network to offer free OTC tests directly, thus eliminating the need for patients to pay upfront and submit reimbursement claims later.¹ Plans and issuers were obligated to cover COVID-19 vaccines without cost sharing, even if administered by out-of-network clinicians, and were required to reimburse for the administration of the vaccine at a reasonable amount, with federal regulations specifying the Medicare reimbursement rate as the reasonable amount. Many payers voluntarily waived or changed certain policies during the pandemic, such as certain cost-sharing requirements, prior authorization requirements, telehealth coverage, and others – some of which have even been implemented permanently. Plans also typically have processes for applying for waivers to receive out-of-network care with prior approval, though they are not obligated to approve such requests.

Many patient considerations in the context of out-of-network costs have essentially been obviated – at least in theory – by recent legislative and regulatory actions. State and federal laws have been enacted to remove patients from the middle of billing disputes between physicians/providers and insurers, banning the practice of "surprise medical billing" in cases where patients who receive care from physicians, providers, or hospitals that were not in their plan's network. This includes the federal No Surprises Act (NSA; Public Law 116-260) that went into effect on January 1, 2022, which is in some respects a form of a network waiver for medically necessary care. Broadly, the NSA applies to emergency and non-emergency services, including air ambulance transportation but not ground ambulance transportation. The NSA bans physicians, hospitals, facilities, and other providers from billing of patients more than in-network cost sharing amounts for most emergency care, and requires insurers to cover out-of-network claims with patient cost-sharing at in-network amounts in these cases. However, the NSA protections for patients only exist when an insurer has not retrospectively declared the care and/or transportation "not medically necessary."

The *No Surprises Act* extends its protections to additional services that emergency patients may receive in conjunction with an emergency visit even *after* they are stabilized—a new concept known as "post-stabilization services" in the law. Thus, a patient coming to the ED to be treated for a medical emergency cannot be balance billed for any of the out-of-network services they receive up to the point of stabilization, NOR for the care they receive once they are:

- admitted to the hospital; or,
- transferred to another facility via ambulance or other form of emergency medical transportation; or,
- placed into observation.

The protections end when the patient is discharged or when the insurer determines retrospectively that the care did not meet medical necessity criteria. They also can end when under the clinical judgment of the emergency physician, the out-of-network patient could have been transferred to a participating facility safely and without undue financial burden using a *non-emergency* form of transportation (like the patient’s car, a bus, or a taxi), AND the patient signs a notice-and-consent given to them by the subsequent clinician.

There are still some gaps – the NSA does not cover non-emergency services provided in a variety of other settings, such as urgent care centers, clinics, nursing homes, substance use disorder treatment facilities, and others. In many of these non-emergency situations, providers may ask (but not require) patients to provide consent to waive their rights under the NSA and allow them to bill more as an out-of-network provider. So for patients who are forced to seek non-emergency care out-of-network during a declaration of emergency, the NSA’s provisions will not address the situation as they could still find themselves needing to consent to costs of care higher than if they’d received the care in-network. In recognizing this potential gap in existing law, it is worth considering whether there will be any kind of significant numbers of patients seeking or needing non-emergency care during a declaration of emergency.

Background References

¹<https://www.kff.org/coronavirus-covid-19/issue-brief/what-happens-when-covid-19-emergency-declarations-end-implications-for-coverage-costs-and-access/#coverage-costs-and-payment>

²https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_report_issue_4.pdf

³<https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217>

⁴<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8344999/>

⁵<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8276718/>

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

This is not a current initiative of the College and is unbudgeted. Efforts pertaining to this issue would be prioritized with current committee and staff resources for federal and state advocacy initiatives.

Prior Council Action

None that is specific to waiving “network” rules and considerations for insured patients during a Declaration of Emergency.

Prior Board Action

None

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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



RESOLUTION: 33(23)

SUBMITTED BY: Kathy Staats, MD, FACEP
Niki Thran, MD, FACEP
California Chapter

SUBJECT: Ban on Weapons Intended for Military or Law Enforcement Use

PURPOSE: 1) 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 fire multiple rounds; 2) Encourage state and federal policymakers to enact comprehensive legislation addressing the ban on such weapons while respecting the rights of responsible gun owners; 3) Advocate for evidence-based measures, including the ban on such weapons, to prevent and reduce gun-related injuries and fatalities through public education, research, and collaboration with relevant stakeholders; and 4) 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 such weapons, while recognizing the importance of mental health services and violence prevention programs in comprehensive strategies for reducing gun violence.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives related to firearms.

- 1 WHEREAS, ACEP is committed to the promotion of public health and safety; and
- 2
- 3 WHEREAS, Weapons intended for military or law enforcement use, including semi-automatic rifles and
- 4 handguns, designed to rapidly fire multiple rounds, pose a significant threat to public safety and contribute to mass
- 5 shootings and violence; and
- 6
- 7 WHEREAS, The proliferation of weapons intended for military or law enforcement use has resulted in an
- 8 alarming increase in the number and severity of injuries seen in emergency departments across the United States; and
- 9
- 10 WHEREAS, Studies have consistently demonstrated a correlation between the availability of weapons
- 11 intended for military or law enforcement use and increased rates of gun-related injuries and fatalities; and
- 12
- 13 WHEREAS, The possession of weapons intended for military or law enforcement use often serves no
- 14 legitimate purpose for self-defense or hunting, but rather enhances the potential for misuse and harm; and
- 15
- 16 WHEREAS, The banning of weapons intended for military or law enforcement use has proven effective in
- 17 reducing mass shootings and protecting the safety and well-being of individuals and communities in other countries;
- 18 and
- 19
- 20 WHEREAS, Responsible gun ownership and regulation should not infringe upon the rights of law-abiding
- 21 citizens to possess firearms for legitimate purposes, such as self-defense and recreational shooting; therefore be it
- 22
- 23 RESOLVED, That ACEP support a ban on the sale, transfer, importation, and possession of weapons
- 24 intended for military or law enforcement use, including semi-automatic rifles and handguns, that are designed to
- 25 rapidly fire multiple rounds; and be it further
- 26
- 27 RESOLVED, That ACEP encourage policymakers at the local, state, and federal levels to enact
- 28 comprehensive legislation that addresses the ban on weapons intended for military or law enforcement use while
- 29 respecting the rights of responsible gun owners; and be it further

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

33
34 RESOLVED, That ACEP urge members to engage in discussions with their patients, communities, and
35 lawmakers to promote policies and initiatives aimed at reducing the availability and potential harm caused by
36 weapons intended for military or law enforcement use, while recognizing the importance of mental health services
37 and violence prevention programs in comprehensive strategies for reducing gun violence.

References

<https://www.acep.org/patient-care/policy-statements/firearm-safety-and-injury-prevention>

<https://www.rand.org/research/gun-policy/analysis/ban-assault-weapons.html>

<https://www.judiciary.senate.gov/press/dem/releases/studies-gun-massacre-deaths-dropped-during-assault-weapons-ban-increased-after-expiration>

Background

The resolution calls for the College to: 1) 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; 2) 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; 3) 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 4) 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.

A fundamental challenge in the debate over firearms laws and policies revolves around language and semantics, particularly the lack of consensus on definitions and controversy over terminology. Defining objects by intended use is rarely definitive or restrictive. The term “intended for military or law enforcement use, including...” encompasses firearms of all types and historical periods, while also excluding most modern firearms, which are not marketed to the military or police. Conversely, all types of firearms are in current usage with the military and police for various purposes, e.g. basic marksmanship.

Defining firearms by mechanical function (kinetic energy, reloading mechanism, length, rapidity of fire) does not separate traditional and common sporting firearms from military and police firearms, except in the case of fully-automatic reloading mechanisms (firing multiple shots with a single trigger pull) and [ammunition belt fed mechanisms](#).

The term “weapons intended for military or law enforcement use” is most generally used to refer to semi-automatic rifles and shotguns with certain cosmetic similarities, features, or accessories, e.g. pistol or vertical hand grips, removable ammunition magazines, integral mount rails, and bayonet lug. Accessories themselves, not integral to a firearm, have been treated separately under current state and federal laws, e.g. bump stocks (facilitating faster trigger actuation), ammunition magazines (capacity size), sound and flash suppressors, muzzle recoil breaks, folding stocks, forearm braces, and ammunition.

The U.S. Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), for example, [states that](#) “... certain features designed for military application are indicative of non-sporting rifles and shotguns.

Pistol functions, cosmetics, accessories, and ammunition have remained effectively indistinguishable between civilian, military, and police users for centuries. Certain accessories have been regulated at the state and federal levels, e.g. shoulder stocks, forearm braces, forward grips, magazine capacity, and ammunition.

The U.S. Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), for example, [states that](#) “... certain features designed for military application are indicative of non-sporting rifles and shotguns..”

Pro-firearm advocates oppose categorization of AR-15-style and other semi-automatic rifles as assault rifles, assault weapons, or even as weapons intended for military/LE use, and that these firearms are instead categorized as “modern sporting rifles,” according to the Firearm Industry Trade Association’s (NSSF) “[Writer’s Guide to Firearms and Ammunition](#).”

To illustrate the difficulty in reconciling common definitions between the different camps of advocates, consider the following practical comparison: according to the [manual](#) for the Bushmaster XM15 E2S, a AR-15-style semi-automatic rifle available to the public, its rate of fire is 45 rounds per minute. The [M4 carbine](#) used by the U.S. military has a rate of fire of 700-950 rounds per minute. Again, while similar in form and basic function, on this example some would consider the XM15 E2S to be a weapon intended for military or law enforcement use while others would qualify it as a modern sporting rifle. Further complicating regulation is that AR-15-style rifles are offered in various ammunition choices, decreasing capacity of the same magazine by up to 66%.

As of 2023, ten U.S. states [have banned or restricted](#) the sale of AR- and AK-style and other similar firearms: California, Connecticut, Delaware, Hawaii, Maryland, Massachusetts, New Jersey, New York, Illinois, and most recently, Washington. These laws obviously vary by state, but generally prohibit manufacture, sale, and possession of such a firearm unless the owner lawfully possessed it prior to the ban. At the federal level, the [Violent Crime Control and Law Enforcement Act of 1994](#) similarly banned the manufacture, transfer, or possession of these types of firearms and others (“pre-ban” firearms were grandfathered in), prohibited the manufacture of new large-capacity magazines except for government, military, or law enforcement sales, and banned possession and transfer of new large-capacity magazines, though pre-ban magazines were exempted and could be legally transferred and possessed as well. The 1994 law included a sunset clause and its provisions expired in 2004. Similar legislation to reinstate a ban has been introduced in Congress ever since, including the current 118th Congress, however none of these efforts have been successfully considered by Congress and enacted into law.

Evidence of the federal ban’s effectiveness is mostly inconclusive with respect to impact on the overall U.S. homicide rate. Rifles of all types, regardless of features, were involved in 3% of firearm murders in 2020 [according to the Pew Research Center](#). A [2020 RAND analysis](#) of six studies found evidence to be inconclusive of the effect of state or federal bans on mass shootings (inconsistent evidence for the policy’s effect on an outcome, or a single study only found uncertain or suggestive effects), while there is limited evidence that a ban on high-capacity magazines may decrease mass shootings. A 2019 study published in [The Journal of Trauma and Acute Care Surgery](#), however, found that mass-shooting related homicides were reduced in the U.S. during the years of the 1994-2004 ban.

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](#).” Among the policy’s provisions is the directive that ACEP support legislative and regulatory efforts that “[r]estrict the sale and ownership of weapons, munitions, and large-capacity magazines that are designed for military or law enforcement use, and prohibit the sale of after-market modifications that increase the lethality of otherwise legal firearms.” ACEP’s legislative and regulatory advocacy over the years includes working with members of Congress to promote efforts to prevent firearm-related injuries and deaths, reduce firearms-related violence, and support public and private initiatives to fund firearm safety and injury prevention research, and support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices. While not directly the same issue as the firearms identified in this resolution, ACEP has previously supported legislative efforts to ban the manufacture, possession, and sale of “bump stocks” that allow semi-automatic firearms to nearly replicate the firing rate of fully automatic firearms, such as those that were used to perpetrate the October 1, 2017 mass shooting in Las Vegas, NV that claimed the lives of 60 people. ACEP also supported the Trump Administration’s 2019 ban on these and similar devices. This regulatory ban has come under scrutiny recently with two federal appeals courts ruling against the ban and its ultimate fate still uncertain.

The current “[Firearm Safety and Injury Prevention](#)” policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a

meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The PHIPC developed a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process.

The policy statement “[Violence-Free Society](#)” also notes that “ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives.”

In 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 ~~overall~~. 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. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.
- 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 representative will also serve.
- 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. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of \$61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. 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.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP issuing public statements following a mass shooting event advocating for change consistent with the College's policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper "[Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention](#)" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

ACEP has supported the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), including AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants.

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 firearms.

Prior Council Action

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted. Directed ACEP to work with stakeholders to raise awareness and advocate for research funding and legislation to address both firearm violence and intimate partner violence.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 ACEP Position Paper; and that ACEP support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

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 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for funding for research on firearm injury prevention and to work with the AMA and other medical societies to achieve this common cause.

Amended Resolution 31(12) Firearm Violence Prevention adopted. Condemned the recent massacres in Aurora, CO and WI and the daily violence throughout the U.S. and reaffirmed ACEP's commitment against gun violence including advocating for public and private funding to study the health effects of gun violence.

Amended Resolution 41(04) Assault Weapon Ban adopted. ACEP deplors the threat to public safety that is the result of widespread availability of assault weapons and high capacity ammunition devices and urges the Congress and the President to enact and sign into law a comprehensive ban on all sales of assault weapons and high capacity magazines.

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.

Resolution 22(96) National Center for Injury Prevention and Control adopted. Directed ACEP to continue supporting funding for Injury Prevention and Control in the CDC in which firearms research was included.

Amended Resolution 69(95) Firearm Legislation adopted. Sought to limit access to Saturday night specials.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. Advocated for increased taxes on handguns and ammunition with proceeds going to fund the care of victims and/or programs to prevent gun violence and to fund firearm safety education.

Resolution 47(94) Firearm Classification referred to the Board of Directors. Directed ACEP to support legislation classifying firearms into three categories: 1) prohibited; 2) licensed; and 3) unlicensed.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted. Directed ACEP to support legislation requiring photo identification and specific qualifications for firearm possession.

Substitute Resolution 45(94) Firearm Possession adopted. Supported legislation (as was passed in the crime bill) to make it illegal for persons under 21 and persons convicted of violent crimes, spousal and/or child abuse or subject to a protective order to possess firearms; illegal to transfer firearms to juveniles; and support legislation making it illegal to leave a loaded handgun where it is accessible to a juvenile.

Substitute Resolution 44(94) Firearm Legislation adopted. Support comprehensive legislation to limit federal firearms licenses.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted. Supported national safety regulations for firearms.

Amended Resolution 18(93) Firearm Injury Reporting System adopted. Explore collaboration with existing governmental entities to develop a mandatory firearm injury reporting system.

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 16(93) Possession of Handguns by Minors adopted. Support federal legislation to prohibit the possession of handguns by minors.

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.

Resolution 15(90) Gun Control not adopted. Sought for ACEP to undertake a complete review of all medical, legal, technical, forensic, and other pertinent literature regarding firearm-related violence with emphasis on the effects of firearm availability to the incidence of such violence, and that ACEP withhold public comment on gun control until such study is completed and an informed, unemotional, and unpolarized position on weapons can be formulated.

Amended Resolution 14(89) Ban on Assault Weapons adopted. Support federal and state legislation to regulate as fully automatic weapons are regulated, the sale, possession, or transfer of semi-automatic assault weapons to private citizens and support legislation mandating jail sentences for individuals convicted of the use of a semi-automatic assault weapon in the commission of a crime.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted. Support federal and state legislation to require 15-day waiting period for the sale, purchase, or transfer of any firearm to allow time for a background check on the individual and also support legislation mandating significant penalties for possession of a firearm while committing a crime.

Substitute Resolution 16(84) Ban on Handguns adopted. Deplored the loss of life and limb secondary to the improper use of handguns; supported legislation mandating significant penalties for possession of a handgun while committing a crime; support legislation mandating significant penalties for the illegal sale of handguns; support a waiting period for all prospective handgun buyers; supported successful completion of an education program on handgun safe for all prospective handgun buyers; support development of educational programs on the proper use of handguns for existing owners; support requiring screening of prospective handgun buyers for previous criminal records and mental health problems that have led to violent behavior.

Resolution 15(83) Handgun Legislation not adopted. Urged legislative bodies to enact legislation restricting the availability of handguns to the general public and to monitor the results.

Prior Board Action

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "[Firearm Safety and Injury Prevention](#);" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

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.

January 2019, approved \$20,000 contribution to the American Federation for Firearm Injury Reduction in Medicine (AFFIRM).

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.](#)”

June 2014, approved the Research Committee’s recommendations to convene a consensus conference of firearm researchers and other stakeholders to: 1) develop a research agenda and to consider the use of available research networks (including the proposed EM-PRN) to perform firearm research; 2) identify grant opportunities and promote them to emergency medicine researchers; 3) recommend EMF consider seeking funding for a research grant specifically supporting multi-center firearm research; and 4) advance the development of the EM-PRN so as to create a resource for representative ED-based research on this topic and others.

Resolution 27(13) Studying Firearm Injuries adopted.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Amended Resolution 41(04) Assault Weapon Ban adopted.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

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Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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



RESOLUTION: 34(23)

SUBMITTED BY: Kathy Staats, MD, FACEP
Niki Thran, MD, FACEP
California Chapter

SUBJECT: White Paper on Weapons Intended for Military or Law Enforcement Use

PURPOSE: 1) 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; 2) include a range of components with a comprehensive review of existing literature; examination of specific characteristics and features of weapons intended for military or law enforcement; assessment of the societal impact and psychological consequences; evaluation of existing policies, legislative measures, and firearm regulations; consideration of potential interventions, strategies, and evidence-based approaches; 3) seek funding, partnerships, and collaboration with relevant stakeholders, organizations, and governmental bodies to support the development of the paper; 4) disseminate the paper to members, policymakers, public health officials, medical organizations, and other interested parties; and 5) 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.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Development of a comprehensive white paper would require diverting current budgeted staff resources from other initiatives to support this effort. Unbudgeted costs of organizing/collaborating with relevant stakeholders for development of a comprehensive research paper, if the costs are not offset by funding opportunities, and unbudgeted funds of approximately \$25,000 for an in-person stakeholder meeting for 20 people.

- 1 WHEREAS, ACEP is committed to the promotion of public health, safety, and the well-being of patients; and
2
3 WHEREAS, ACEP recognizes the alarming impact of firearms-related incidents on public health, including
4 the toll of mass shootings and assaults involving weapons intended for military or law enforcement use; and
5
6 WHEREAS, ACEP acknowledges the importance of evidence-based research and information in informing
7 policies and interventions aimed at reducing the risk and impact of firearm-related injuries and fatalities; and
8
9 WHEREAS, There is a need for a comprehensive understanding of the medical implications and public health
10 consequences associated with the use of weapons intended for military or law enforcement use; therefore be it
11
12 RESOLVED, That ACEP develop a white paper on the examination of weapons intended for military or law
13 enforcement use to inform evidence-based policies, interventions, and public health strategies to address the risks and
14 consequences associated with these firearms and seek collaboration among experts in emergency medicine, public
15 health, and other stakeholders as appropriate to ensure a multidisciplinary approach in the development of the white
16 paper; and be it further
17
18 RESOLVED, That the ACEP white paper on the examination of weapons intended for military or law
19 enforcement use include, but not be limited to, the following components:
20
21 1. A comprehensive review of existing literature, studies, and research on the medical and public health
22 impact of weapons intended for military or law enforcement use, including injury patterns, morbidity,
23 mortality, and the unique challenges they present to emergency medical response and care.

- 24 2. Examination of the specific characteristics and features of weapons intended for military or law
25 enforcement use that contribute to increased lethality and potential for mass casualties.
- 26 3. Assessment of the societal impact and psychological consequences associated with the use of weapons
27 intended for military or law enforcement use in mass shootings and other acts of violence.
- 28 4. Evaluation of existing policies, legislative measures, and firearm regulations pertaining to weapons
29 intended for military or law enforcement use at the federal and state levels and analysis of their
30 effectiveness in preventing and mitigating firearm-related injuries and fatalities.
- 31 5. Consideration of potential interventions, strategies, and evidence-based approaches to reduce the risks and
32 impact of weapons intended for military or law enforcement use on public health and safety, including but
33 not limited to, firearm safety education, mental health services, and law enforcement initiatives; and be it
34 further

35
36 RESOLVED, That ACEP seek funding, partnerships, and collaboration with relevant stakeholders,
37 organizations, and governmental bodies to support the development of the white paper on the examination of weapons
38 intended for military or law enforcement use; and be it further

39
40 RESOLVED, That upon completion of a white paper on the examination of weapons intended for military or
41 law enforcement use, ACEP will disseminate it to members, policymakers, public health officials, medical
42 organizations, and other interested parties to promote awareness, education, and evidence-based decision-making on
43 the topic of weapons intended for military or law enforcement use; and be it further

44
45 RESOLVED, That ACEP actively engage in advocacy efforts to promote evidence-based policies aimed at
46 reducing the risks and impact of weapons intended for military or law enforcement use on public health and safety.

References

<https://www.acep.org/patient-care/policy-statements/firearm-safety-and-injury-prevention>

<https://www.rand.org/research/gun-policy/analysis/ban-assault-weapons.html>

<https://www.judiciary.senate.gov/press/dem/releases/studies-gun-massacre-deaths-dropped-during-assault-weapons-ban-increased-after-expiration>

Background

The resolution directs the College to 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 include in the white paper, 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.

It further directs the College to 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; upon completion of a white paper on the examination of weapons intended for military or law enforcement use, ACEP will disseminate to its 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, 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.

A fundamental challenge in the debate over firearms laws and policies revolves around language and semantics, particularly the lack of consensus on definitions and controversy over terminology. Defining objects by intended use is rarely definitive or restrictive. The term “intended for military or law enforcement use, including…” encompasses firearms of all types and historical periods, while also excluding most modern firearms, which are not marketed to the military or police. Conversely, all types of firearms are in current usage with the military and police for various purposes, e.g., basic marksmanship.

Defining firearms by mechanical function (kinetic energy, reloading mechanism, length, rapidity of fire) does not separate traditional and common sporting firearms from military and police firearms, except in the case of fully-automatic reloading mechanisms (firing multiple shots with a single trigger pull) and [ammunition belt fed mechanisms](#).

The term “weapons intended for military or law enforcement use” is most generally used to refer to semi-automatic rifles and shotguns with certain cosmetic similarities, features, or accessories, e.g. pistol or vertical hand grips, removable ammunition magazines, integral mount rails, and bayonet lug. Accessories themselves, not integral to a firearm, have been treated separately under current state and federal laws, e.g. bump stocks (facilitating faster trigger actuation), ammunition magazines (capacity size), sound and flash suppressors, muzzle recoil breaks, folding stocks, forearm braces, and ammunition.

Pistol functions, cosmetics, accessories, and ammunition have remained effectively indistinguishable between civilian, military, and police users for centuries. Certain accessories have been regulated at the state and federal levels, e.g., shoulder stocks, forearm braces, forward grips, magazine capacity, and ammunition.

The U.S. Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), for example, [states that](#) “... certain features designed for military application are indicative of non-sporting rifles and shotguns.”

Pro-firearm advocates oppose categorization of AR-15-style and other semi-automatic rifles as assault rifles, assault weapons, or even as weapons intended for military/LE use, and that these firearms are instead categorized as “modern sporting rifles,” according to the Firearm Industry Trade Association’s (NSSF) [“Writer’s Guide to Firearms and Ammunition.”](#)

To illustrate the difficulty in reconciling common definitions between the different camps of advocates, consider the following practical comparison: according to the [manual](#) for the Bushmaster XM15 E2S, a AR-15-style semi-automatic rifle available to the public, its rate of fire is 45 rounds per minute. The [M4 carbine](#) used by the U.S. military has a rate of fire of 700-950 rounds per minute. Again, while similar in form and basic function, on this example some would consider the XM15 E2S to be a weapon intended for military or law enforcement use while others would qualify it as a modern sporting rifle. Further complicating regulation is that AR-15-style rifles are offered in various ammunition choices, decreasing capacity of the same magazine by up to 66%.

As of 2023, ten U.S. states [have banned or restricted](#) the sale of AR- and AK-style and other similar firearms: California, Connecticut, Delaware, Hawaii, Maryland, Massachusetts, New Jersey, New York, Illinois, and most recently, Washington. These laws obviously vary by state, but generally prohibit manufacture, sale, and possession of such a firearm unless the owner lawfully possessed it prior to the ban. At the federal level, the [Violent Crime Control and Law Enforcement Act of 1994](#) similarly banned the manufacture, transfer, or possession of these types of firearms and others (“pre-ban” firearms were grandfathered in), prohibited the manufacture of new large-capacity magazines except for government, military, or law enforcement sales, and banned possession and transfer of new large-capacity

magazines, though pre-ban magazines were exempted and could be legally transferred and possessed as well. The 1994 law included a sunset clause and its provisions expired in 2004. Similar legislation to reinstate a ban has been introduced in Congress ever since, including the current 118th Congress, however none of these efforts have been successfully considered by Congress and enacted into law.

Evidence of the federal ban's effectiveness is mostly inconclusive with respect to impact on the overall U.S. homicide rate. Rifles of all types, regardless of features, were involved in 3% of firearm murders in 2020 [according to the Pew Research Center](#). A [2020 RAND analysis](#) of six studies found evidence to be inconclusive of the effect of state or federal bans on mass shootings (inconsistent evidence for the policy's effect on an outcome, or a single study only found uncertain or suggestive effects), while there is limited evidence that a ban on high-capacity magazines may decrease mass shootings. A 2019 study published in [The Journal of Trauma and Acute Care Surgery](#), however, found that mass-shooting related homicides were reduced in the U.S. during the years of the 1994-2004 ban.

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](#)." Among the policy's provisions is the directive that ACEP support legislative and regulatory efforts that "[r]estrict the sale and ownership of weapons, munitions, and large-capacity magazines that are designed for military or law enforcement use, and prohibit the sale of after-market modifications that increase the lethality of otherwise legal firearms." ACEP's legislative and regulatory advocacy over the years includes working with members of Congress to promote efforts to prevent firearm-related injuries and deaths, reduce firearms-related violence, and support public and private initiatives to fund firearm safety and injury prevention research. While not directly the same issue as the firearms identified in this resolution, ACEP has previously supported legislative efforts to ban the manufacture, possession, and sale of "bump stocks" that allow semi-automatic firearms to nearly replicate the firing rate of fully automatic firearms, such as those that were used to perpetrate the October 1, 2017 mass shooting in Las Vegas, NV that claimed the lives of 60 people. ACEP also supported the Trump Administration's 2019 ban on these and similar devices. This regulatory ban has come under scrutiny recently, though, with two federal appeals courts ruling against the ban and its ultimate fate still uncertain.

The current "[Firearm Safety and Injury Prevention](#)" policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The PHIPC developed a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process.

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- 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 ~~overall~~. 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. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.

- 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 representative will also serve.
- 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. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of \$61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. 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.

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- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP Resolution 36(19) Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence Page 3 issuing public statements following a mass shooting event advocating for change consistent with the College's policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper "[Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention](#)" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered

with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

ACEP has supported the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), including AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants.

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. Development of a comprehensive white paper would require diverting current budgeted staff resources from other initiatives to support this effort. Unbudgeted costs of organizing/collaborating with relevant stakeholders for development of a comprehensive research paper, if the costs are not offset by funding opportunities, and unbudgeted funds of approximately \$25,000 for an in-person stakeholder meeting for 20 people.

Prior Council Action

The Council has discussed and adopted many resolutions about firearms, although none have focused solely on developing a comprehensive white paper on weapons intended for military or law enforcement use.

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted. Directed ACEP to work with stakeholders to raise awareness and advocate for research funding and legislation to address both firearm violence and intimate partner violence.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 ACEP Position Paper; and that ACEP support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

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 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for funding for research on firearm injury prevention and to work with the AMA and other medical societies to achieve this common cause.

Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs referred to the Board of Directors. Called for a task force to develop a research network of EDs to study the impact of firearm violence and invite interested stakeholders to participate in the network.

Amended Resolution 31(12) Firearm Violence Prevention adopted. Condemned the recent massacres in Aurora, CO and WI and the daily violence throughout the U.S. and reaffirmed ACEP's commitment against gun violence including advocating for public and private funding to study the health effects of gun violence.

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.

Resolution 22(96) National Center for Injury Prevention and Control adopted. Directed ACEP to continue supporting funding for Injury Prevention and Control in the CDC in which firearms research was included.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted. Supported national safety regulations for firearms.

Amended Resolution 18(93) Firearm Injury Reporting System adopted. Explore collaboration with existing governmental entities to develop a mandatory firearm injury reporting system.

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.

Resolution 15(90) Gun Control not adopted. Sought for ACEP to undertake a complete review of all medical, legal, technical, forensic, and other pertinent literature regarding firearm-related violence with emphasis on the effects of firearm availability to the incidence of such violence, and that ACEP withhold public comment on gun control until such study is completed and an informed, unemotional, and unpolarized position on weapons can be formulated.

Prior Board Action

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "[Firearm Safety and Injury Prevention](#);" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

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 27(13) Studying Firearm Injuries adopted.

December 2013, assigned Referred Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs to the Research Committee to provide a recommendation to the Board of Directors regarding further action on the resolution.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

Resolution 22(96) National Center for Injury Prevention and Control adopted.

Resolution 47(94) Firearm Classification referred to the Board of Directors.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted.

Amended Resolution 18(93) Firearm Injury Reporting System adopted.

Amended Resolution 17(93) Firearm Injury Prevention adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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



RESOLUTION: 35(23)
SUBMITTED BY: District of Columbia Chapter
SUBJECT: Declaring Firearm Violence a Public Health Crisis

PURPOSE: Declare firearm violence a public health crisis in the United States.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives related to firearms and communications to members and the public. Potential unbudgeted costs depending on other ways ACEP might address the issue, possibly as much as \$100,000 depending on the scope of the campaign.

1 WHEREAS, Emergency physicians have the privilege of working on the front lines of health crises; and

2
3 WHEREAS, Emergency physicians have the responsibility to care for victims of firearms violence in our
4 communities; and

5
6 WHEREAS, Firearm violence is an [increasing threat](#) to our public health; and

7
8 WHEREAS, Each day, [327 people are shot](#) in the United States; and

9
10 WHEREAS, Firearm violence is the [number one cause of death](#) for children and teens in the United States;
11 and

12
13 WHEREAS, ACEP previously [stated](#) that emergency physicians have a public health responsibility to address
14 the effects of firearm violence in our communities; and

15
16 WHEREAS, The "[Firearm Safety and Injury Prevention](#)" policy statement, last revised in 2019, upholds
17 ongoing support for research, new legislation and regulatory actions, community engagement, addressing social
18 determinants of health in reducing firearm violence, increased mental health resources, and more; and

19
20 WHEREAS, ACEP [believes](#) that engaging in firearm violence discussions from the purview of public health
21 and safety is our professional and ethical obligation for our communities; and

22
23 WHEREAS, Other national medical groups (including the, [American Academy of Family Physicians](#),
24 [American Academy of Pediatrics](#), [American College of Surgeons](#), [American Medical Association](#), [American](#)
25 [Psychological Association](#), [Association of American Medical Colleges](#), [American Public Health Association](#)) have
26 declared firearm violence to be a public health crisis; therefore be it

27
28 RESOLVED, That ACEP declare firearm violence to be a public health crisis in the United States.

Background

The resolution calls for the College to declare firearm violence a public health crisis in the United States. While the resolution does not specify how ACEP might approach the issue, the authors cite similar examples where other physician and medical associations have declared firearm violence a public health crisis using methods such as a white paper, policy statement, letter to Congress or media campaign.

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements, including the policy statement “[Firearm Safety and Injury Prevention](#)” (as also cited in the resolution).

The first paragraph of the policy states:

“The American College of Emergency Physicians condemns the current rates of injury and death from firearms in the United States. Firearm injury is a leading cause of death among young Americans, is the most common means of suicide death among all Americans, and has psychological and financial ramifications for victims, their families, and the healthcare system. As emergency physicians, we witness the toll firearm injuries take on our patients each day across the United States. We support the need for funding, research, and protocols *to help address this public health issue* [emphasis added].”

While the policy does not emphatically state firearm violence is a public health crisis, it does call attention to firearm violence as a public health issue and also identifies comprehensive legislative, regulatory, public health, and health care efforts that ACEP supports. The policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The resolution was assigned to the PHIPC. The committee drafted a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process.

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.”

Recently, ACEP federal advocacy staff recently worked closely with Representative Robin Kelly (D-IL), Vice Chair of the House Gun Violence Prevention Task Force, to help develop and substantially inform the “[Gun Violence as a Public Health Emergency Act](#)” (H.R. 5010). Essentially all the information and suggestions provided by ACEP staff and ACEP member experts on the topic were included in the product ultimately introduced in the House of Representatives on July 27, 2023. The legislation calls for the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention to publish data on national firearm deaths and injuries, disaggregated by age, sex, gender, location, type of violence, and type of firearm; information on the types of programs used to respond to and reduce gun violence and their effectiveness; and, data on federal funding and the frequency of research relating to gun violence. ACEP’s legislative and regulatory priorities over the years have also included working with members of Congress to promote efforts that may prevent firearm-related injuries and deaths, reduce firearms-related violence, and support public and private initiatives to fund firearm safety and injury prevention research and support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

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 overall. 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. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.

- 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 representative will also serve.
- 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. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of \$61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. 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.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP Resolution 36(19) Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence Page 3 issuing public statements following a mass shooting event advocating for change consistent with the College's policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper "[Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention](#)" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention

programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

ACEP has supported the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), including AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants.

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 firearms and communications to members and the public. Potential unbudgeted costs depending on other ways ACEP might address the issue, possibly as much as \$100,000 depending on the scope of the campaign.

Prior Council Action

The Council has discussed and adopted many resolutions about firearms, although none have focused solely on declaring firearms a public health crisis.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 ACEP Position Paper; and that ACEP support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

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 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 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "[Firearm Safety and Injury Prevention](#);" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved

October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

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.

January 2019, approved \$20,000 contribution to the American Federation for Firearm Injury Reduction in Medicine (AFFIRM).

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](#).”

Amended Resolution 11(93) Violence Free Society adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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



RESOLUTION: 36(23)

SUBMITTED BY: California Chapter
Leslie Mukau, MD, FACEP
Valerie Norton, MD, FACEP
Bing Pao, MD, FACEP
Scott Pasichow, MD, MPH, FACEP
Katherine Staats, MD, FACEP
Niki Thran, MD, FACEP
Randall Young, MD, FACEP

SUBJECT: Mandatory Waiting Period for Firearm Purchases

PURPOSE: 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.

FISCAL IMPACT: Budgeted staff resources for ongoing federal advocacy initiatives related to firearms and budgeted committee and staff resources for revising policy statements. Unbudgeted resources would be needed to assist chapters in promoting legislation on mandatory waiting periods and would require diverting current budgeted staff resources from other state advocacy work to support this effort.

1 WHEREAS, More than 48,000 people died in firearm-related incidents in 2021 in the United States, a 23%
2 increase compared to 2019; and
3

4 WHEREAS, Studies show that a mandatory waiting period prior to firearm purchases diminishes the
5 incidence of firearm-related injuries and deaths; and
6

7 WHEREAS, The American Medical Association supports a waiting period of at least one week before
8 purchasing any form of firearm in the United States; and
9

10 WHEREAS, ACEP has an interest in reducing firearm-related injuries and deaths; therefore be it
11

12 RESOLVED, That ACEP advocate for a mandatory federal waiting period prior to firearm purchases; and
13 be it further
14

15 RESOLVED, That ACEP assist state chapters in promoting legislation on mandatory waiting periods at
16 the state level; and be it further
17

18 RESOLVED, That ACEP add language to its “[Firearm Safety and Injury Prevention](#)” policy statement
19 supporting mandatory waiting periods prior to firearm purchases.

References

1. Luca M, Malhotra D, Poliquin C., “[Handgun waiting periods reduce gun deaths.](#)” Proc Natl Acad Sci U S A. 2017;114(46):12162-12165.
2. AMA Policy: Waiting Period Before Gun Purchase H-145.992: <https://policysearch.ama-assn.org/policyfinder/detail/waiting%20period?uri=%2FAMADoc%2FHOD.xml-0-549.xml>
3. <https://www.pewresearch.org/short-reads/2023/04/26/what-the-data-says-about-gun-deaths-in-the-u-s/>

Background

The resolution calls for 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 its "[Firearm Safety and Injury Prevention](#)" policy statement supporting mandatory waiting periods prior to firearm purchases.

Advocates of mandatory waiting periods for firearms purchases cite evidence that mandatory waiting periods reduce firearms-related injuries and deaths, including suicides, by allowing a prospective buyer to "cool off" and prevent acting upon impulsive behaviors or emotions that may otherwise lead to harm of others or oneself. Several studies have found evidence that waiting periods reduce gun homicides, such as the [Luca, Malhotra, and Poliquin study](#) that found a 17 percent reduction in gun homicides based on changes in state-level policy since 1970. [Another study](#) of four handgun laws – waiting periods, universal background checks, gun locks, and open carrying regulations – found significantly lower firearm suicide rates. Analyses of multiple studies conducted by RAND's Gun Policy in America initiative have found moderate evidence that mandatory waiting periods [reduce total homicides](#), limited evidence that waiting periods may reduce firearm homicides, and limited evidence that waiting periods may [reduce total suicides](#) and moderate evidence that waiting periods may reduce firearms suicides.

Those opposed to mandatory waiting periods suggest that waiting periods are an "[unnecessary time tax](#)" on both purchasers and licensed firearms dealers after a federal background check has been carried out under the National Instant Criminal Background Check System (NICS). Additionally, advocates of more permissive firearms policies suggest that these waiting periods are unnecessary burdens that could put an individual who needs a firearm for protection at risk, and that an individual intent on committing a criminal act with a firearm is unlikely to purchase a firearm through legal means so waiting periods disproportionately affect law-abiding citizens.

There is currently no waiting period for firearms purchases at the federal level. Currently, 10 states and the District of Columbia have laws establishing waiting periods applicable to some types of firearms. The specifics of these laws vary by state, but below is a brief overview:

Waiting periods for all firearms purchases:

- California – 10 days
- Colorado – 3 days
- D.C. – 10 days
- Florida – 3 days or time required to complete background check, whichever is later
- Hawaii – 14 days
- Illinois – 72 hours
- Rhode Island – 7 days

Waiting periods for certain types of firearms purchases:

- Minnesota – 30 days. Applies to handguns and "semiautomatic military-style assault weapons" according to [statute](#). All or a portion of the waiting period may be waived by chief of police or sheriff under certain conditions.
- Washington – 10 days. Applies to semi-automatic rifles.

Waiting periods for handgun purchases only:

- Maryland – 7 days
- New Jersey – 7 days

From 1994 through 1998, the Brady Handgun Violence Prevention Act ([P.L. 103-159](#)) imposed a federal 5-day waiting period for handgun purchases until superseded by the implementation of NICS in 1998. NICS applies to all types of firearms, not just handguns, and requires all firearms manufacturers, dealers, and importers who hold a

Federal Firearms License (FFL) to submit a background check on all buyers before transferring a firearm (sales/transfers between private parties do not require background checks). The vast majority of NICS background checks are returned immediately ([85.30 percent in 2020, 87.98 percent in 2021](#)), with the remainder requiring additional information or investigation which the Federal Bureau of Investigation (FBI) has three days to complete. The FBI NICS Section targets an immediate determination rate of 90 percent. If a NICS request is not completed within three days, the FFL holder may proceed to complete the sale and transfer the firearm to an individual, though they are not required to – Walmart, for example, voluntarily chooses to not complete so-called “default proceed” sales.

The “default proceed” sale process is now referred to by some as the “Charleston loophole” as this is how the perpetrator of the 2015 mass shooting at the Emanuel AME Church in Charleston, SC, was able to acquire a firearm though he should have been prevented from purchasing one. Federal legislation to address this issue, the Enhanced Background Checks Act, has been introduced several times in Congress. This proposal would provide the FBI with additional time to complete a background check before a firearm sale is completed, and if a background check has not been completed within 10 days, the purchaser may request an escalated FBI review. This escalated review triggers a more intensive FBI investigation intended to resolve the case within an additional 10-business day period. If that additional 10-day period lapses, the FFL may proceed with the sale or transfer to the purchaser. This legislation passed the House of Representatives in both the 116th Congress and 117th Congress, but was not considered in the Senate. ACEP has and continues to support this legislation, in line with the current “Firearm Safety and Injury Prevention policy statement.”

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.”](#) Among the policy’s provisions is the directive that ACEP “support universal background checks for all firearm transactions, including private sales and transfers,” as well as “support adequate enforcement of existing laws and support new legislation that prevents high-risk and prohibited individuals from obtaining firearms.” The policy statement also states that ACEP supports public health and health care efforts that “promote access to effective, affordable, and sustainable mental health services for emergency department patients with acute mental illness for whom access to a firearm poses a real risk to life for themselves or others” and “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 current [“Firearm Safety and Injury Prevention”](#) policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The PHIPC developed a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process. If adopted, this resolution would be assigned to the PHIPC to review the policy statement during the 2023-24 committee year.

The policy statement [“Violence-Free Society”](#) also notes that “ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives.”

In 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 ~~overall~~. 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. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.
- 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 representative will also serve.
- 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. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of \$61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. 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.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP Resolution 36(19) Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence Page 3 issuing public statements following a mass shooting event advocating for change consistent with the College's policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper “[Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention](#)” on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

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 federal advocacy initiatives related to firearms and budgeted committee and staff resources for revising policy statements. Unbudgeted resources would be needed to assist chapters in promoting legislation on mandatory waiting periods and would require diverting current budgeted staff resources from other state advocacy work to support this effort.

Prior Council Action

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 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.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted. Support federal and state legislation to require 15-day waiting period for the sale, purchase, or transfer of any firearm to allow time for a background check on the individual and also support legislation mandating significant penalties for possession of a firearm while committing a crime.

Substitute Resolution 16(84) Ban on Handguns adopted. Deplored the loss of life and limb secondary to the improper use of handguns; supported legislation mandating significant penalties for possession of a handgun while committing a crime; support legislation mandating significant penalties for the illegal sale of handguns; support a waiting period for all prospective handgun buyers; supported successful completion of an education program on handgun safe for all prospective handgun buyers; support development of educational programs on the proper use of handguns for existing owners; support requiring screening of prospective handgun buyers for previous criminal records and mental health problems that have led to violent behavior.

Prior Board Action

October 2019, approved the revised policy statement “[Firearm Safety and Injury Prevention](#);” approved April 2013 with current title, replacing rescinded policy statement titled “Firearm Injury Prevention;” revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

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 11(93) Violence Free Society adopted.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted.

Substitute Resolution 16(84) Ban on Handguns adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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



RESOLUTION: 37(23)

SUBMITTED BY: Leslie Mukau, MD, FACEP
Valerie Norton, MD, FACEP
Bing Pao, MD, FACEP
Katherine Staats, MD, FACEP
Niki Thran, MD, FACEP
Randall Young, MD, FACEP
California Chapter

SUBJECT: Support for Child-Protective Safety Firearm Safety and Storage Systems

PURPOSE: Support efforts to improve firearm safety in the United States, including smart gun technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives related to firearms. Unbudgeted funds may be required if further action beyond advocacy is needed.

1 WHEREAS, Firearm-related fatalities are now the number one cause of death in the United States in children
2 and adolescents since 2020^{2,3,4}, with a disproportionate effect on children from communities of color⁵; and
3

4 WHEREAS, Firearm safety laws, including those that address child-protective firearm safety and storage
5 systems, have been associated with reduced firearm-related mortality¹; and
6

7 WHEREAS, Smart gun technology has the potential to reduce accidental firearm injuries and teenage suicide;
8 therefore be it
9

10 RESOLVED, That ACEP support efforts to improve firearm safety in the United States, including smart gun
11 technology, while respecting responsible firearm ownership; and be it further
12

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

References

1. <https://www.pewresearch.org/short-reads/2023/04/26/what-the-data-says-about-gun-deaths-in-the-u-s/>, accessed June 17, 2023.
2. Stevens J, Pickett K, Reppucci ML, Nolan M, Moulton SL. National trends in pediatric firearm and automobile fatalities. *J Pediatr Surg.* 2023 Jan;58(1):130-135.
3. Kaufman EJ, Richmond TS, Hoskins K. Youth Firearm Injury: A Review for Pediatric Critical Care Clinicians. *Crit Care Clin.* 2023 Apr;39(2):357-371.
4. Goldstick JE, Cunningham RM, Carter PM. Current causes of death in children and adolescents in the United States. *NEJM.* 2022;386(20):1955-6.
5. Lanfear CC, Bucci R, Kirk DS, Sampson RJ. Inequalities in Exposure to Firearm Violence by Race, Sex, and Birth Cohort From Childhood to Age 40 Years, 1995-2021. *JAMA Netw Open.* 2023 May 1;6(5):e2312465.

Background

The resolution directs the College to support efforts to improve firearm safety in the United States, including smart gun technology, while respecting responsible firearm ownership, and to promote child-protective firearm safety and storage systems.

Smart gun technology only allows a firearm to be operated by an authorized user. These systems may include fingerprint or other biometric recognition, radiofrequency identification (RFID) tags and readers, other proximity sensors or detectors, magnetic rings, or mechanical locks. While such technology has been developed, tested, and theoretically feasible for commercial firearms sales in the U.S. for decades, only recently (July 2023) has a manufacturer released a smart gun to the market. Reliability testing failures have thus far prevented military or police acceptance. Such technology has been promoted by advocates of greater firearms safety and injury prevention as a safety feature that could help prevent unauthorized use, reducing both unintentional and intentional injuries (especially for children and teenagers), preventing accidental discharges, discouraging firearms theft and illicit sales. Others, while not necessarily opposed to the technology itself, have expressed concerns that smart gun technology may lead to legal mandates for all firearms to be equipped with these systems. Advocates for more permissive firearms laws and regulations also state concerns that smart gun technology may fail or be unreliable in critical moments, such as when an individual is under duress; that systems may be defeated or manipulated by bad actors; or, that smart gun systems using wireless/RFID technology could be monitored by criminals or law enforcement to detect who is carrying a firearm in a given area (thus hindering the purpose of concealed carry). Additionally, smart guns are typically significantly more expensive than their more traditional counterparts, limiting potential uptake, and retrofitting the technology to existing firearms is not feasible.

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. According to the American Academy of Pediatrics (AAP), 16 states and the District of Columbia have laws requiring firearms to be stored locked, two states have laws requiring trigger locks to accompany firearm purchases, and nine states requiring firearms to be stored locked and trigger locks to accompany purchases. Some safe storage laws do not require all firearms to be stored locked, but are limited to child access prevention. Virginia law, for example, prohibits any individual from “recklessly” leaving a loaded, unsecured firearm in such a manner as to endanger the life or limb of any child under the age of fourteen, and also prohibits any individual from knowingly authorizing a child under the age of twelve to use a firearm unless under the direct supervision of an adult. 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.” Those opposed to safe storage mandates, note concerns that restrictive laws prevent quick, timely access to firearms for self-defense, and further that the U.S. Supreme Court already ruled in *District of Columbia v. Heller* (2008) that D.C.’s requirement that rifles must be unloaded or disassembled or bound by a trigger lock violated the Second Amendment.

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.” Among the policy’s provisions is the directive that ACEP “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 current “Firearm Safety and Injury Prevention” policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of

research and legislation. The PHIPC developed a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process.

The policy statement “[Violence-Free Society](#)” also notes that “ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives.”

In 2018, the Public Health and Injury Prevention Committee developed the information paper “[Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention](#)” that provides information on prevention of firearm injuries, including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs, and listings of community-based firearm violence prevention programs by state.

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 overall. 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. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.
- 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 representative will also serve.
- 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. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of \$61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. 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.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP Resolution 36(19) Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence Page 3 issuing public statements following a mass shooting event advocating for change consistent with the College's policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper “[Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention](#)” on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

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 firearms. Unbudgeted funds may be required if further action beyond advocacy is needed.

Prior Council Action

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

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 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for funding for research on firearm injury prevention and to work with the AMA and other medical societies to achieve this common cause.

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.

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 43(94) Support of National Safety Regulations for Firearms adopted. Supported national safety regulations for firearms.

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 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

October 2019, approved the revised policy statement "[Firearm Safety and Injury Prevention](#);" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

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 27(13) Studying Firearm Injuries adopted.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted.

Amended Resolution 17(93) Firearm Injury Prevention adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

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



RESOLUTION: 38(23)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals

PURPOSE: 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.

FISCAL IMPACT: Budgeted staff resources for continuing current advocacy initiatives.

1 WHEREAS, Critical access hospitals and rural emergency hospitals play a crucial role in providing
2 emergency care in geographically underserved areas, often operating with limited resources and facing unique
3 challenges; and

4
5 WHEREAS, These rural healthcare facilities require staffing by board certified emergency physicians who
6 possess the necessary skills and expertise to treat a wide range of injuries, illnesses, and perform interventions,
7 including resuscitative procedures and trauma stabilization across all age groups; and

8
9 WHEREAS, Insufficient reimbursement for professional services in rural emergency departments has led to
10 financial constraints, forcing these departments to rely on inadequately trained personnel, such as nurse practitioners
11 and physicians assistants, without the presence of a board certified emergency physician on site; and

12
13 WHEREAS, Section 125 of the Consolidated Appropriations Act of 2021 established the Rural Emergency
14 Hospital (REH) as a new Medicare provider type, allowing struggling rural hospitals to continue operating with
15 outpatient and emergency services to preserve access to essential healthcare services in underserved areas; and

16
17 WHEREAS, Under the act, REHs have the opportunity to receive enhanced payment upon meeting certain
18 requirements, recognizing the additional challenges and resource limitations faced by these health care facilities;
19 therefore be it

20
21 RESOLVED, That ACEP advocate for sufficient reimbursement for emergency physician services in critical
22 access hospitals and rural emergency hospitals to ensure the availability of board certified emergency physicians who
23 possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing
24 the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient
25 safety, and supporting the sustainability of health care services in rural communities.

Background

The resolution calls 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.

With rural EDs representing 53% of all hospitals in the U.S. and 24% of total ED patient volume the care provided at these sites significantly affects the overall health of the U.S. population and, as such, demands the attention of our organization.

To increase access to emergency services in rural areas, the implementation of the REH designation under Medicare was included in the Consolidated Appropriations Act 2021 (Public Law 116-260) passed by Congress in late December 2020 and would allow critical access hospitals and small rural hospitals (with fewer than 50 beds) to convert to an REH beginning January 1, 2023. Once established, an REH will not provide any inpatient services, but must be able to provide 24/7 coverage for emergency services. They must also meet other requirements, including, but not limited to, having transfer agreements in place with a level I or II trauma center; adhering to quality measurement reporting requirements to be set by CMS; and following new emergency department conditions of participation (COPs). REHs will receive a five percent reimbursement bump for facility payments that hospitals traditionally receive for outpatient services under the Medicare OPPS and will receive an additional facility payment on top of that. However, while this new provider designation provides higher facility payments for REHs, emergency physicians will not receive higher payments under the Medicare Physician Fee Schedule (PFS) for providing services in an REH. CMS is currently in the process of writing the regulations and processing comments on the new designation that will be included in the CY2023 OPPS rule.

ACEP worked with Congress on the legislative language that was included in the initial Consolidated Appropriations Act and was proactive in reaching out to CMS to help construct various REH requirements. In June 2021, ACEP specifically requested that although REHs can legally be staffed by non-physician practitioners, we strongly believe that all care provided in REHs should be supervised by a board-certified emergency physician, even remotely via telehealth. ACEP also had a Congressional meeting on this before any regulations were released. ACEP submitted comprehensive response on proposed regulations establishing conditions of participation for REHs that were released in July 2022. ACEP also submitted a joint response to the regulation with the American Academy of Family Physicians focusing on the issue of scope of practice and the importance of having physician-led teams provide the care that is delivered in REHs. We strongly recommended that physicians should supervise all care delivered by non-physician practitioners in REHs. When possible, board-certified emergency physicians should conduct that supervision, but we understand that, due to workforce issues, that is not always possible. When a board-certified emergency physician is not available, it is still critical that physicians experienced and/or trained in emergency medicine (such as family physicians) oversee care being delivered by non-physician practitioners in REHs.

ACEP has also advocated for increased reimbursement for clinicians, including emergency physicians, that may work in rural emergency hospitals (REHs) once they have been established. To incentivize physicians and other clinicians to work in rural areas and appropriately staff REHs, ACEP requested in our official [response](#) to the Calendar Year (CY) 2023 OPPS proposed rule that the Centers for Medicare & Medicaid Services (CMS) consider creating an add-on code or modifier under the Medicare Physician Fee Schedule (PFS) that clinicians could append to claims for services delivered in REHs. CMS could consider setting the value of this add-on code or modifier at five percent of the PFS rate for each code that is billed – consistent with the additional OPPS payment that the statute provides. In other words, although the statute provides an additional payment for facilities, ACEP argued that there must also be a commensurate payment for clinicians under the PFS in order for REHs to have the resources and staff necessary to be a viable option for patients who need emergency treatment or other services in rural areas.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas called for ACEP to 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. Whereas global budgeting models have focused on the hospital/facility side of reimbursement, not on professional physician fee reimbursement that is still largely dependent on patient volumes or subsidies, this resolution proposed a global budgeting model specifically for professional physician fee reimbursement could address this gap, decoupling emergency care from more traditional volume-dependent payment, helping incentivize and maintaining financial viability of coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians. Some in favor of this

approach propose that in such a system, emergency physicians would be paid at a market-determined fixed rate, whether employed directly by a hospital under a global physician budget or employed by a practice management organization that contracts directly with the facility. Proponents of this model suggest that this would help eliminate the challenges of balancing high vs. low reimbursed visits relative to the resources expended, would help guarantee 24/7/365 coverage of rural EDs, and would also help provide a financial cushion to provide for surge capacity. Some of the key considerations noted by proponents and observers alike are the need for a well-defined catchment area or the ability to identify an appropriate reference population needed to determine a global budget, as well as if the service area can provide enough patient volume to sustain the model. Some have also noted that given the growth of new value-based payment pathways, rural hospitals may be able to adopt other payment mechanisms (e.g., managed care programs, accountable care organizations, etc.) that are easier to implement while achieving the same ultimate results in care delivery transformation. Another potential challenge may be the willingness for payers to participate in an all-payer global budgeting model and other issues posed by longstanding conflict between hospitals/systems and payers.

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, conducted by Ed Salsberg, PhD, at George Washington showed that few, if any, of those who answered the survey took jobs in the rural area, 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.

In May 2018, ACEP met with the Centers for Medicare & Medicaid Services (CMS) to discuss innovative payment approaches that would improve access to care in rural areas. ACEP staff provided an overview of a data analysis ACEP prepared on Medicare ED utilization in rural areas, and discussed how ACEP's alternative payment model, the Acute Unscheduled Care Model (AUCM), could be implemented in these areas. Since that meeting, ACEP's federal affairs staff have continued to follow up with CMS and provide additional information to help inform the ongoing work in this area. CMS has not yet approved the AUCM model for use.

ACEP's current legislative and regulatory priorities for the First 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.
- Monitor the willingness of critical access hospitals and rural hospitals to convert to Rural Emergency Hospitals, and develop policy suggestions that would make this a more attractive option.
- Develop and propose federal legislation to address unique challenges for the current and future EM workforce, with special consideration for solutions to promote access to board-certified EPs in rural and underserved communities.
- Support student loan forgiveness for physicians choosing to practice EM in rural areas.

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 staff resources for continuing current advocacy initiatives.

Prior Council Action

The Council has discussed and adopted many resolutions regarding rural emergency care. The following resolutions are specific to advocating for sufficient reimbursement for emergency physician services in critical access hospitals and rural emergency hospitals and to ensure the availability of board certified emergency physicians in these underserved areas.

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 resolves adopted and last three resolves 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.

Prior Board Action

February 2023, approved the legislative and regulatory priorities for the First Session of the 118th Congress that include several initiatives related to rural emergency care.

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.”

January 2022, approved the legislative and regulatory priorities for the Second Session of the 117th Congress that included several initiatives related to rural emergency care.

Resolution 35(21) Preserving Care in Rural Critical Access Hospitals and Rural Emergency Hospitals first two resolves adopted.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas adopted.

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

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.

Background Information Prepared by: David McKenzie
Reimbursement Director

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



RESOLUTION: 39(23)

SUBMITTED BY: Bing Pao, MD, FACEP
Thomas Sugarman, MD, FACEP
California Chapter

SUBJECT: Medicaid Reimbursement for Emergency Services

PURPOSE: Advocate at the federal and state level for Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates and submit a resolution to the AMA to advocate for reimbursing emergency physicians at rates equivalent to or above Medicare rates.

FISCAL IMPACT: Budgeted staff resources for ongoing federal and state advocacy initiatives.

1 WHEREAS, EMTALA requires emergency departments to provide care to any patient that seeks emergency
2 service; and

3
4 WHEREAS, Emergency departments must provide care even if a patient is uninsured and can't afford to pay
5 for emergency medical care; and

6
7 WHEREAS, Emergency physicians must accept Medicare and Medicaid payments even if the reimbursement
8 is below the cost of care¹; and

9
10 WHEREAS, Emergency departments are not reimbursed for providing standby capacity; and

11
12 WHEREAS; More than 150 rural hospitals nationwide closed between 2005 and 2019 mainly because of
13 financial difficulties²; and

14
15 WHEREAS, The federal government reimbursed emergency providers at Medicare rates for uninsured covid
16 related care³; and

17
18 WHEREAS, Many states reimburse emergency providers at or above Medicare rates for Medicaid enrollees⁴;
19 and

20
21 WHEREAS, The No Surprises Act has allowed commercial plans to reduce payment for emergency
22 professional care and increase the financial burden for emergency providers to care for the uninsured and under-
23 insured; and

24
25 WHEREAS, Access to emergency care is being threatened because of the financial strain of adequately
26 staffing emergency departments; therefore be it

27
28 RESOLVED, That ACEP advocate at the federal level and support chapters in advocating at the state level for
29 Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates; and be it
30 further

31
32 RESOLVED, That ACEP submit a resolution to the American Medical Association to advocate for
33 reimbursing emergency physicians at rates equivalent to or above Medicare rates.

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Background

The resolution requests that ACEP advocate at the federal and state level for Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates and submit a resolution to the AMA to advocate for reimbursing emergency physicians at rates equivalent to or above Medicare rates.

Medicaid patients currently count for around 40% of the payer mix in many emergency departments. This is a significant increase from close to 20% 15 years ago before the original Patient Protection and Affordable Care Act (PPACA, also known as the Affordable Care Act or ACA) required all states to expand Medicaid eligibility and shifted much of the previously uninsured population to Medicaid coverage. The current percentage may start to decline with the unwinding of Medicaid expansion following the end of the public health emergency, although with a likely increase in the percentage of uninsured patients.

Historically, Medicaid payments are set by individual states based on statutory and budget constraints and make up the majority of state general fund spending. Each state is responsible for paying a percentage of their claims with the federal government picking up the other half or more of the cost of Medicaid. If a state runs out of the budget for Medicaid payments before the year is over, it may suspend payment in arrears until the next budget cycle, thereby starting the next year's budget already underfunded for new claims.

When Medicaid rates are very low in a state for primary care office visits, it tends to drive this vulnerable population to seek care in the emergency department where EMTALA mandates they receive appropriate care. All these factors place a heavy burden on the emergency department to provide quality care, usually at a payment rate lower than the cost it entails. The federal budget has little room for increased spending, so achieving Medicaid payment parity rates with Medicare will be a heavy lift.

ACEP has advocated at the state and federal level for parity between Medicaid and Medicare going back to at least the ACA in 2010. Individual state chapters have also advanced legislation to put Medicaid reimbursement on par with Medicare rates, with mixed success. Advocacy efforts have been geared toward Medicaid expansion in states that failed to expand Medicaid eligibility and funding for the most vulnerable populations following the implementation of the ACA.

The AMA has been a proponent of parity between Medicaid and Medicare rates since 2013 when they supported the *Ensuring Access to Primary Care for Women and Children Act* that would continue the current requirement that Medicaid pay at rates no lower than Medicare for services provided by family physicians, general internists, and pediatricians, as well for as ob-gyns who provide a significant volume of certain primary care services. More recently, the AMA House of Delegates has supported parity for additional services beyond primary care, however this has yet to become part of the AMA's policy objectives.

Over the years, ACEP has developed Medicaid [resources](#) for members and chapters in advocating for adequate and fair reimbursement policies at the state level. Resolution 40(22) Support for Medicaid Expansion directed ACEP to develop a policy statement in support of expanding Medicaid to the levels allowable by federal law and develop a toolkit to assist ACEP chapters in efforts to advocate for Medicaid expansion in their states. This resolution was assigned to the State Legislative/Regulatory Committee and is in progress.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Fiscal Impact

Budgeted staff resources for ongoing federal and state advocacy initiatives.

Prior Council Action

The Council has discussed and adopted many resolutions regarding Medicaid, Medicare, and reimbursement, although, none that are specific to advocating at the federal and state level for Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates. The following resolutions are related to advocacy for Medicaid reimbursement rates.

Resolution 40(22) Support for Medicaid Expansion adopted. Directed ACEP to develop a policy statement in support of expanding Medicaid to the levels allowable by federal law and develop a toolkit to assist ACEP chapters in efforts to advocate for Medicaid expansion in their states.

Resolution 30(21) Unfair Health Plan Payment Policies adopted. Directed the College to develop model legislation and advocate for enactment at both the state and federal levels, prohibiting health plans from implementing new payment policies during the term of a provider's contracts, unless the new policy is required by new laws or regulations, as well as to advocate at the American Medical Association to pass legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

Amended Resolution 29(21) Downcoding adopted. Directed ACEP to develop strategies to assist chapters in identifying if downcoding is occurring in their state; work with the Centers for Medicare & Medicaid Services and private insurers to prevent the practice of downcoding in state Medicaid programs and by private insurers; and work with chapters to develop specific model legislative language to require transparency when insurance companies make changes to or require additional information for a claim.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted. The resolution directed ACEP to commission an independent study on the financial influence exerted by health insurers to leverage EMTALA mandates and withhold appropriate reimbursement and work with other allied organizations to better understand their impact on physician delivery of emergency care.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts and work to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in states that have the definition in law.

Prior Board Action

June 2023, approved the revised policy statement “[Fair Payment for Emergency Department Services](#);” revised and approved June 2022 and April 2016; originally approved April 2009.

June 2023, approved the revised policy statement “[Fair Reimbursement When Services are Mandated](#)” with the current title; revised and approved April 2017 titled “Fair Coverage when Services are Mandated;” reaffirmed April 2011 and September 2005; originally approved June 1999 titled “Compensation when Services are Mandated.”

Resolution 40(22) Support for Medicaid Expansion adopted.

Resolution 30(21) Unfair Health Plan Payment Policies adopted.

Amended Resolution 29(21) Downcoding adopted.

June 2021, approved an RFP to commission an independent study on the financial influence of health insurers on emergency physicians, with a focus on Emergency Medical Treatment and Labor Act (EMTALA)-related mandates and associated reimbursement issues affecting emergency physicians.

June 2021, approved filing the report of the EDPMA/ACEP Unfair Health Plan Payment Policy Task Force and utilizing the recommendations contained in the report as options for future implementation to address unfair health plan payment policies.

April 2021, approved the revised policy statement “[Compensation Arrangements for Emergency Physicians](#);” revised and approved April 2015, April 2002 and June 1997; reaffirmed October 2008 and April 1982; originally approved June 1988.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted.

October 2020, approved the revised policy statement “[Third-Party Payers and Emergency Medical Care](#);” revised and approved April 2014, June 2007, July 2000, and January 1999; approved March 1993 with title “Managed Health Care Plans and Emergency Care;” originally approved September 1987.

February 2020, approved prudent layperson model state legislation stipulating that “the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway.”

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

July 2019, reviewed the information paper “[Medicaid Cost savings Measures for Emergency Care](#).”

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

Background Information Prepared by: David McKenzie
Reimbursement Director

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



RESOLUTION: 40(23)

SUBMITTED BY: Dual Training Section
Geriatric Emergency Medicine Section
Observation Medicine Section
Maryland Chapter

SUBJECT: Support for Reimbursement of Geriatric ED Care Processes

PURPOSE: Directs the College to advocate for development of policies that will reimburse geriatric emergency care.

FISCAL IMPACT: Budgeted resources as part of ACEP's ongoing efforts to increase emergency physician and ED reimbursement.

1 WHEREAS, Older adults visit the emergency department (ED) at disproportionately higher rates compared to
2 younger adults, a trend anticipated to continue in the coming decades.¹ These older adults patients have increased
3 length of stays², use more resources³ and are more likely to be hospitalized compared to younger adults³; and
4

5 WHEREAS, The American College of Emergency Physicians (ACEP), has been instrumental in encouraging
6 the implementation of care processes in geriatric emergency medicine by initiating the Geriatric Emergency
7 Department Accreditation Program in 2018; and
8

9 WHEREAS, Over 420 EDs have received recognition from ACEP as an accredited geriatric ED; and
10

11 WHEREAS, Many of these care processes in place among accredited geriatric emergency departments have
12 been shown to decrease ED length of stay⁷, ED revisits^{4,5}, hospital admissions and re-admissions⁶ as well as improve
13 the patient experience^{5,7}; and
14

15 WHEREAS, These care processes include but are not limited to functional and cognitive screening, falls
16 evaluations, delirium management interventions, caregiver burden assessment, post-discharge follow up programs,
17 medication reconciliation procedures; and
18

19 WHEREAS, Implementation of such care processes requires additional education and training for staff as
20 well as incremental increases in resources to help ensure appropriate delivery; and
21

22 WHEREAS, Similar care processes in other health care settings such as transitional care management after an
23 inpatient stay is reimbursable; and
24

25 WHEREAS, Such geriatric specific ED care process and interventions are often not reimbursed through
26 traditional evaluation and management codes, thereby limiting more widespread adoption of such practices; therefore
27 be it
28

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

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Background

This resolution directs the College to 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.

ACEP has a longstanding interest in improving geriatric emergency care. The Geriatric Emergency Medicine Section works to:

- continuously improve ED training and cultural attitudes towards aging,
- advance better policies, protocols and guidelines for geriatric-centered care,
- improve evidence-based risk stratification
- inform members about geriatric-specific risk management issues, and
- advocate for availability of specialized equipment and adaptations to the ED environment of care to prevent further illness and injury.

ACEP has also developed the Geriatric Emergency Department Accreditation (GEDA) program. GEDA represents a major ongoing investment of time, energy and ACEP resources to promote the goals of quality of care for older people; enhanced staffing and education; geriatric-focused policies and protocols including transitions of care; quality improvement and metrics; and optimal preparation of the physical environment in the form of tiered accreditation levels and surveys of facilities. GEDA is informed by the “[Geriatric Emergency Department Guidelines](#)”, a joint policy statement between ACEP, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine.

Geriatric care processes for emergency departments (EDs) include but are not limited to functional and cognitive screening, falls evaluations, delirium management interventions, caregiver burden assessment, post-discharge follow up programs, and medication reconciliation procedures, all of which require education and training for staff and specific resources to incorporate into ED care. However, geriatric focused, ED-based care does not have a specific reimbursement payment mechanism for emergency departments that have implemented some or all of the recommended care processes.

For example, accurate medication reconciliation is a critical part of safe geriatric care. While there is a CPT code for medication reconciliation for outpatients (CPT 1111F, medication reconciliation after discharge), it does not apply to the ED and is therefore not a separately billable charge. There are also care transition codes (Transitional Care Management, CPT 99495 and 99496) that currently apply to transitioning from an inpatient to a community setting that could be adjusted to support care transition efforts and care-coordination from the ED to avoid inpatient hospitalization. Advocating for expansion of these CPT codes to apply to the ED setting could allow for reimbursement of geriatric care.

The Fiscal Year 2024 Inpatient Prospective Payment System proposed rule from the Centers for Medicare and Medicaid Services (CMS) included a request for comment on future inclusion of an attestation-based Geriatric Hospital structural measure in the Hospital Inpatient Quality Reporting Program (Hospital IQR). Data for selected

measures are used for paying a portion of hospitals based on the quality and efficiency of care. Further, CMS sought comment on the consideration of a geriatric care hospital designation that would recognize hospitals that have implemented best practices for geriatric care. ACEP's [response](#) to this comment solicitation supported the Geriatric Hospital measure and requested to work with CMS going forward in the process of designing a geriatric care hospital designation and advocacy work in support of this response is ongoing.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

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

Fiscal Impact

Budgeted resources as part of ACEP's ongoing efforts to increase emergency physician and ED reimbursement.

Prior Council Action

Substitute Resolution 38(14) Geriatric Emergency Department Accreditation referred to the Board of Directors. The resolution directed ACEP to work with regulatory agencies that are or may become involved in the development of accreditation requirements for geriatric emergency departments.

Prior Board Action

June 2023, approved including the “GEDA ED Boarding Care Processes and Outcomes” to the Geriatric Emergency Department Accreditation Program Criteria for Level 1 and Level 2 accreditation or re-accreditation.

September 2022, approved the revised Geriatric Emergency Department Accreditation Program Governance Charter; revised and approved June 2021, April 2020, September 2019, April 2019; initial governance charter approved April 2017.

September 2022, rescinded the policy statement “Quality Improvement Initiatives for the Care of Geriatric Patients in the Emergency Department;” originally approved April 2016. The creation of the Geriatric Emergency Department Accreditation Program eliminated the need for the policy statement.

June 2019, approved the revised Geriatric ED Accreditation Program Criteria.

January 2019, reaffirmed the “[Geriatric Emergency Department Guidelines](#);” originally approved October 2013.

January 2017, approved proceeding with the Geriatric Emergency Department Accreditation Program and the program criteria.

September 2016, Board authorized staff to proceed in developing a formal business plan and framework of a Geriatric ED Accreditation Program.

April 2015, approved the Emergency Medicine Practice Committee's recommendation to collaborate with regulatory agencies if they pursue development of accreditation requirements for geriatric EDs. The committee was assigned an objective for the 2015-16 committee year to develop a policy statement in support of quality improvement initiatives for the care of geriatric patients in the ED.

Background Information Prepared by: Erin Grossmann
Regulatory & External Affairs Manager

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



RESOLUTION: 41(23)
SUBMITTED BY: Michigan College of Emergency Physicians
SUBJECT: Use of Medical Coders in Payment Arbitration

PURPOSE: Advocate with CMS to require under the No Surprises Act that Independent Dispute Resolution Entities (IDREs) be required to use experienced medical coders in arbitration cases in which the code level assigned is in dispute.

FISCAL IMPACT: Budgeted staff resources for ongoing efforts related to the IDR process.

1 WHEREAS, The No Surprises Act permits Independent Dispute Resolution Entities (IDREs) to arbitrate
2 disputes between emergency physicians and patients' health insurance plans when there is a conflict between the
3 charges billed to the patient and the Qualifying Payment Amount (QPA) offered by the health plan; and
4

5 WHEREAS, Such disputes often result from downcoding by the health plan based on the plan's judgement
6 that the medical record provides insufficient documentation to justify a higher code; and
7

8 WHEREAS, Downcoding results in a QPA that is substantially less than the reimbursement requested; and
9

10 WHEREAS, To maintain their status as neutral third parties, IDREs should utilize a professional medical
11 billing coder to determine the correct billing code, based on the actual documentation submitted in the medical record;
12 and
13

14 WHEREAS, Centers for Medicare and Medicaid Services (CMS) has not committed to requiring IDREs to
15 use medical coders to adjudicate the correct billing code as part of the arbitration process; therefore be it
16

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

Background

This resolution requests ACEP to advocate for 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.

As part of the No Surprises Act an Independent Dispute Resolution (IDR) process was developed as a mechanism to settle disputes between payers and providers on individual claims about the appropriateness and fairness of the resulting payment allowed. Independent Dispute Resolution Entities (IDREs) are the entities that arbitrate these disputes. This resolution calls for ACEP to advocate that the IDREs must hire independent experienced coders as a neutral party to determine the appropriateness of codes assigned to the disputed claims.

Arbiters are not experts at coding and coders are not experts at arbitration. The current regulations do not disallow use of coders, but also do not mandate them in cases involving coding disputes, which creates ambiguity.

While considering allowing, or even encouraging an IDR to use an independent certified coding expert to assist in the analysis, one should be cognizant of the following considerations.

The IDR process does not authorize the IDR to consider the appropriateness of the coding level assigned to the claim(s) in question. The sole task of the IDR is to determine the appropriate payment to be made to the claim(s) in question. A determination that the claim(s) should have been adjudicated at a different level is outside of the IDR's scope of authority. The dispute is typically over the Qualified Payment Amount (QPA) rather than the code level assigned by the original coder who were hopefully trained experts in ED coding and billing rules.

The No Surprises Act final rule was issued in August 2022 and due to ACEP's advocacy, it implements the specific protections from downcoding ACEP asked for in its response to the IFRs. While there are some concerning provisions in the rule, it establishes for the first time a federally-recognized official definition of downcoding as well as a requirement that if a QPA is based on a downcoded service code or modifier, the plan must provide an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which modifiers were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded. The rule also notes that without information on what the QPA would have been had the claim not been downcoded, the provider may be at a disadvantage during open negotiation compared to the plan or issuer.

ACEP was instrumental in getting the Departments to require insurers who downcode to justify their reasoning and what the QPA would have been in the absence of downcoding. A Joint ACEP/EDPMA No Surprises Act Task Force has been meeting with CMS for years to advocate on our IDR concerns.

If an independent coding expert were somehow to be used in the IDR process, the fees charged by the independent coding expert would need to be paid by the IDR, which in turn would likely need to pass on those fees to the parties involved in the IDR potentially with the losing party having to pay the expense. These additional fees would further increase the burden of the high cost of the IDR process currently.

ACEP Advocacy & Practice Affairs staff were [successful in strengthening](#) existing prudent layperson protections with inclusion of new language in the first interim final rule (IFR) to implement the No Surprises Act. While this language focused predominantly on retroactive denials, it could help strengthen our opposition to downcoding broadly. ACEP Advocacy & Practice Affairs staff continued efforts to gain further protections from downcoding via regulatory channels by providing strong recommendations in comment letters on the first IFR, and in advance of the second IFR's release. The second IFR mainly focused on the federal independent dispute resolution process. ACEP, and most all physician organizations, expressed extreme concern regarding the qualified payment amount in the independent resolution process. ACEP issued a statement on October 1, 2021, opposing the IFR, and another statement on November 9, 2021, standing firmly with more than 150 bipartisan members of Congress calling on the Biden Administration to change the IFR. ACEP, the American Society of Anesthesiologists (ASA), and the American College of Radiology (ACR), filed a lawsuit against the federal government on December 22, 2021, charging that the IFR goes against the language of the No Surprises Act and will ultimately harm patients and access to care. Lawsuits were also filed by the American Medical Association and American Hospital Association, the Texas Medical Association, an individual in New York, an air ambulance association, and the Georgia College of Emergency Physicians. ACEP/ASA/ACR filed a motion for summary judgement in the lawsuit on February 9, 2022. A federal judge in Texas ruled on February 23, 2022, in the lawsuit filed by the Texas Medical Association, that the No Surprises Act implementation fails to follow the letter of the law, and that giving unequal weight to the Qualified Payment Amount (QPA) tilts the process unreasonably in favor of insurance companies. The court also determined that by skipping a customary notice and comment period while the law was being finalized, the government failed to follow its own well-established and transparent regulatory process. The federal government has appealed to the Texas court ruling and TMA lawsuits I through IV continue to work their way through the legal process.

ACEP and the Medical Association of Georgia were involved in litigation with Anthem/Blue Cross Blue Shield regarding retroactive denial of emergency department claims starting in July 2018. On October 22, 2020, the 11th Circuit Court ruled in favor of the appeal filed by ACEP and the Medical Association of Georgia. The case was remanded back to the Northern District Court in Georgia. The wording of the opinion was strongly supportive of ACEP's position. It was announced on March 9, 2022, that ACEP and the Medical Association of Georgia agreed to

withdraw the lawsuit in response to the discontinuation of Blue Cross Blue Shield Healthcare Plan (BCBSHP) of Georgia, Inc.'s "avoidable ER" program. The change was effective March 28, 2022.

ACEP continues to work in conjunction with EDPMA to analyze claims data, as well as developing a contract with an outside vendor to collect additional information about claims denials to get a better understanding of the scope of this problem. In addition to supplementing ACEP's advocacy actions with federal regulators, the results of these data collection efforts would also be helpful in ACEP's legislative efforts to persuade federal lawmakers to address this issue. The Federal Government Affairs Committee, the Reimbursement Committee, and the State Legislative/Regulatory Committee continue to track actions by insurers to deny and downgrade claims. ACEP has sent letters protesting actions by United Health Care and various Medicaid plans. ACEP met with several members of Congress in the Maryland delegation to highlight inappropriate denials by United's Optum for mental health care provided by emergency physicians in the ED in the state. ACEP has also been working with the VA chapter to resolve downcoding issues in the state with Medicaid managed care plans. In July 2022, ACEP sent [a joint letter](#) with the California Chapter to CCIIO and the entire California Congressional delegation to bring attention to payment denials by Anthem to small groups in the state. The letters have already prompted follow-up investigatory actions by several members of the delegation and the federal agencies.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Fiscal Impact

Budgeted staff resources for ongoing efforts related to the IDR process.

Prior Council Action

Amended Resolution 29(21) Downcoding adopted. Directed ACEP develop strategies to assist chapters in identifying if downcoding is occurring in their state; work with the Centers for Medicare & Medicaid Services and private insurers to prevent the practice of downcoding in state Medicaid programs and by private insurers; and work with chapters to develop specific model legislative language to require transparency when insurance companies make changes to or require additional information for a claim.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted. The resolution directed ACEP to commission an independent study on the financial influence exerted by health insurers to leverage EMTALA mandates and withhold appropriate reimbursement and work with other allied organizations to better understand their impact on physician delivery of emergency care.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts and work to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in states that have the definition in law.

Prior Board Action

June 2023, approved the revised policy statement “[Fair Payment for Emergency Department Services;](#)” revised and approved June 2022 and April 2016; originally approved April 2009.

June 2023, approved the revised policy statement “[Fair Reimbursement When Services are Mandated](#)” with the current title; revised and approved April 2017 titled “Fair Coverage When Services Are Mandated;” reaffirmed April 2011 and September 2005; revised and approved June 1999 titled “Compensation When Services Are Mandated;” originally approved September 1992.

June 2023, approved the revised policy statement “[Prior Authorization;](#)” revised and approved April 2017, April 2010, February 2003; originally approved October 1998.

Amended Resolution 29(21) Downcoding adopted.

June 2021, approved and RFP to commission an independent study on the financial influence of health insurers on emergency physicians, with a focus on Emergency Medical Treatment and Labor Act (EMTALA)-related mandates and associated reimbursement issues affecting emergency physicians.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted.

October 2020, approved the revised policy statement “[Third-Party Payers and Emergency Medical Care;](#)” revised and approved April 2014, June 2007, July 2000, and January 1999; approved March 1993 with title “Managed Health Care Plans and Emergency Care;” originally approved September 1987.

February 2020, approved prudent layperson model state legislation stipulating that “the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway.”

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

February 2018, reaffirmed the policy statement “[Assignment of Benefits;](#)” reaffirmed April 2012; originally approved April 2006.

July 2018, ACEP and the Medical Association of Georgia filed suit against Anthem’s Blue Cross Blue Shield of Georgia in federal court to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.

January 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25).

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

Background Information Prepared by: David McKenzie
Reimbursement Director

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



RESOLUTION: 42(23)
SUBMITTED BY: Indiana Chapter
SUBJECT: On-site Physician Staffing in Emergency Departments

PURPOSE: Work with chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments, and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

FISCAL IMPACT: Budgeted committee and staff resources for ongoing federal and state advocacy initiatives.

1 WHEREAS, ACEP believes that all patients who present to emergency departments (EDs) deserve to have
2 access to high quality, patient-centric, care delivered by emergency physician-led care teams; and
3

4 WHEREAS, ACEP defines an emergency physician as a physician who is certified (or eligible to be certified)
5 by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency
6 Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in emergency
7 medicine or pediatric emergency medicine, or who is eligible for active membership in the American College of
8 Emergency Physicians; and
9

10 WHEREAS, ACEP has a policy statement “Guidelines Regarding the Role of Physician Assistants and
11 Advanced Practice Registered Nurses in the Emergency Department” most recently approved March 2022; and
12

13 WHEREAS, Indiana ACEP has successfully passed legislation requiring on-site and on-duty physician
14 coverage at all emergency departments in the state; therefore be it
15

16 RESOLVED, That ACEP work with state chapters to encourage and support legislation promoting the
17 minimum requirement of on-site and on-duty physicians in all emergency departments; and be it further
18

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

Background

This resolution directs 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.

The State Legislative/Regulatory Committee (SLRC) was assigned an objective for the 2022-23 committee year to “Monitor legislative and regulatory efforts by nurse practitioners and physician assistants to expand their scope of practice in emergency medicine in a way that is inconsistent with ACEP policy and develop resources to assist state chapter advocacy on this issue.” The committee developed a toolkit after the successful passage of the Indiana legislation and used the language from that legislation ([HOUSE BILL No. 1199](#)) along with other model provisions, drafting notes and definitions, as well as current regulatory language to consider. The toolkit will be distributed to chapters in time for the 2023-24 state legislative season.

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."

ACEP has continually promoted 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.

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 for ongoing federal and state advocacy initiatives.

Prior Council Action

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

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 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
Director, State Government Relations

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



2023 Council Meeting Reference Committee Members

Reference Committee C – Emergency Medicine Practice Resolutions 43-55

Dan Freess, MD, FACEP (CT) – Chair
Angela P. Cornelius, MD, FACEP (TX)
Joshua R. Frank, MD, FACEP (WA)
Patrick B. Hinfey, MD, FACEP (NJ)
Jeffrey F. Linzer, Sr., MD, FACEP (GA)
Jennifer L. Savino, DO, FACEP (PA)

Jonathan Fisher, MD, FACEP
Travis Schulz, MLS, AHIP



RESOLUTION: 43(23)
SUBMITTED BY: Emergency Medicine Workforce Section
SUBJECT: Adopt Terminology “Unsupervised Practice of Medicine”

PURPOSE: 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.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement and continued advocacy initiatives.

1 WHEREAS, The American Association of Nurse Practitioners (AANP) is advocating for “Full practice
2 authority” to have independent practice without physician supervision or collaboration; and
3

4 WHEREAS, “Full practice authority” is a term created by nurse practitioner groups and has no legal or
5 regulatory definition; and
6

7 WHEREAS, ACEP’s NP/PA supervision policy statement recommends direct on-site supervision of non-
8 physician practitioners as the gold standard; and
9

10 WHEREAS, Having a standard terminology would help define our goal of supervised practice in the
11 emergency department; therefore be it
12

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

Background

This resolution calls for 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.

Currently, Nurse Practitioners (NP) can practice independently in 27 states and in Washington, DC as well in the Veterans Affairs System.¹ ACEP’s policy statement “[Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department](#)” states unequivocally that nurse practitioners (NPs) and physician assistants (PAs) should not practice independently in the ED²:

“Emergency Physician Supervision of PAs and NPs

ACEP believes:

- PAs and NPs should not perform independent, unsupervised care in the ED.
- The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician.”

A March 2022 [public opinion survey](#) from ACEP and Morning Consult shows that the vast majority of adults most trust a physician to lead their medical care, and many patients would be concerned if a physician was unavailable during their medical emergency.

- Eight-in-ten adults (79%) prefer a doctor/physician to lead their medical care while in the emergency department.
- Nine-in-ten adults 65 and over (91%) prefer a doctor/physician to lead their medical care in the emergency department
- After learning more about the training requirements for each of the medical professionals, adults still preferred a doctor/physician to lead their medical care in the emergency department.

A study from Stanford in October 2022 found that relying on 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. NPs were more likely than physicians to order x-rays, CT scans, and seek formal consults. These choices also impact patient outcomes. NPs practicing without physician supervision increased length of stay in the emergency department by 11% and raised 30-day preventable hospitalizations by 20%.^{4,5}

Adoption of the resolution would codify the terminology used to describe independent practice as unsupervised care and further support the need for supervision of NPs and PAs.

ACEP has developed resources that are available on the website to assist members in [fighting for physician-led care](#).

Background References

1. <https://www.aanp.org/advocacy/state/state-practice-environment>
2. <https://www.acep.org/patient-care/policy-statements/guidelines-regarding-the-role-of-physician-assistants-and-nurse-practitioners-in-the-emergency-department>
3. <https://www.emergencyphysicians.org/article/access/poll-adults-view-247-access-to-the-er-essential--prefer-care-led-by-physicians-in-a-crisis>
4. <https://www.acep.org/who-we-are/leadership/board-blog/board-blog-articles/november-4-2022-new-data-underscores-cost-and-health-outcome-concerns-with-independent-practice>
5. <https://www.nber.org/papers/w30608>

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 for development of a policy statement and continued advocacy initiatives.

Prior Council Action

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 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 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

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.”

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved 1) funds of up to \$50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP [definition of an emergency physician](#); 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

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.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

January 2019, reaffirmed the policy statement “[Providers of Unsupervised Emergency Department Care](#);” revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers in the ED.

June 2012, reviewed the information paper "Physician Assistants and Nurse Practitioners in Emergency Medicine."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted.

May 2001, recommendations of the Staffing Task Force presented to the Board.

September 1999, the MLP/EMS Task Force recommendations were presented to the Board. The Board approved dissemination of the results of the surveys.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce & Emergency Medicine Practice

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



RESOLUTION: 44(23)

SUBMITTED BY: Emily Ager, MD
Kimberly Chernoby, MD
Kelly Quinley, MD
Rachel Solnick, MD
Katherine Wegman, MD
American Association of Women Emergency Physicians Section

SUBJECT: Clinical Policy – Emergency Physicians’ Role in the Medication & Procedural Management of Early Pregnancy Loss

PURPOSE: Develop a new clinical policy with two critical questions related to the medication management and procedural management of early pregnancy loss.

FISCAL IMPACT: Budgeted committee and staff resources for the development of each new single-question clinical policy. The development of each new single-question clinical policy takes approximately one year and requires staff (0.8 FTE) and volunteer time, as well as the use of outside methodologists. Each new clinical policy would need to be added to the currently budgeted and prioritized list of new and existing policies.

1 WHEREAS, Approximately 900,000 emergency department visits per year in the U.S. are related to vaginal
2 bleeding and miscarriage in the first trimester¹, and as such, constitute a significant portion of emergency medicine
3 time and resources; and

4
5 WHEREAS, Up to 20% of pregnancies end in early pregnancy loss (miscarriage in the first trimester), and
6 compared with other ED patients, these patients are more likely to be younger, be Black or Hispanic, or be publicly
7 insured¹; and

8
9 WHEREAS, Pregnancy complications are the fifth most common reason women between ages 15-64 visit
10 Emergency Departments in the U.S.²; and

11
12 WHEREAS, As many as 84% of pregnant people visit an Emergency Department during pregnancy³; and

13
14 WHEREAS, Legal changes in the US resulting in reduced access to family planning and abortion services
15 will likely lead to increasing numbers of patients experiencing early pregnancy loss to seek care in an Emergency
16 Department⁴; and

17
18 WHEREAS, A February 2023 report found that 217 labor and delivery units have closed across the US since
19 2011⁵, meaning that more Emergency Physicians will provide care for patients experiencing early pregnancy loss
20 without the benefit of in-house Obstetricians and Gynecologists, and/or with the nearest obstetrical specialist located
21 outside of their facility and farther away; and

22
23 WHEREAS, Research shows patients experiencing early pregnancy loss who are given options for medical
24 management or procedural management versus expectant management alone are more satisfied than those not given
25 the option⁶; and

26
27 WHEREAS, Research shows that medication management of early pregnancy loss using mifepristone and
28 misoprostol compared to expectant management leads to higher rates of completed miscarriage and lower rates of
29 complications such as hemorrhage requiring blood transfusion⁷; and
30

31 WHEREAS, Research indicates that adopting procedural management with uterine aspiration in the
32 Emergency Department in lieu of admission and operating room-based uterine aspiration can reduce patient wait
33 times and hospital costs in an era when our healthcare system is financially strained⁸; and
34

35 WHEREAS, Research shows that procedural management of early pregnancy loss reduces the risk of
36 bleeding, re-admission, and need for subsequent procedure for failed therapy⁹; and
37

38 WHEREAS, The American College of Obstetricians & Gynecologists’ (ACOG) Practice Bulletin on Early
39 Pregnancy Loss states mifepristone and misoprostol should be used to medically manage miscarriage where
40 available¹⁰; and
41

42 WHEREAS, A recent change in FDA policy means that mifepristone can now be dispensed from retail
43 pharmacies like other medications prescribed from the Emergency Department¹¹; and
44

45 WHEREAS, Mifepristone and misoprostol are routinely prescribed in outpatient settings and via telemedicine
46 making them safe for prescription from the Emergency Department^{12, 13}; and
47

48 WHEREAS, Offering medication management to patients with first-trimester miscarriage can reduce
49 emergency bounceback visits for patients when compared to discharging patients with no treatments (expectant
50 management)¹⁴; and
51

52 WHEREAS, Pregnant people who present with hemorrhage or hemodynamic instability from early pregnancy
53 loss should be treated urgently, often with procedural uterine evacuation¹⁰; and
54

55 WHEREAS, As a primary approach, procedural uterine evacuation results in faster and more predictable
56 complete evacuation. The success of procedural uterine evacuation of early pregnancy loss approaches 99%¹⁶,
57 meaning these patients do not need more medications or another procedure; and are less likely to require unscheduled
58 medical care; and
59

60 WHEREAS, Procedural management (also known as uterine aspiration or suction curettage) is most
61 commonly performed in an office setting with a manual vacuum aspirator, under local anesthesia without the addition
62 of sedation^{17, 18}; and
63

64 WHEREAS, Training programs exist that teach miscarriage management to emergency physicians including
65 medication and procedural management, such as the Training, Education and Advocacy in Miscarriage Management
66 (TEAMM) project, a University of Washington-affiliated program that has assisted over 100 clinical and academic
67 sites, including emergency medicine clinicians, develop tailored interventions to integrate early pregnancy loss
68 management into their services¹⁹; and
69

70 WHEREAS, ACOG also hosts a training program where OBGYN specialists travel to Emergency
71 Departments and hospitals to help clinicians train in uterine aspiration and medical management of early pregnancy
72 loss²⁰; and
73

74 WHEREAS, Research shows that emergency medicine clinicians can incorporate manual uterine aspiration
75 for the management of early pregnancy loss into their clinical practice²¹; and
76

77 WHEREAS, In 2022, the ACEP Council adopted a resolution to encourage hospitals and emergency medicine
78 residency training programs to provide education, training, and resources outlining best clinical practices on early
79 pregnancy loss care²²; however, what educational expectations this entails in terms of medical versus procedural
80 management as of yet is unclear; and
81

82 WHEREAS, In 2022, the ACEP Council adopted a resolution that ACEP supports an individual’s ability to
83 access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental
84 health care²³; and
85

86 WHEREAS, ACEP clinical policies provide guidance on the clinical management of emergency department
87 patients and are not intended to represent a legal standard of care nor the only diagnostic and management options that
88 the emergency physician should consider and ACEP recognizes the importance of the individual physician’s judgment
89 and patient preferences; and

90
91 WHEREAS, Past ACEP clinical policies regarding early pregnancy have incorporated data from studies
92 conducted in care settings outside the emergency department²⁴; therefore be it

93
94 RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation
95 on the following clinical question: For patients experiencing early pregnancy loss, is medication management safe,
96 effective, and patient-centered compared to expectant management?; and be it further

97
98 RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation
99 on the following clinical question: For patients experiencing early pregnancy loss, is procedural management safe,
100 effective, and patient-centered compared to expectant management.

References

1. Benson LS, Magnusson SL, Gray KE, Quinley K, Kessler L, Callegari LS. Early pregnancy loss in the emergency department, 2006-2016. *J Am Coll Emerg Physicians Open*. 2021 Nov 5;2(6):e12549. doi: 10.1002/emp2.12549. PMID: 34766105; PMCID: PMC8571073.
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Background

This resolution calls for ACEP to develop a new clinical policy with two critical questions related to the medication management and procedural management of early pregnancy loss.

An estimated quarter of all women will experience the early loss of a pregnancy (EPL) in their lifetime (Ghosh 2021). Twenty percent of these losses will require some form of intervention to completely clear the uterus of retained tissue (Manning, 2023). Methods for managing a miscarriage include expectant management, medication management, and procedural management. Over 70% of obstetricians provide either procedural or medication interventions for miscarriage management (KFF, 2023). However, an [August 2023 report from the March of Dimes](#) demonstrates that almost one in ten counties in the United States do not have an obstetrics unit in their hospitals, leaving 5.6 million women in counties with limited maternity care, including EPL management. Each year, over 900,000 patients present to the emergency department with early pregnancy loss (EPL) (Benson, 2021), accounting for 2.7% of all ED visits for women ages 15-44 years.

ACEP’s Emergency Medicine Reproductive Health & Patient Safety Task Force developed the policy statement “[Access to Reproductive Health Care in the Emergency Department](#).” This policy states, in part, “ACEP encourages 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.”

The Clinical Policies Committee (CPC) defines a clinical policy as an evidence-based recommendation informed by a systematic review of critically appraised literature developed in accordance with accepted guideline development standards. The CPC can include studies that have not been conducted in the emergency department. Clinical policies are comprised of one or more critical questions. Critical questions addressed are drafted as PICO (Problem/Population, Intervention, Comparison, Outcome) questions. A review of the clinical policy development process was initiated in 2019. During the review, workgroups of the CPC assessed the development, methodology, and value of the policies to stakeholders. One of the obstacles identified to the timely updating of clinical policies was

the multiple question format. A multi-question clinical policy takes, on average, 18-24 months from initiation to completion. Each clinical policy is currently updated, on average, every 8.6 years. In April 2021, the CPC proposed trialing single-question clinical policies with the goal of reducing the time from initiation to completion to approximately 12 months. When fully implemented, the single-question format will enable the CPC to revise up to 10 clinical policies per year in addition to assigned policy statements and will allow the CPC to consider issues that are of the greatest importance to members while allowing faster turnaround time for clinical policy updates.

ACEP’s current [“Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy”](#) is based on two critical questions:

1. Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the ED with abdominal pain and/or vaginal bleeding and a β -hCG level below a discriminatory threshold?
2. In patients who have an indeterminate transvaginal ultrasound result, what is the diagnostic utility of β -hCG for predicting possible ectopic pregnancy?

This clinical policy was approved in 2016 and is currently in the process of being updated. The writing group has decided to proceed with updating the clinical policy to include a single critical question regarding the safety of imaging modalities in suspected pulmonary embolism. In accordance with CPC procedures, the critical questions called for in this resolution would require development of two new single-question clinical policies.

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 committee and staff resources for the development of each new single-question clinical policy. The development of each new single-question clinical policy takes approximately one year and requires staff (0.8 FTE) and volunteer time, as well as the use of outside methodologists. Each new clinical policy would need to be added to the currently budgeted and prioritized list of new and existing policies.

Prior Council Action

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted. Directed ACEP to develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide and advocate for universal access to emergency contraception in the emergency department.

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

June 2023, approved the policy statement “[Access to Reproductive Health Care in the Emergency Department.](#)”

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted.

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.

October 2016, approved the revised “[Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy](#)” and rescinded the 2012 clinical policy.

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



RESOLUTION: 45(23)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Social Emergency Medicine Section

SUBJECT: Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss

PURPOSE: 1) Create a task force with ABEM, CORD, and other relevant stakeholders to determine best approaches for preparing emergency medicine trainees for the management of early pregnancy loss, particularly in care settings where immediate obstetrical services may not be available; 2) Recognize the role of emergency physicians 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 no obstetrical services are available; and 3) Develop a policy statement acknowledging the emergency physician's role in the management of 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.

FISCAL IMPACT: Unbudgeted staff resources for establishing and supporting a task force and unbudgeted funds of approximately a minimum of \$10,000 for an in-person meeting for 10 people.

1 WHEREAS, Approximately 900,000 emergency visits per year in the U.S. are related to vaginal bleeding and
2 miscarriage in the first trimester,ⁱ and as such, constitute a significant portion of emergency medicine time and
3 resources; and
4

5 WHEREAS, Up to 20% of pregnancies end in early pregnancy loss (aka miscarriage in the first trimester),
6 and compared with other ED patients, these patients are more likely to be younger, be Black or Hispanic, or be
7 publicly insuredⁱⁱ; and
8

9 WHEREAS, Legal changes in the US resulting in reduced access to family planning and abortion services
10 will likely lead to increasing numbers of patients experiencing early pregnancy loss to seek care in an emergency
11 department;ⁱⁱⁱ; and
12

13 WHEREAS, A February 2023 report found that 217 labor and delivery units have closed across the US since
14 2011^{iv} with a disproportionate impact on rural areas. This reduction in accessibility to prenatal care forces pregnant
15 individuals to travel further for the care of emergent pregnancy complications, and it implies that in many areas of the
16 US emergency physicians may be the most well-equipped and most proximal physicians to care for a pregnancy-
17 related emergency; and
18

19 WHEREAS, Research shows patients given options for medical management or procedural management
20 versus expectant management alone are more satisfied than those not given the option;^v; and
21

22 WHEREAS, Research indicates that adopting uterine aspiration in the emergency department in lieu of
23 admission and operating room-based uterine aspiration can reduce patient wait times and hospital costs in an era when
24 our healthcare system is financially strained^{vi}; and
25

26 WHEREAS, The American College of Obstetricians & Gynecologists' Practice Bulletin on Early Pregnancy
27 Loss states mifepristone should be used to medically manage miscarriage where available,^{vii} and emergency
28 physicians with education and training would be capable of prescribing these medications; and

29 WHEREAS, Offering medication management to patients with first-trimester miscarriage can reduce
30 emergency bounceback visits for patients when compared to discharging patients with no treatments^{viii}; and
31

32 WHEREAS, Pregnant people who present with hemorrhage or hemodynamic instability from early pregnancy
33 loss should be treated urgently, often with procedural uterine evacuation^{ix}; and
34

35 WHEREAS, As a primary approach, procedural uterine evacuation results in faster and more predictable
36 complete evacuation^x. The success of procedural uterine evacuation of early pregnancy loss approaches 99%^{xi},
37 meaning these patients do not need more medications or another procedure; and are less likely to require unscheduled
38 medical care; and.
39

40 WHEREAS, Suction curettage is most commonly performed in an office setting with a manual vacuum
41 aspirator, under local anesthesia without the addition of sedation^{xii, xiii}; and
42

43 WHEREAS, Training programs exist that teach miscarriage management, such as the Training, Education and
44 Advocacy in Miscarriage Management (TEAMM) project, a University of Washington-affiliated program that has
45 assisted over 100 clinical and academic sites, including emergency medicine clinicians, develop tailored interventions
46 to integrate early pregnancy loss management into their services^{xiv}; and
47

48 WHEREAS, ACOG also hosts a training program where OBGYN specialists travel to emergency
49 departments and hospitals to help clinicians train in uterine aspiration and medical management of miscarriage^{xv}; and
50

51 WHEREAS, Research shows that emergency medicine physicians can incorporate manual uterine aspiration
52 for the management of miscarriages into their clinical practice^{xvi}; and
53

54 WHEREAS, Some EM residency programs are currently planning to start or have recently started training
55 their residents in providing manual uterine aspirations for patients with first-trimester miscarriage; and
56

57 WHEREAS, In 2022, ACEP Council passed a resolution to encourage hospitals and emergency medicine
58 residency training programs to provide education, training, and resources outlining best clinical practices on
59 miscarriage care.^{xvii} However, what educational expectations this entails in terms of medical versus procedural
60 management as of yet is unclear; and
61

62 WHEREAS, In 2022, ACEP Council passed a resolution that ACEP supports an individual's ability to access
63 the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health
64 care; therefore be it
65

66 RESOLVED, That ACEP, ABEM, CORD and other relevant stakeholders, form a task force to determine the
67 best approaches for preparing emergency medicine trainees for the management of early pregnancy loss, including
68 prescribing medication management (utilizing ACOG best practice approaches), and to provide or support provision
69 of manual uterine aspiration procedural management, such that future emergency physicians will be able respond to
70 early pregnancy loss emergencies in care settings where immediate obstetrical services may not be available; and be it
71 further
72

73 RESOLVED, That ACEP recognize the importance of the emergency physician's role in stabilizing and
74 treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural
75 management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no
76 obstetrical services available; and be it further
77

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

References

- ⁱ <https://onlinelibrary.wiley.com/doi/full/10.1002/emp2.12549>
- ⁱⁱ <https://onlinelibrary.wiley.com/doi/full/10.1002/emp2.12549>
- ⁱⁱⁱ <https://www.acepnow.com/article/the-emergency-department-after-the-fall-of-roe-are-you-prepared/>
- ^{iv} <https://www.statnews.com/2023/04/18/neonatal-care-closure-rural-labor-delivery-services/>
- ^v <https://pubmed.ncbi.nlm.nih.gov/36920395/>
- ^{vi} <https://pubmed.ncbi.nlm.nih.gov/7926246/>
- ^{vii} <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss>
- ^{viii} <https://pubmed.ncbi.nlm.nih.gov/22381604/>
- ^{ix} <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss>
- ^x Sotiriadis A , Makrydimas G , Papatheodorou S , Ioannidis JP . Expectant, medical, or surgical management of first-trimester miscarriage: a meta-analysis . *Obstet Gynecol* 2005 ; 105 : 1104 – 13 .
- ^{xi} Zhang J , Gilles JM , Barnhart K , Creinin MD , Westhoff C , Frederick MM . A comparison of medical management with misoprostol and surgical management for early pregnancy failure. National Institute of Child Health Human Development (NICHD) Management of Early Pregnancy Failure Trial . *N Engl J Med* 2005 ; 353 : 761 – 9 .
- ^{xii} Goldberg AB , Dean G , Kang MS , Youssof S , Darney PD . Manual versus electric vacuum aspiration for early first-trimester abortion: a controlled study of complication rates . *Obstet Gynecol* 2004 ; 103 : 101 – 7 .
- ^{xiii} Dalton VK , Harris L , Weisman CS , Guire K , Castleman L , Lebovic D . Patient preferences, satisfaction, and resource use in office evacuation of early pregnancy failure . *Obstet Gynecol* 2006 ; 108 : 103 – 10
- ^{xiv} <https://www.miscarriagemanagement.org/impact>
- ^{xv} <https://www.acog.org/programs/optimizing-care-for-pregnancy-loss/about-the-program>
- ^{xvi} <https://pubmed.ncbi.nlm.nih.gov/29248332/>
- ^{xvii} <https://www.acep.org/what-we-believe/actions-on-council-resolutions/council/action-on-2022-resolutions>

Background

This resolution calls for ACEP to: 1) Create a task force with ABEM, COD, and other relevant stakeholders to determine best approaches for preparing emergency medicine trainees for the management of early pregnancy loss, particularly in care settings where immediate obstetrical services may not be available; 2) Recognize the role of emergency physicians 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 no obstetrical services are available; and 3) Develop a policy statement acknowledging the emergency physician's role in the management of 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 issue of access to and provision of prophylaxis, contraception, abortion, and other reproductive health measures continues to be in a state of significant uncertainty as a result of the decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization*, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. Given wide variation in state regulation of abortion and reproductive health procedures there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine and the provision of emergency reproductive health care. Some advocates have expressed concerns that this uncertainty may also discourage physicians or hospitals from providing emergency reproductive health care out of an abundance of caution to avoid potential legal exposure. Additionally, there are worries that there may be additional civil and criminal penalties at the state level against health care physicians for assisting individuals in accessing emergency care for pregnancy loss, or aggressive enforcement of mandatory reporting laws that may put physicians in legal peril.

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.

A February 2023 [report](#) found that 217 labor and delivery units have closed across the nation since 2011 and additionally, the 2021 National Vital Statistics System reported a 38% increase in [maternal mortality rates](#). Given the closures of obstetric units and reproductive health clinics around the United States, limiting access to women's health services for the most disadvantaged, EDs will increasingly need to fill gaps in care. Therefore, provision of comprehensive and high-quality early pregnancy loss care in the ED setting will be one critical component to ensuring healthy outcomes and equitable care for women in the United States.

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).

On August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, submitted a [brief](#) in the U.S. District Court for the District of Idaho in support of in support of the U.S. Department of Justice's challenge to an Idaho law in *United States v. State of Idaho*. If applied to emergency medical care, the brief argued that Idaho Law would force physicians to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA – or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus [brief](#), this time in 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.

ACEP also appointed a cross-disciplinary Emergency Medicine Reproductive & Patient Safety Health Task Force to help identify and develop recommendations to address gaps in existing regulation or statute that could create clinical and legal barriers to how emergency physicians practice emergency medicine. The work of the task force has informed the creation of [ACEP Emergency Reproductive Health resource center](#) that includes updated federal and state regulations. The task force also developed the policy statement "[Access to Reproductive Health Care in the Emergency Department](#)" that was approved by the Board of Directors in June 2023.

[The Model of the Clinical Practice of Emergency Medicine](#) (EM Model) is designed for use as the core document for the specialty of emergency medicine and provides the foundation for developing medical school and residency curricula, certification examination specifications, continuing education objectives, research agendas, residency program review requirements, and other documents necessary for the definition, skills acquisition, assessment, and practice of the specialty. The 2022 EM Model includes topics in obstetrics and gynecology, including first trimester bleeding and abortion. However, the Dobbs decision will exacerbate existing disparities in maternal health access and delivery and will likely drive related pregnancy and miscarriage care to the ED. Emergency medicine education will necessarily expand to include contraception screening and provision, manual uterine evacuation, and the provision of medication abortions in the ED. There is precedent for emergency physicians performing these functions, but they need to be further developed and more widely incorporated into residency training. Additionally, it is increasingly important for emergency physicians to be well-versed in pregnancy, abortion, and miscarriage management and to collaborate with obstetrics and gynecology colleagues to provide compassionate, patient-centered care, minimize trauma, and prevent criminalization of patients beyond residency programs. This could include incorporation of online resources such as [Innovating Education in Reproductive Health](#), [Training in Early Abortion for Comprehensive Healthcare](#), and [Training, Education, & Advocacy in Miscarriage Management](#), as well as utilization of teaching and education for multi-modal formats such as simulations. The COVID-19 pandemic showed the utility of using virtual learning and programs could leverage the virtual environment and organize shared grand rounds or other conferences, where lecturers from different practice environments could interact.

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Fiscal Impact

Unbudgeted staff resources for establishing and supporting a task force and unbudgeted funds of approximately \$10,000 for an in-person meeting for 10 people.

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Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted. Directed ACEP to develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide and advocate for universal access to emergency contraception in the emergency department.

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

June 2023, approved the policy statement “[Access to Reproductive Health Care in the Emergency Department.](#)”

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted.

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.

October 2016, approved the revised “[Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy](#)” and rescinded the 2012 clinical policy.

June 2022, approved the policy statement “[Interference in the Physician-Patient Relationship](#)”

Background Information Prepared by: Sam Shahid, MBBS, MPH
Senior Manager, Practice Management

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



RESOLUTION: 46(23)

SUBMITTED BY: Emily Ager, MD
Kimberly Chernoby, MD
James Feldman, MD, FACEP
Kelly Quinley, MD
Rachel Solnick, MD
Katherine Wegman, MD
Social Emergency Medicine Section

SUBJECT: Consensus with ACOG on the Care of Pregnant Individuals with Substance Use Disorder

PURPOSE: 1) Endorse ACOG’s Committee Opinion No. 473: “Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist;” and 2) adopt a policy statement discouraging drug enforcement policies that deter women from seeking prenatal care, and advocates for the retraction of drug enforcement policies in states with legislation that punishes women for substance abuse during pregnancy.

FISCAL IMPACT: Budgeted committee and staff resources to review the ACOG policy statement and develop a new policy statement. Unbudgeted staff resources for advocacy specific to the new policy statement.

1 WHEREAS, Substance use disorder is a medical condition with evidence-based treatment modalities¹; and
2
3 WHEREAS, 25 states and the District of Columbia consider substance use during pregnancy to be child abuse
4 under civil child-welfare statutes, and 3 consider it grounds for civil commitment²; and
5
6 WHEREAS, Punitive drug enforcement policies that deter women from seeking prenatal care are contrary to
7 the welfare of both the mother and the fetus³; and
8
9 WHEREAS, Research has shown that incarceration or the threat of incarceration are ineffective in reducing
10 the incidence of alcohol or drug abuse during pregnancy^{4,5,6}; therefore be it
11
12 RESOLVED, That ACEP endorse the [American College of Obstetricians & Gynecologists Committee](#)
13 [Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist](#); and be it
14 further
15
16 RESOLVED, That ACEP issue a publicly available policy statement: “Drug enforcement policies that deter
17 women from seeking prenatal care are contrary to the welfare of the mother and the fetus. In states with legislation
18 that punishes women for substance abuse during pregnancy, ACEP advocates for the retraction of such policies.”

Resolution References

¹<https://www.samhsa.gov/medications-substance-use-disorders>
²<https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy>
³<https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy.pdf>
⁴Poland ML, Dombrowski MP, Ager JW, Sokol RJ. Punishing pregnant drug users: enhancing the flight from care. Drug Alcohol Depend 1993;31:199–203
⁵Chavkin W. Drug addiction and pregnancy: policy crossroads. Am J Public Health 1990;80:483–7
⁶Schempf AH, Strobino DM. Drug use and limited prenatal care: an examination of responsible barriers. Am J Obstet Gynecol 2009;200:412.e1–412.e10

Background

This resolution requests ACEP to endorse the American College of Obstetricians & Gynecologists Committee Opinion No. 473: “Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist” and adopt a policy statement that discourages drug enforcement policies that deter women from seeking prenatal care, and advocates for the retraction of drug enforcement policies in states with legislation that punishes women for substance abuse during pregnancy.

The first resolved asks that ACEP “endorse the American College of Obstetricians & Gynecologists Committee Opinion No. 473: “Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist.” The AGOG Committee Opinion No. 473: “[Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist](https://www.acog.org/-/media/project/acog/acogorg/clinical/list-of-titles/combined-list-of-titles.pdf)” was originally approved by the ACOG in 2011 and reaffirmed in 2022. All requests for endorsement must be reviewed and approved in accordance with ACEP’s established processes for endorsement of policy statements or documents from other organizations. ACOG has not requested endorsement from ACEP.

AGOG, as an organization produces seven types of documents from their board and committee work. These are defined on their website (<https://www.acog.org/-/media/project/acog/acogorg/clinical/list-of-titles/combined-list-of-titles.pdf>) as follows:

- **Clinical Consensus:** documents provide recommendations on focused clinical issues based on a careful examination of available scientific data, supplemented with expert opinion when the evidence is limited.
- **Committee Opinions:** provide ACOG committee assessments of emerging issues in obstetric and gynecologic practice.
- **Committee Statements:** address issues related to the practice of obstetrics and gynecology, such as ethics and access to care for underserved populations.
- **Clinical Practice Guidelines:** provide clinical management recommendations that are developed through assessment of the benefits and harms of care options based on a systematic review of the evidence.
- **Practice Bulletins:** are evidence-based documents that summarize current information on techniques and clinical management issues for the practice of obstetrics and gynecology.
- **Obstetric Care Consensus:** documents are developed jointly with the Society for Maternal-Fetal Medicine and include high-quality, consistent, and concise clinical recommendations for practicing obstetricians and maternal-fetal medicine subspecialists.
- **Technology Assessments:** provide an overview of technology in obstetrics and gynecology.

In addition to being highly specific to the role and responsibilities of the obstetrician-gynecologist, this particular document (Opinion # 473) has not met apparent higher levels of evidentiary and ACOG Board guidance present in Clinical Consensus documents, Committee Statements, Practice Bulletins, and Clinical Practice guidelines. Additionally, opinion #473 was issued out of a single ACOG committee (Committee on Health Care for Underserved Women) and does not align fully with a similar opinions from other ACOG committees.

The second resolved asks that ACEP “adopt a policy statement that discourages drug enforcement policies that deter women from seeking prenatal care, and advocates for the retraction of drug enforcement policies in states with legislation that punishes women for substance abuse during pregnancy”.

Since 1991, ACEP has supported the emergency physicians’ ability to protect the confidentiality of their patients’ personal health information during emergency medical treatment. The policy statements “[Code of Ethics for Emergency Physicians](#)” and “[Confidentiality of Patient Information](#)” are general in scope and not explicitly specific to drug enforcement policies that target or deter women seeking prenatal care contrary to the mother and fetus. However, the two policy statements do already address the difficult decisions emergency physicians may face in sharing patient information in response to requests by law enforcement, parents or guardians of minor children, public health officers, and the media. Current policy has been carefully crafted so that no particular patient population or condition is specifically included or excluded. It is therefore able to be applied to all patients presenting for emergency care regardless of variation in local, state, or federal laws as a guiding principle for the emergency physician.

The policy statement “[Law Enforcement Information Gathering in the Emergency Department](#)” is also general in scope and, while not explicitly specific to prenatal care, adds to ACEP’s position on physician-patient confidentiality by stating the following with regard to sharing personal health information with law enforcement:

“ACEP recognizes that law enforcement officials perform valuable functions in the emergency department (ED), and that one of these functions is investigation of criminal acts. As part of these investigations, law enforcement officials may request personal health information (PHI) gathered in the ED. Emergency physicians may honor these requests only under the following circumstances:

1. The patient consents to release of the requested PHI to law enforcement officers, or
2. Applicable laws or regulations mandate the reporting of the requested PHI to law enforcement officers, or
3. Law enforcement officers produce a subpoena or other court order requiring release of the requested PHI to them.”

This policy statement further states:

“Emergency physicians may conscientiously refuse to carry out or comply with legal orders that they deem violate emergency patient and privacy-related rights or jeopardize the welfare of their patients, recognizing that there may be legal or professional repercussions for these decisions.”

ACEP’s 2023 policy statement “[Access to Reproductive Care in the Emergency Department](#)” states:

“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.” The policy statement further states that “ACEP opposes the statutory provision of criminal penalties for any medically appropriate care provided in the emergency department.”

Mandatory notification and reporting policies for pregnant and postpartum women with substance use disorder vary by state and the state’s definition of child abuse and neglect.¹ Depending on the state’s policies and definition of child abuse and neglect, mandatory reporting can be either a facilitator or a barrier to the provision of substance use disorder treatment for pregnant and postpartum women. In states that consider substance use during pregnancy to be child abuse and possible grounds for civil commitment, pregnant women may not trust health care personnel to protect them from the social and legal consequences of their substance abuse and therefore be less forthcoming about their substance use.

Finally, 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.”

Background Reference

1. Bureau of Justice Assistant U.S. Department of Justice. *Substance Use and Pregnancy—Part 1 Current State Policies on Mandatory Reporting of Substance Use During Pregnancy, and Their Implications (March 2023)*. Available at <https://bja.ojp.gov/library/publications/substance-use-and-pregnancy-part-1-current-state-policies-mandatory-0>. Accessed August 10, 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 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 committee and staff resources to review the ACOG policy statement and develop a new policy statement.
Unbudgeted staff costs for advocacy specific to the new policy statement.

Prior Council Action

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 46(18) Law Enforcement Information Gathering in the ED Policy Statement. Called for the revision of the policy statement "Law Enforcement Information Gathering in the Emergency Department" to provide clarification and guidance on the ethical and legal obligations for searches, with or without a warrant, in investigations involving DUI.

Prior Board Action

June 2023, approved the policy statement "[Access to Reproductive Health Care in the Emergency Department.](#)"
June 2023, approved the revised policy statement "[Law Enforcement Information Gathering in the Emergency Department.](#)" revised and approved June 2017 and April 2003, originally approved September 2003. originally approved September 2003.

February 2023, approved the revised policy statement “[Confidentiality of Patient Information](#),” revised and approved January 2017 with the current title; reaffirmed October 2008, October 2002, and October 1998; originally approved January 1994 titled “Patient Confidentiality.”

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.

Juen 2022, approved the policy statement “[Interference in the Physician-Patient Relationship](#).”

Amended Resolution 46(18) “Law Enforcement Information Gathering in the ED Policy Statement” adopted.

January 2017, approved the revised policy statement “[Code of Ethics for Emergency Physicians](#),” 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.”

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

Kaeli Vandertulip, MSLS, MBA, AHIP
Clinical Practice Manager

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



RESOLUTION: 47(23)

SUBMITTED BY: Kevin Durgun MD
Adam Kruse, MD
Brooks Walsh MD
District of Columbia Chapter
Social Emergency Medicine Section
EMS-Prehospital Care Section

SUBJECT: Clarification of and Taking a Position Against Use of Excited Delirium Syndrome

PURPOSE: 1) Rescind approval of the 2009 White Paper Report on Excited Delirium Syndrome; 2) remove or update content and/or literature on website that relies on the outdated information regarding “excited delirium” or conditions with a similar definition as described in the 2009 paper; 3) disseminate the position that ACEP no longer endorses or approves 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 4) future ACEP work on the evaluation and management of in-hospital and out-of-hospital behavioral emergencies should utilize experts in EMS, neurology, emergency psychiatry, and health equity, and also consider the perspectives of community and advocacy leaders.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, ACEP approved, published, and circulated a 2009 White Paper Report with the consensus that
2 Excited Delirium Syndrome is a unique syndrome^{1, 2}; and
3

4 WHEREAS, The trade press³ and law enforcement organizations⁴⁻⁶ have cited the 2009 White Paper with the
5 characterization that ACEP recognized excited delirium syndrome as a medical condition without contest from ACEP
6 and that such citations persist today in first responder training and policy, and emergency physician expert court
7 testimony⁵⁻⁶; and
8

9 WHEREAS, Multiple medical organizations have rescinded support of, or explicitly stated positions against
10 the “condition or diagnosis of excited delirium” or excited delirium syndrome including the American Academy of
11 Emergency Medicine⁷, the National Association of Medical Examiners⁸, and the American College of Medical
12 Toxicology⁹; and
13

14 WHEREAS, ACEPs 2021 Task Force Report on Hyperactive Delirium Syndrome was “not to be construed as
15 an update or refutation of the 2009 paper” and does not formally disavow ACEP support of the 2009 White Paper on
16 Excited Delirium¹⁰; and
17

18 WHEREAS, The ACEP Board of Directors released a statement April 14, 2023 that states ACEP “does not
19 recognize the use of the term “excited delirium” and its use in clinical settings”¹¹, despite use of the term elsewhere on
20 the ACEP website, and with multiple references within the 2021 ACEP Task Force Report on Hyperactive
21 Delirium^{12,13}; therefore be it
22

23 RESOLVED, That ACEP clarify its position in writing, that the 2009 white paper is inaccurate and outdated,
24 and that while the ACEP Board of Directors had previously approved the 2009 White Paper Report on Excited
25 Delirium, it has withdrawn such approval; and be it further
26

27 RESOLVED, That ACEP and its sections either remove or update content and/or literature on its website that
28 relies on the outdated information regarding “excited delirium” or conditions with a similar definition as that

29 described in the 2009 White Paper Report on Excited Delirium; and be it further

30

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

34

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

Resolution References

1. 2008 Council Resolution 21: Excited Delirium
<https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=CF76C941-5383-EB11-A9C2-995F1D3A2B04>
2. DeBard ML, Adler J, Bozeman W, et al. American College of Emergency Physicians; 2009. Accessed June 2, 2023.
https://www.prisonlegalnews.org/media/publications/acep_report_on_excited_delirium_syndrome_sept_2009.pdf
3. ACEP Recognizes Excited Delirium Syndrome: Emergency Medicine News 10/2009
<https://journals.lww.com/em-news/Documents/ExDS-pdf-final.pdf>
4. IACP. Excited delirium syndrome. International Association of Chiefs of Police. November 1, 2015. Accessed June 2, 2023.
<https://www.theiacp.org/resources/resolution/excited-delirium-syndrome>.
5. Budhu J, O'Hare M, Saadi A. Brookings Institute; 2020. Accessed June 2, 2023. <https://www.brookings.edu/blog/how-we-rise/2020/08/10/how-excited-delirium-is-misused-to-justify-police-brutality/>.
6. Bhatia B de S, Naples-Mitchell J, Saadi A, Sherwin J. Physicians for Human Rights; 2022. Accessed June 2, 2023.
<https://phr.org/our-work/resources/excited-delirium/>.
7. AAEM. AAEM revised excited delirium statement. AAEM. June 1, 2023. Accessed June 2, 2023.
<https://www.aaem.org/statements/excited-delirium/>.
8. NAME. Excited Delirium Statement. National Association of Medical Examiners. March 2023. Accessed June 2, 2023.
<https://name.memberclicks.net/assets/docs/Excited%20Delirium%20Statement%203%20-%202023.pdf>.
9. ACMT. ACMT position statement on end the use of excited delirium. American College of Medical Toxicology. May 1, 2023. Accessed June 2, 2023. <https://www.acmt.net/news/acmt-position-statement-on-end-the-use-of-excited-delirium/>.
10. Hatten BW, Bonney C, Dunne RB, et al. American College of Emergency Physicians; 2021. Accessed June 2, 2023.
<https://www.acep.org/siteassets/new-pdfs/education/acep-task-force-report-on-hyperactive-delirium-final.pdf>.
11. ACEP. ACEP's position on hyperactive delirium. ACEP. April 14, 2023. Accessed May 3, 2023.
<https://www.acep.org/news/acep-newsroom-articles/aceps-position-on-hyperactive-delirium>.
12. Wong D. Excited Delirium for the TEMS provider. American College of Emergency Physicians Tactical And Law Enforcement Medicine Section. June 16, 2021. Accessed May 3, 2023.
<https://web.archive.org/web/20230306183449/https://www.acep.org/talem/newsroom/jun2021/excited-delirium-for-the-tems-provider/>.
13. Bradley K. Perspectives on excited delirium and ketamine. ACEP Tactical and law Enforcement Medicine Section. May 4, 2022. Accessed May 3, 2023. <https://www.acep.org/talem/newsroom/april-2022/perspectives-on-excited-delirium-and-ketamine>.

Background

This resolution requests that ACEP rescind approval of the 2009 White Paper Report on Excited Delirium Syndrome; remove or update content and/or literature on website that relies on the outdated information regarding “excited delirium” or conditions with a similar definition as described in the 2009 paper; disseminate the position that ACEP no longer endorses or approves 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 future ACEP work on the evaluation and management of in-hospital and out-of-hospital behavioral emergencies should utilize experts in EMS, neurology, emergency psychiatry, and health equity, and also consider the perspectives of community and advocacy leaders.

ACEP first addressed a form of altered mental status distinguished by disordered thinking and psychomotor agitation, often accompanied by a hyperadrenergic state, with the 2009 task force report titled “Excited Delirium Task Force White Paper Report on Excited Delirium Syndrome.”¹ The 20-member task force, consisted primarily of emergency physicians, provided a review of the history, epidemiology, clinical perspectives, potential pathophysiology,

diagnostic characteristics, differential diagnoses, and clinical treatment of what at the time was commonly referred to in the medical community as “excited delirium syndrome.”

Since 2009, ACEP has made efforts to study the existence of excited delirium syndrome as a disease entity and has worked to synthesize the most current information available regarding the recognition, evaluation, and management of patients presenting with the constellation of signs and symptoms associated with a syndrome not fitting a previously established medical condition. In 2020, in response to urgent questions surrounding the initial management of excited delirium raised by ACEP membership, the scientific community, community leaders, media, and governmental agencies, a 10-member task force of emergency physicians was appointed. This task force was complimented by a 17-member multi-specialty review panel with representatives from the American Academy of Clinical Toxicology, American College of Medical Toxicology, American Society of Anesthesiologists, American Society of Health-System Pharmacists, Emergency Nurses Association, National Association of EMS Physicians, National Association of Medical Examiners, and the Washington Advocates for Patient Safety.²

In June 2021, the ACEP Board of Directors approved the “[ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings](#).” Since the completion of the report, ACEP has used the term “hyperactive delirium with severe agitation” when referring to patients exhibiting agitated or combative behavior associated with a delirious state where the individual is not capable of interacting with other individuals or the environment.² The term “hyperactive delirium with severe agitation” is the term commonly used in recent research for delirium associated with increased neuromuscular activity, often accompanied by agitation and is more descriptive of the identified mental status and level of activity exhibited by patients of interest, and expands upon the term “hyperactive delirium.”²

ACEP’s website includes “[ACEP’s Position on Hyperactive Delirium](#).” The webpage states that “ACEP does not recognize the use of the term ‘excited delirium’ and its use in clinical settings.”³ The statement further states that any multidisciplinary work on hyperactive delirium should include emergency physicians as well as stakeholders with diverse backgrounds and expertise in EMS, toxicology, neurology, emergency psychiatry, law enforcement, and health equity.³ **The 2009 report no longer exists on the ACEP website and references to the term “excited delirium” only appear in reference to past resolutions, in citations appearing in external publications, or in the context of the 2021 report.**

Work is currently underway to summarize the 2021 “ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings” for submission to *JACEP Open* for publication consideration when finalized. A first draft of this summary is expected in early October 2023.

ACEP’s [Frontline podcast](#), hosted by Ryan Stanton, MD, FACEP, featured a discussion with ACEP Board member Jeff Goodloe, MD, FACEP, on July 11, 2022, about hyperactive delirium, the risk, management, and the evidence. ACEP also developed the online course “[Recognition and Management of Hyperactive Delirium in Emergency Settings](#)” that is available in the online learning center.

Background References

1. Debard ML, Adler J, Bozeman W, et al. Excited Delirium Task Force White Paper Report on Excited Delirium Syndrome. September 2009.
2. Hatten BW, Bonney C, Dunne RB, et al. ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings. 23 June 2021. Available at: www.acep.org/siteassets/new-pdfs/education/acep-task-force-report-on-hyperactive-delirium-final.pdf
3. American College of Emergency Physicians. ACEP’s Position on Hyperactive Delirium. 14 April 2023. Available at: <https://www.acep.org/news/acep-newsroom-articles/aceps-position-on-hyperactive-delirium>.

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

Amended Resolution 38(21) Prehospital Oversight and Management of Patients Experiencing Hyperactive Delirium with Severe Agitation adopted. Directed the College to advocate at the state and national levels to have ABEM/AOBEM-certified providers serve as the only and highest-level medical experts on the management of hyperactive delirium with severe agitation and partner with the NAEMSP on all issues pertaining to out-of-hospital management of hyperactive delirium with severe agitation.

Amended Resolution 21(08) Excited Delirium. Directed the College to establish a multidisciplinary group to study “excited delirium” and to make clinical recommendations.

Prior Board Action

Amended Resolution 38(21) Prehospital Oversight and Management of Patients Experiencing Hyperactive Delirium with Severe Agitation adopted.

June 2021, approved the “[ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings.](#)”

October 2009, approved the “White Paper Report on Excited Delirium Syndrome” and authorized its distribution to appropriate entities.

Amended Resolution 21(08) Excited Delirium adopted.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

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



RESOLUTION: 48(23)
SUBMITTED BY: New York Chapter
SUBJECT: Medical Malpractice Certificate of Merit

PURPOSE: Requests ACEP to recommend an affidavit of merit must be from a doctor who is board certified and licensed in the same specialty.

FISCAL IMPACT: Budgeted committee and staff resources to develop a new a policy statement or revise existing policy statements.

1 WHEREAS, In most states medical malpractice actions must be accompanied by a certificate from the plaintiff's
2 attorney, declaring that he or she consulted with a licensed physician who has determined there are adequate grounds for
3 pursuing such action; and
4

5 WHEREAS, The affidavit of merit mandate is intended to filter out frivolous claims before they are brought to
6 court^[a]; and
7

8 WHEREAS, Several states (New York, Ohio, and Minnesota, as examples) allow for certificates of merit to be
9 produced by any physician, regardless of his or her specialty or expertise; and
10

11 WHEREAS, Several states (New Jersey, Michigan, and Pennsylvania, as examples) currently require that a
12 certificate of merit be produced by a physician of the same specialty as the potential defendant; therefore be it
13

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

^[a]So currently a retired dermatologist could review a case against an emergency physician.

Background

This resolution requests ACEP to recommend an affidavit of merit must be from a doctor who is board certified and licensed in the same specialty.

ACEP has three current policy statements that address the medical background of expert witnesses:

[“Expert Witness Cross-Specialty Testimony for Standard of Care”](#)

Expert witness cross-specialty testimony occurs when a physician in one medical specialty provides an expert witness opinion regarding the standard of care in a different medical specialty. Since medical expert witness testimony has the potential to establish standards of care, the American College of Emergency Physicians believes that the standard of care for emergency medicine should only be established and attested to by emergency physicians.

[“Expert Witness Guidelines for the Specialty of Emergency Medicine”](#) (excerpted)

To qualify as an expert witness in the specialty of emergency medicine, a physician shall:

- Be currently licensed in a state, territory, or area constituting legal jurisdiction of the United States as a doctor of medicine or osteopathic medicine;
- Be certified by a recognized certifying body in emergency medicine;

[“Medical Practice Review and the Practice of Medicine”](#) (excerpted)

- Opinions regarding the appropriateness and quality of medical care, including but not limited to expert witness testimony, peer review, utilization review and decisions regarding insurance coverage involving care authorization or care denial, should constitute the practice of medicine as defined in state Medical Practice Acts and should be limited to currently licensed physicians whose practice is governed by the respective state’s Board of Medicine.
- Opinions, not related to internal group operations, regarding the appropriateness of medical care should be made by physicians who practice or have practiced in the same specialty, who possess an active, unrestricted license (preferably in the same state), and with at least comparable certification and expertise as the physician whose medical care is under review.

ACEP also has a current policy statement opposing affidavits of merit by an anonymous party.

[“Anonymous Affidavits of Merit”](#) (excerpted)

Anonymous testimony, in any form, prevents confirmation of the expert’s qualifications, authoritative expertise, and potential bias, all of which are crucial to fair and proper evaluation of claims.

As described in the resolution, an affidavit of merit is a sworn statement that a medical expert has reviewed a medical malpractice claim and determined that there are sufficient grounds for pursuit of the action. According to the National Conference of State Legislatures, [28 states](#) have requirements for filing an affidavit or certificate of merit for a medical liability and malpractice claim to move forward. Qualifications to provide an affidavit of merit in some states, such as Michigan, require the health professional to meet the same qualifications as an expert witness to testify in court in such a case. Other states, such as Nevada, that require an affidavit of merit do not require the health professional providing the affidavit to meet the same criteria as an expert witness.

ACEP’s existing policy on expert witness qualifications will, in some states, leave unaddressed the qualifications of the health professional providing an affidavit of merit in a medical malpractice claim.

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 developing a new a policy statement or revising existing policy statements.

Prior Council Action

Amended Substitute Resolution 46(85) Ethics of Expert Witness Testimony adopted. The resolution directed ACEP to develop expert witness criteria requiring only clinically active emergency physicians provide expert witness testimony in cases related to care rendered by an emergency physician; investigate the feasibility of developing model state legislation that includes the criteria; and investigate the ramifications of establishing a malpractice review panel to which expert testimony can be submitted for review.

Prior Board Action

April 2022, approved the revised policy statement [“Anonymous Affidavits of Merit;”](#) originally approved June 2016.

June 2021, reaffirmed the policy statement [“Expert Witness Guidelines for the Specialty of Emergency Medicine;”](#) revised and approved June 2015, June 2010, August 2000, and September 1995; originally approved September 1990.

June 2020, approved the policy statement “[Expert Witness Cross-Specialty Testimony for Standard of Care.](#)”

May 2018, approved the policy statement “[Medical Practice Review and the Practice of Medicine.](#)”

Amended Substitute Resolution 46(85) Ethics of Expert Witness Testimony adopted.

Background Information Prepared by: Laura Wooster, MPH
Senior Vice President, Advocacy & Practice Affairs

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



RESOLUTION: 49(23)

SUBMITTED BY: Jennifer Conn, MD, FACEP
Olga Gokova, MD, FACEP
Rachel Levitan, MD
Anne Richter, MD, FACEP
Arizona College of Emergency Physicians

SUBJECT: Patients Leaving the ED Prior to Completion of Care Against Medical Advice

PURPOSE: Affirm that patients leaving the ED against medical advice prior to completion of care may not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, all indicated consults, all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, Patients initiate an episode of care by presenting to the emergency department for evaluation of a
2 medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a
3 prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence
4 of immediate medical attention to result in: a) placing the patient's health in serious jeopardy; b) serious impairment
5 to bodily functions; or c) serious dysfunction of any bodily organ or part; and
6

7 WHEREAS, Patients without intent to harm themselves or others have the right to choose to leave the
8 emergency department and sign out against medical advice at any point during their evaluation, workup, and
9 management ending their episode of care; and
10

11 WHEREAS, Emergency physicians manage multiple emergent patients simultaneously and may be unable to
12 immediately avail themselves to the patient desiring to leave; and
13

14 WHEREAS, Leaving the emergency department against medical advice prior to completion of care does not
15 allow the emergency provider to completely evaluate the patient, order indicated tests and imaging, review and act on
16 results, discuss all results with the patient including incidental findings that require follow up, obtain appropriate
17 consults, admit or transfer the patient, nor prepare a complete list of discharge diagnoses, prescriptions, instructions
18 and referrals; and
19

20 WHEREAS, Emergency physicians do not usually practice in a setting where they may schedule a follow up
21 appointment with a patient; and
22

23 WHEREAS, The expectation of patients who utilize emergency departments expect their episodes of care and
24 discharge paperwork to be complete; therefore be it
25

26 RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department
27 prior to completion of care may not have received a complete evaluation, results of all ancillary testing including
28 incidental findings, all indicated therapies, and all indicated consults; and be it further
29

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

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

Background

This resolution asks ACEP to create a document acknowledging that patients leaving the emergency department (ED) prior to the completion of care and those leaving against medical advice (AMA) may not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, all indicated consults, all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure. It further calls for ACEP to advocate that emergency physicians and hospital systems jointly share responsibility for developing systems to communicate such information to patients who leave prior to the completion of ED care and/or leave AMA. A similar resolution was submitted to the Council last year that was not adopted. The 2022 resolution used the terminology “will not” instead of “may not” in the first and third resolved statements. The second resolved statement is an addition to the resolution.

Patients who leave the ED do so for a variety of reasons.. The rates of AMA range from 0.1-2.7% of ED visits. Patients leaving AMA are at higher risk for bad outcomes and increased costs. Patients leaving AMA are 10 times more likely to initiate a litigation process against the emergency physician and the hospital than a typical ED patient with a rate of around 1 lawsuit per 300 AMA cases.^{1,2} The rates of those leaving prior to the completion of care but do not have an AMA disposition is unknown.

Patients who leave the ED AMA must have the decisional capacity, understand, and acknowledge the risks of leaving. There may be limitations in the ability of the emergency physician to provide the patient with a complete ED evaluation, result discussions, correct disposition including diagnosis, medication recommendation and reconciliation, discharge coordination for after-visit following up or return precautions when a patient leaves prior to completion of treatment. Patients who leave AMA often leave with short notice or leave with no notice so there may be limited opportunity for the emergency physician to intervene.

There is significant medical-legal risk associated with the failure of the patient to receive a complete ED evaluation, discharge information and follow-up when the patient leaves prior to completion of treatment. There is concern that emergency physicians may be held to an expectation of providing a complete discharge process including treatment plans and referrals for follow-up to patients who have left prior to the completion of ED care and/or AMA, even if the results return after patient departure. This expectation could expose emergency physicians to increased liability for failure to provide this information.

CPT codes encompass some of these concepts, but there are no ACEP documents that acknowledge the implications or their potential impacts of leaving AMA. ACEP’s current policy statement “[Interpretation of Diagnostic Imaging Tests](#)” states (in part):

“Organizations should create service standards and operating procedures that clarify testing availability, timeliness, interpretation responsibility (including the role of residents), communication methods for preliminary and final results, as well as quality assurance, discrepancy follow-up, and incidental finding communication.”

“Organizations should provide clear guidance and support for the management of patient communication as it pertains to changes in findings, diagnosis, or need for further intervention, including the communication of incidental findings that were not available when the patient was in the ED.”

Background References

- ¹ Kazimi M, Niforatos JD, Yax JA, Raja AS. Discharges against medical advice from U.S. emergency departments. *Am J Emerg Med.* 2020 Jan;38(1):159-161. doi: 10.1016/j.ajem.2019.06.003. Epub 2019 Jun 3. PMID: 31208842.
- ² Sayed ME, Jabbour E, Maatouk A, Bachir R, Dagher GA. Discharge Against Medical Advice From the Emergency Department: Results From a Tertiary Care Hospital in Beirut, Lebanon. *Medicine (Baltimore).* 2016 Feb;95(6):e2788. doi:

10.1097/MD.0000000000002788. PMID: 26871837; PMCID: PMC4753933.

ACEP Strategic Plan Reference

Career Fulfillment – Goal: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 55(22) Patients Leaving the Emergency Department Prior to Completion of Care Against Medical Advice not adopted.

Prior Board Action

June 2018, approved the revised policy statement “[Interpretation of Diagnostic Imaging Tests](#)”;” revised and approved February 2013, and June 2006 with current title; reaffirmed October 2000; originally approved March 1990 titled “Interpretation of Diagnostic Studies.”

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

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



RESOLUTION: 50(23)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Government Services Chapter

SUBJECT: Metric Shaming

PURPOSE: 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.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement and/or other resources for physicians local to present to their administration. Efforts beyond a policy statement would require significant advocacy efforts at a national and state level and are not included in current budgeted and prioritized work of the College. Resources would need to be reallocated from other strategic priority projects.

1 WHEREAS, Performance metrics of individual emergency physicians are frequently collected in a variety of
2 practice settings, including and not limited to door to doctor time, time to admission, total RVUs produced, and total
3 CPTs performed; and
4

5 WHEREAS, There are instances that the metrics of individual emergency physicians are publicly displayed or
6 electronically transmitted unblinded which identify physicians by name; and
7

8 WHEREAS, Unblinded performance metric reports may lack appropriate context to clinical performance
9 without consideration for acuity, time of shift, patients received from provider handoffs, language barriers,
10 complexity, available clinical personnel, bed capacity, and other factors which confound the association of such
11 metrics with relative emergency physicians' performance; and
12

13 WHEREAS, Unnecessary dissemination of raw metrics of emergency physicians without adequate context
14 could negatively impact the collegial practice environment or future employability of an emergency physician; and
15

16 WHEREAS, Individual emergency physicians may feel shame and experience lower self-esteem as a result of
17 about poor rankings when unblinded raw metrics of emergency physicians are disseminated publicly; and
18

19 WHEREAS, Lower self-esteem and unnecessary shame may worsen burnout, depression, anxiety, and even
20 suicide; therefore be it
21

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

Background

This resolution calls for ACEP to develop practices and policies to prevent the publishing, transmitting, and releasing of unblinded metric-related information about individual emergency physician performance.

ACEP's policy statement "[Patient Experience of Care Surveys](#)" reviews the methodological and statistical issues with existing patient experience surveys. It states that many factors that lead to poor patient experience scores, such as wait

times and boarding, are beyond the control of the individual emergency physician. The policy specifically states that patient experience of care survey scores should not be used for credentialing, contract renewal, or incentive bonus programs and that rank ordered percentiles should be abandoned.

ACEP's policy statement "[Compensation Arrangements for Emergency Physicians](#)" recognizes that "quality emergency medical care is provided by physicians under different methods of compensation. Specific arrangements may also include performance incentives based on measures such as productivity, patient experience, and other measurable variables."

Most of these individual metrics are gathered and held at the local level. Reporting identified metrics at the local level would require local cooperation. ACEP could create additional policy and develop materials to open the discussion with the medical staff and C-Suite within an institution. Such actions may or may not be successful at the local level. ACEP's Emergency Department Accreditation Program could, in the near future, consider a standard regarding such reporting.

Reporting of this data at a regional, state, or national level would require significant state and federal advocacy. Such reporting has far more impact on non-hospital based physicians whose patients have time and options in the selection of their physician. Therefore, reporting at this level may be achieved through efforts by the AMA rather than ACEP.

CMS has worked with the RAND Corporation since 2010 on what was initially called the ED PEC survey and later called the ED CAHPS survey. Several ACEP leaders were members of the Technical Expert Panel that modified the original ED PEC survey and made it much more friendly to physicians. CMS has decided to not make the ED CAHPS survey mandatory. It should be noted that in its revised format, the survey still has 24 questions and an additional 11 demographic questions. 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. ACEP further urged CMS that the patient engagement module ACEP offers for all participants in the Clinical Emergency Data Registry (CEDR) is superior to ED CAHPS and advocated that performance improvement cannot be accomplished without the capability to give individual clinicians feedback and resultant skills training to improve physician-patient communication.

Quality metrics are used as a means to measure "quality." While every attempt is made to make these metrics as fair as possible, often there are ways to "game" the measure. Additionally, there can be obstacles outside of the physician's control that interfere with the ability to meet a metric, such as boarding.

During the pandemic, and in the post pandemic era, with massive boarding and workplace stress, many emergency physicians have been deeply affected by low scores on patient experience surveys or quality metrics. All physicians want to do the best for their patients. Social media such as EM Docs have revealed that many physicians feel ashamed, depressed, or angry about poor scores, particularly when they are working very hard in very difficult situations.

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 for development of a policy statement and/or other resources for physicians local to present to their administration. Efforts beyond a policy statement would require significant advocacy efforts at

a national and state level and are not included in current budgeted and prioritized work of the College. Resources would need to be reallocated from other strategic priority projects.

Prior Council Action

Amended Resolution 55(21) Patient Experience Scores adopted. Called for the College to 1) Acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy. 2) Define standardized inclusion and exclusion criteria for patient experience survey populations. 3) Define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias and appropriate power calculations so that sufficient surveys are collected to yield more statistically valid results. 4) Advocate for patient experience survey validity and work with CMS and other stakeholders to implement change to current ED 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

February 2023, approved the revised policy statement "[Patient Experience of Care Surveys](#);" revised and approved June 2016 with current title; originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 55(21) Patient Experience Scores adopted.

April 2021, approved the revised policy statement, "[Compensation Arrangements for Emergency Physicians](#);" revised and approved April 2015, April 2002, June 1997, reaffirmed October 2008, April 1992; originally approved June 1988.

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: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

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



RESOLUTION: 51(23)
SUBMITTED BY: Ohio Chapter
SUBJECT: Quality Measures and Patient Satisfaction Scores

PURPOSE: 1) Advocate that patient experience surveys be extend to all categories of ED patients; 2) oppose reimbursement metrics or employment decisions based on patient experience surveys until they are shown to be valid and their effect on patient outcomes is known; and 3) work with stakeholders to study the relationship between MIPS quality measures and patient experience.

FISCAL IMPACT: Budgeted committee and staff resources for updating the current policy statement. Unbudgeted staff resources for federal advocacy. Unbudgeted expenses of potentially \$150,000 – \$250,000 for ACEP to fund research on association of MIPS Quality Measures, Patient Satisfaction, and outcomes.

1 WHEREAS, Emergency physicians are often assessed by their hospital and healthcare system by their patient
2 satisfaction scores; and

3
4 WHEREAS, There is limited objective data linking patient satisfaction to quality patient care; and

5
6 WHEREAS, Compensation tied to patient satisfaction alone can lead to increased job dissatisfaction and burn
7 out, negatively impacting both physicians and patients; and

8
9 WHEREAS, Current measures for patient satisfaction surveying of Emergency Department patients fall short
10 of recommendations put forth in ACEP’s current Policy Statement “[Patient Experience of Care Surveys](#),” and

11
12 WHEREAS, Quality measures and databases such as CEDR, E-QUAL initiatives, MIPS, etc are based on
13 empiric data proven to improve patient outcomes; and

14
15 WHEREAS, Reimbursement is increasingly tied to patient outcomes; and

16
17 WHEREAS, The current CMS Merit-based Incentive Payment System (MIPS) program has been established
18 with potential negative payment adjustments in future years for emergency medicine physicians; and

19
20 WHEREAS, MIPS is largely based upon care delivered to patients who would be discharged safely from the
21 Emergency Department; and

22
23 WHEREAS, MIPS criteria involve areas where there frequently exist patient expectations about care that
24 would be received prior to arrival in the Emergency Department; therefore be it

25
26 RESOLVED, That ACEP advocate for alignment with current policy and previous recommendations that
27 patient satisfaction surveys be extended to all categories of emergency department patients for true validity; and be it
28 further

29
30 RESOLVED, That ACEP oppose reimbursement metrics and employment decisions correlated with or
31 dependent on patient satisfaction surveys until external validity can be established and their effect on patient outcomes
32 is known; and be it further

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

Background

This resolution calls for ACEP to advocate that patient experience survey be extended for all categories of ED patients and not just discharged patient and oppose reimbursement metrics or employment decision based on patient experience survey until they are shown to be valid and lead to improved outcomes like other quality metrics. ACEP is further directed to work with stakeholders to study the relationship between MIPS quality measures and patient experience.

ACEP's policy statement "[Patient Experience of Care Surveys](#)" states:

"The American College of Emergency Physicians (ACEP) recognizes that patient experience of care surveys that are methodologically and statistically sound can be reflective of the patient's perception of their health care experience, and that patient outcomes can be related to perceived patient experience of care."

"ACEP holds that patient experience of care survey tools should be:

- Administered to all categories of ED patients regardless of location seen or admission/discharge/observation/transfer status to create a broad representation of patient experiences without marginalizing certain populations."

"Due to the difficulty in refining whether patient experience of care scores are the result of physician performance or due to demands and restrictions on the current health care system, implicit bias, or other factors out of the control of the physician, patient experience of care metrics should not be used in isolation for purposes such as credentialing, contract renewal, or incentive bonus programs."

The policy statement would need to be updated to reflect the intent of the resolution.

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

¹Pines 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.

²Fenton 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 – 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 for updating the current policy statement. Unbudgeted staff resources for federal advocacy. Unbudgeted expenses of potentially \$150,000 – \$250,000 for ACEP to fund research on association of MIPS Quality Measures, Patient Satisfaction, and outcomes.

Prior Council Action

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 so that sufficient surveys are collected to yield more statistically valid results. Advocate for patient experience survey validity and work with CMS and other stakeholders to implement change to current ED 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

February 2023, approved the revised policy statement "[Patient Experience of Care Surveys](#);" revised and approved June 2016; originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 55(2) Patient Experience Scores adopted.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

J

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

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
Senior Director, Workforce & Emergency Medicine Practice

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



RESOLUTION: 52(23)
SUBMITTED BY: New York Chapter
SUBJECT: Summit and New Tools for Transforming Acute Care

PURPOSE: Convene a task force to focus on developing new strategies, quality care, and performance metrics for creating new alternative care models and provide a report to the 2024 Council meeting with a strategy for expanding and transforming acute care delivery in the community setting.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources for federal and state advocacy initiatives to support these efforts, potentially additional unbudgeted and unknown costs for consultant resources, unbudgeted staff resources for supporting a task force, and unbudgeted funds of a minimum of \$10,000 (depending on the size of the task force) for convening an in-person task force meeting.

1 WHEREAS, The U.S. Centers for Medicare and Medicaid Services (CMS) has lifted restrictions on the
2 originating site of care, approving new services since the onset of COVID-19; and
3

4 WHEREAS, ACEP members create diversified health systems that often entail advanced care models; and
5

6 WHEREAS, ACEP hopes to contribute to novel acute care delivery methods given some studies show
7 patients value acute services even outside of the emergency department; and
8

9 WHEREAS, Key stakeholders including payors, health systems, and medical organizations in emergency
10 medicine must network, build the professional reputation and present the latest advancements involving acute,
11 unscheduled alternative care models; and
12

13 WHEREAS, Value-Based Care – a critical health care delivery and payment approach for emergency
14 medicine – will depend upon prioritizing and building models that achieve true cost savings and improve clinical care
15 quality; therefore be it
16

17 RESOLVED, That ACEP convene a task force focused on crafting new strategies, quality care, and
18 performance metrics for creating new alternative care models; and be it further
19

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

Background

This resolution requests ACEP to convene a task force to focus on developing new strategies, quality care, and performance metrics for creating new alternative care models and provide a report to the 2024 Council meeting with a strategy for expanding and transforming acute care delivery in the community setting. The resolution follows the trend to shift from traditional fee-for-service reimbursement to innovative, value-based care payment models facilitated by the Medicare Access and CHIP Reauthorization Act (MACRA), which made sweeping changes to Medicare reimbursement, creating opportunities to create new alternative care models.

An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. The APM landscape consists of a continuum of risk-assuming models based on quality

and value. Currently, individual emergency physicians and emergency medicine groups do not have any opportunities to directly participate in APMs. To fill the gap in available APMs for emergency physicians, ACEP first convened an APM Task Force in 2015 that considered several options for constructing an emergency medicine-focused APM. The task force considered several models and ultimately developed the Acute Unscheduled Care Model (AUCM)..

The goal of the AUCM is to provide a voluntary alternative to the traditional fee-for-service payments for Medicare patients who receive emergency care. It is structured as a bundled payment model, focusing on specific “episodes” of unscheduled acute care. Under a bundled payment approach, if the cost of an episode of care is less than a pre-determined price for that episode, then a participating provider or group can keep that difference. However, if the cost winds up being more than the pre-determined price, participants would be responsible for those losses and owe Medicare the difference.

A deliverable from the AUCM work is to improve the ability of emergency physicians to reduce inpatient admissions and observation stays when appropriate through enhanced care coordination. Emergency physicians would become key members of the continuum of care as the model focuses on ensuring follow-up care for emergency patients, minimizing redundant post-emergency department (ED) services, and avoiding post-ED discharge safety events that lead to follow-up ED visits or inpatient admissions.

The AUCM has not been fully implemented. ACEP submitted its AUCM proposal to a federal government advisory committee called the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in 2017. The AUCM model was ultimately recommended by the PTAC to the HHS Secretary for full implementation in late 2018, including in its [official report](#) a designation of “Deserves Priority Consideration,” as the PTAC believed the model filled an enormous gap in terms of available APMs to emergency physicians and groups. The HHS Secretary formally [responded](#) to the PTAC’s recommendation in September 2019, noting he believes that core concepts of the AUCM should be incorporated into other APMs that the Center for Medicare & Medicaid Innovation Center (CMMI) is developing. Highlights of the response can be found [here](#).

Within HHS, the Centers for Medicare & Medicaid Services (CMS)’ Center for Medicare & Medicaid Innovation Center (CMMI) is primarily responsible for testing APMs. Despite many attempts to work with CMMI on model implementation, CMMI has yet to implement the model in any meaningful way.

Since CMMI has not incorporated the AUCM into the Medicare APMs it is developing, ACEP started an initiative in 2020 to promote participation in emergency medicine-focused APMs being offered by other payors like Medicaid and private insurers. Through this initiative, ACEP created [background materials about the AUCM](#) and toolkits to help emergency physicians participate in APMs.

The Alternative Payment Models Task Force centered around developments of alternative care models that culminated exclusively in the creation of the AUCM. The task force was appointed following adoption of Substitute Resolution 31(14) Financing Health Insurance and the task force continued its work through 2017.

ACEP Strategic Plan Reference

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources for federal and state advocacy initiatives to support these efforts, potentially additional unbudgeted and unknown costs for consultant resources, unbudgeted staff resources for supporting a task force, and unbudgeted funds of a minimum of \$10,000 (depending on the size of the task force) for convening an in-person task force meeting.

Prior Council Action

Amended Resolution 19(16) Health Care Financing Task Force adopted. Directed ACEP to study alternative health care financing models, including single-payer, that foster competition and preserve patient choice and that the task

force report to the 2017 ACEP Council regarding its investigation.

Substitute Resolution 31(14) Financing Health Insurance adopted. Directed ACEP to create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve choice for patients and that the task force report to the 2015 ACEP Council regarding its investigation.

Resolution 20(12) Single Payer Universal Health Insurance not adopted. The resolution supported the adoption of single payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Substitute Resolution 21(10) Medicare-for-All Health Insurance referred to the Board. The resolution directed the Board to appoint a task force to investigate alternative models of health care financing.

Prior Board Action

September 2018, reviewed the Health Care Financing Task Force report and approved distributing it to the 2018 Council. .

Amended Resolution 19(16) Health Care Financing Task Force adopted.

October 2016, the Board reviewed a status report of the Alternate Payment Models task force created by Resolution 31(14).

Substitute Resolution 31(14) Financing Health Insurance adopted.

October 2009, reviewed the Value Based Emergency Care Task Force report.

Background Information Prepared by: Erin Grossmann
Regulatory & External Affairs Manager

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



RESOLUTION: 53(23)

SUBMITTED BY: Andrew Fenton, MD, FACEP
Roneet Lev, MD, FACEP
Aimee Moulin, MD, FACEP
California Chapter

SUBJECT: Treating Physician Determines Patient Stability

PURPOSE: Create a policy that the treating emergency physician at the patient’s bedside is best qualified to determine a patient’s stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient; and amend ACEP’s “Code of Ethics for Emergency Physicians” policy statement such that it is unethical for an emergency physician, who has not personally evaluated the patient, to coerce or threaten financial penalties to the treating emergency physician.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement and revising the “Code of Ethics for Emergency Physicians” policy statement.

1 WHEREAS, Emergency department (ED) patients are often transferred between EDs for either higher level of
2 care, or to a similar level of care (lateral transfer) at the request of the patient’s insurance carrier; and
3

4 WHEREAS, Lateral transfer requests by insurance carriers are becoming more common and will increase
5 nationwide with the expansion of Accountable Care Organizations/Health Maintenance Organizations who care for
6 capitated patients; and
7

8 WHEREAS, A key piece of the decision to transfer a patient is the bedside emergency physician’s assessment
9 of the patient’s clinical needs and stability for transfer, which often includes a complex clinical and logistical
10 decision-making of the risks and benefits to the patient; and
11

12 WHEREAS, EMTALA law states that a patient with an emergency medical condition who is unstable cannot
13 be transferred without a physician certification that benefits outweigh the risk of transfer; and
14

15 WHEREAS, There may be a difference of opinion on whether a patient is stable for transfer between the
16 treating emergency physician at the bedside and a physician limited to evaluating the patient’s stability without
17 personal evaluation; and
18

19 WHEREAS, The treating emergency physician at the bedside is the physician who is best qualified, and who
20 is legally liable, to determine a patient’s stability; and
21

22 WHEREAS, Physicians acting as representatives of insurance carriers who overrule the treating emergency
23 physician’s determination of stability may threaten patient safety; and
24

25 WHEREAS, ACEP policy statement “[EMTALA and On-call Responsibility for Emergency Department](#)
26 [Patients](#)” states: “Physician services (including medically necessary post-stabilization care), when provided in
27 response to the request for emergency care, should be recognized as emergency services for reimbursement purposes
28 and should be compensated in a fair and equitable manner.”; and
29

30 WHEREAS, There have been occurrences of financial coercion to transfer a patient that a treating emergency
31 physician deems to be unstable, such as refusing to reimburse physician services or to hold a patient financially
32 responsible; therefore be it

33 RESOLVED, That ACEP enact policy that the treating emergency physician at the patient’s bedside is best
34 qualified to determine a patient’s stability for transfer and their decision should not be overruled by a physician or a
35 non-physician practitioner who has not personally evaluated the patient; and be it further
36

37 RESOLVED, That ACEP amend its “Code of Ethics for Emergency Physicians” policy statement to state that
38 it is unethical for an emergency physician, who has not personally evaluated the patient, to coerce a treating
39 emergency physician, to transfer a patient when the treating physician believes the patient is unstable for transfer and
40 that a transfer may compromise a patient’s safety; and be it further
41

42 RESOLVED, That ACEP amend its “Code of Ethics for Emergency Physicians” policy statement to state that
43 it is unethical for an emergency physician, who has not personally evaluated the patient, to threaten a financial penalty
44 for further treating the patient claiming treatment constitutes “post-stabilization care” when the treating emergency
45 physician believes a transfer or discontinuation of care may compromise a patient's safety.

Background

This resolution call upon ACEP to create a policy that the treating emergency physician at the patient’s bedside is best qualified to determine a patient’s stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient. It further requires that ACEP amend its Code of Ethics such that it is unethical for an emergency physician, who has not personally evaluated the patient, to coerce or threaten financial penalties to the treating emergency physician regarding the transfer of patients.

Emergency patients who present to hospitals may not be covered by in-network insurance. When the treating physician calls for authorization to admit the patient, they may experience pressures to transfer the patient to in-network hospitals that could be in the form of perceived, implied, or actual administrative, financial or other penalties.

Section II.D.3.b. (page 12) of the “[Code of Ethics for Emergency Physicians](#)” entitled “Adequate in-hospital and outpatient resources must be available to protect emergency patient interests” states the following:

“Patients requiring hospitalization for further care should not be denied access to an appropriate medical facility on the basis of financial considerations. Transfer to an appropriate accepting medical facility for financial reasons may be effected if a) the patient provides consent and b) there is no undue risk to the patient. Admission or transfer decisions should be made on the basis of a patient's best interest.

It is unethical for an emergency physician to participate in the transfer of an emergency patient to another medical facility unless the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the risks of the transfer or unless a competent patient, or a legally responsible person acting on the patient's behalf, gives informed consent for the transfer. Emergency physicians should be knowledgeable about applicable federal and state laws regarding the transfer of patients between health care facilities.

Although the care and disposition of the patient are primarily the responsibility of the emergency physician, on-call consultants should share equitably in the care of indigent patients. This may include an on-site evaluation by the consultant if requested by the emergency physician.

For patients who do not require immediate hospitalization but need medical follow-up, adequate outpatient medical resources should be available both to continue proper treatment of the patient's medical condition and to prevent the development of subsequent foreseeable emergencies resulting from the original medical problem.”

ACEP’s policy statements are reviewed on a 5-year cycle as part of the policy sunset review process. The “Code of Ethics for Emergency Physicians” is currently being reviewed by the Ethics Committee for potential revisions.

In 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (42 U.S.C. §1395dd) to ensure public access to emergency services regardless of insurance status or ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

EMTALA governs how unstable patients are transferred from one hospital to another. Under the law, a patient is considered stable for transfer if the treating physician determines that no material deterioration is reasonably likely to occur during or as a result of the transfer between facilities. EMTALA does not apply to the transfer of stable patients; however, if the patient is unstable, then the hospital may not transfer the patient unless: A physician certifies the medical benefits expected from the transfer outweigh the risks OR a patient makes a transfer request in writing after being informed of the hospital's obligations under EMTALA and the risks of transfer.

In addition, the transfer of unstable patients must be “appropriate” under the law, such that: 1) the transferring hospital must provide ongoing care within its capability until transfer to minimize transfer risks; 2) provide copies of medical records; 3) must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer; and 4) the transfer must be made with qualified personnel and appropriate medical equipment.

As noted in the resolution, ACEP’s policy statement “[EMTALA and On-call Responsibility for Emergency Department Patients](#)” states:

“Physician services (including medically necessary post-stabilization care), when provided in response to the request for emergency care, should be recognized as emergency services for reimbursement purposes and should be compensated in a fair and equitable manner.”

Further, ACEP’s policy statement on “[Appropriate Interfacility Patient Transfer](#)” addresses some of the issues raised in the first resolved, specifically who is qualified to determine a patient’s stability for transfer, although it does not address such decisions being overruled by a physician or a non-physician practitioner who has not personally evaluated the patient. The policy states:

“The medical facility’s policies and procedures and/or medical staff bylaws should identify the individuals responsible for and qualified to perform MSEs. The policies and procedures or bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital. The examining physician at the transferring hospital should use his or her best judgment regarding the condition of the patient when determining the timing of transfer, mode of transportation, level of care provided during transfer, and the destination of the patient.”

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Fiscal Impact

Budgeted committee and staff resources for development of a policy statement and amending the “Code of Ethics for Emergency Physicians” policy statement.

Prior Council Action

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

June 2023, reviewed draft revisions to the “[Code of Ethics for Emergency Physicians](#)” policy statement and referred the policy back to the Ethics Committee for further work.

January 2022, approved the revised policy statement “[Appropriate Interfacility Patient Transfer](#),” revised and approved January 2016 with the current title; revised and approved February 2009, February 2002, and June 1997; revised and approved September 1992 titled “ Appropriate Inter-Hospital Patient Transfer;” originally approved September 1989 titled “ Principles of Appropriate Patient Transfer.”

January 2019, approved the revised 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” (1987).

January 2017, approved the revised policy statement “[Code of Ethics for Emergency Physicians](#),” 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 23(11) EMTALA adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
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Leslie P. Moore, JD
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Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 54(23)
SUBMITTED BY: Michigan College of Emergency Physicians
SUBJECT: Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions

PURPOSE: Discuss with TJC ACEP’s opposition to credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

FISCAL IMPACT: Budgeted staff resources for ongoing communications with TJC. Potential unbudgeted travel costs of \$3,200 for an in-person meeting with The Joint Commission.

1 WHEREAS, Emergency medicine is a broad-based specialty involving the diagnosis and treatment of
2 emergency conditions; and

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4 WHEREAS, Board certification in emergency medicine verifies proficiency in the diagnosis and treatment of
5 emergency conditions; and

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7 WHEREAS, Residency training in emergency medicine includes training and education in the diagnosis and
8 treatment of emergency conditions; and

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10 WHEREAS, ACEP maintains that physician board certification in emergency medicine encompasses the
11 knowledge requirements for physician credentialing; and

12
13 WHEREAS, ACEP opposes “medical merit badges” for credentialing requirements; and

14
15 WHEREAS, ACEP has guidelines regarding credentialing and delineation of clinical privileges in emergency
16 medicine (“[Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine](#)” and “[Guidelines
17 for Credentialing and Delineation of Clinical Privileges in Emergency Medicine](#)” Policy Resource and Education
18 [Paper](#)); and

19
20 WHEREAS, The Joint Commission creates policies requiring credentialing committees to include language
21 regarding the diagnosis and treatment of individual emergency conditions, such as ischemic stroke, in delineation of
22 clinical privileges; and

23
24 WHEREAS, The Joint Commission may, by such precedent, proceed to require delineation of clinical
25 privileges language for numerous other specific emergency conditions; and

26
27 WHEREAS, Hospitals are required to include this language in order to maintain Joint Commission
28 certification; and

29
30 WHEREAS, The imposition of a requirement of any credentialing or certification process imposed by the
31 Joint Commission represents a threat to the independent practice of Emergency Medicine, recognized board-
32 certification processes, and is a violation of ACEP guidelines; therefore be it

33
34 RESOLVED, That ACEP engage with The Joint Commission to oppose credentialing policies that require
35 new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency
36 conditions.

Background

This resolution calls for ACEP to 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.

The Joint Commission does not set specialty specific requirements for physician credentialing. The Joint Commission holds hospitals and medical staff credentialing boards to the specifications delineated in facility policies and/or facility delineated standards. ACEP has engaged in many efforts to educate hospitals and medical staff credentialing entities on the training, core competencies and scope of care that is encompassed in accredited emergency medicine residency training and validated via subsequent board certification by the American Boards of Emergency Medicine (ABEM), Osteopathic Emergency Medicine (AOBEM), or Pediatrics (ABP) and ABEM partner boards for dual/subspecialties.

Emergency physicians are trained in a broad range of acute medical conditions during residency and must complete an intensive written and oral examination demonstrating mastery of the skills necessary to diagnose and treat these conditions. To maintain certification, emergency physicians must complete their Maintenance of Certification which tests these skills on an ongoing basis.

ACEP has a number of existing policies regarding required CME and short courses. The policy statement "[CME Burden](#)" discusses the increasing burden of required courses. The policy states

"The American College of Emergency Physicians (ACEP) believes that continuous board certification by the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, skills, and current understanding in the practice of emergency medicine regardless of any additional CME mandated or obtained."

ACEP's policy statement "[Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment](#)" states:

"The American College of Emergency Physicians (ACEP) believes that board certification by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, knowledge, and skill in the practice of emergency medicine." It goes on to say that ACEP strongly opposes required completion of courses such as "Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), and Basic Trauma Life Support (BTLS), or a specified number of CME hours in a sub-area of emergency medicine, as conditions for privileges, renewal of privileges, employment, qualification by hospitals, government agencies, or any other credentialing organization's standards to provide care for designated disease entities."

ACEP's policy statement "[Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine](#)" states:

"ACEP believes that the ED medical director* should be responsible for assessing and making recommendations to the hospital's credentialing body related to the qualifications of providers of emergency care with respect to the clinical privileges granted to them. At a minimum, those applying for privileges as emergency physicians should be eligible for ACEP membership. Board certification by ABEM or AOBEM, or pediatric emergency medicine subspecialty certification by the American Board of Pediatrics is an excellent, but not the sole benchmark for decisions regarding an individual's ability to practice emergency medicine. Especially in rural areas, physicians who trained in other specialties may provide emergency care and be granted privileges by an objective measurement of care provided, sufficient experience, prior training, and evidence of continuing medical education."

"*ED medical director refers to the chair, medical director, or their designee."

ACEP provides a set of personalized cards that attest that they are currently board certified by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (ABOEM) and have expertise in procedural sedation, cardiac resuscitation, and trauma. ABEM also offers a personalized letter attesting to these same areas of expertise.

ACEP also is a CME partner for an ABEM MyEMCert module on resuscitation, for which physicians receive a certificate of completion.

ACEP is heavily involved with other emergency medicine organizations opposing such requirements, particularly when the material is already part of emergency medicine certification/maintenance of certification. In early the Coalition Opposing Medical Merit Badges (COMMB, now called COBCEP – the Coalition of Board Certified Emergency Physicians) was formed with the following members: American Academy of Emergency Medicine (AAEM), AAEM/RSA, ABEM, ACEP, Association of Academic Chairs in Emergency Medicine (AACEM), Council of Residency Directors in Emergency Medicine (CORD), Emergency Medicine Residents' Association (EMRA), and the Society for Academic Emergency Medicine (SAEM). SAEM/RAMS has subsequently joined the coalition. The purpose of the coalition states:

“Board-certified emergency physicians who actively maintain their board certification should not be required to complete short-course certification in advanced resuscitation, trauma care, stroke care, cardiovascular care, or pediatric care in order to obtain or maintain medical staff privileges to work in an emergency department. Similarly, mandatory targeted continuing medical education (CME) requirements do not offer any meaningful value for the public or for the emergency physician who has achieved and maintained board certification. Such requirements are often promulgated by others who incompletely understand the foundation of knowledge and skills acquired by successfully completing an Accreditation Council for Graduate Medical Education–accredited Emergency Medicine residency program. These “merit badges” add no additional value for board-certified emergency physicians. Instead, they devalue the board certification process, failing to recognize the rigor of the ABEM Maintenance of Certification (MOC) Program. In essence, medical merit badges set a lower bar than a diplomate’s education, training, and ongoing learning, as measured by initial board certification and maintenance of certification. **The Coalition finds no rational justification to require medical merit badges for board-certified emergency physicians who maintain their board certification.** Our committed professional organizations provide the best opportunities for continuous professional development and medical merit badges dismiss the quality of those educational efforts.”

The coalition has met at least quarterly since 2017. Through the years the group has created the aforementioned letter from ABEM and cards from ACEP and AAEM, worked to clarify the requirements of The Joint Commission (TJC), worked with the American College of Surgeons Committee on Trauma (ACS-COT) which ultimately removed the requirement for Advanced Trauma Life Support (ATLS) for ABEM/AOBEM certified emergency physicians, worked with the VA hospital and American Society of Anesthesiology on a procedural sedation policy, clarification of the Pediatric Emergency Care Coordinator as part of the Pediatric Readiness Project, sent multiple letters and personal contacts regarding the NY State requirement for Pediatric Advanced Life Support/Advanced Pediatric Life Support (PALS/APLS), created a letter regarding a waiver of required CLIA competency assessments for point of care testing, and opposed Pennsylvania Department of Health requirement for Basic Cardiac Life Support (BCLS) training. In 2019, COMMB changed its name to the Coalition of Board Certified Emergency Physicians (COBCEP) and they continue to work on the military requirement for Basic Life Support (BLS) and requirements for BLS, ACLS, and PALS for emergency physicians who practice in Puerto Rico. The group is currently working on the impact of state required physician education. After ACEP assisted with pilot testing through the Emergency Medicine Practice Research Network, ABEM sent a survey to their diplomates regarding the types of courses required, the estimated time to complete these requirements, the estimated cost of meeting these requirements, and the usefulness of the material required. Several thousand individuals completed the survey and the results are currently being analyzed.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Fiscal Impact

Budgeted staff resources for ongoing communications with TJC. Potential unbudgeted travel costs of \$3,200 for an in-person meeting with The Joint Commission.

Prior Council Action

Amended Resolution 43(15) Required CME Burden adopted. Called for the College to address annual requirements for CME in specific areas that could lead to reduced ongoing education in other clinical area and work with other organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to care for all ED patients.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted. Directed ACEP to adopt a position that board certification in emergency medicine through the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, and/or sub-board on Pediatric Emergency Medicine of the American Board of Pediatrics, along with participation in Maintenance of Certification programs currently required by these Boards is sufficient for practicing emergency physicians to maintain hospital privileges, health plan participation and medical group inclusion, and Maintenance of Licensure, and requiring additional certifications beyond board certification for emergency physicians, such as Basic Life Support, Advanced Cardiac Life Support, Advanced Trauma Life Support, and Pediatric Advanced Life Support, and other maintenance programs is redundant and unnecessary.

Resolution 21(09) Opposition to Credentialing, Certification, or “Signing-Off” Processes by Other Specialties adopted. Directed ACEP to establish College liaisons and relationships with other medical specialty societies, the American Medical Association, the Alliance for Specialty Medicine, the Coalition for Patient -Centric Imaging, and other interested parties actively and fully opposes the imposition upon the specialty of Emergency Medicine of a requirement of any credentialing, certification, or "signing -off" process by other specialties for any core skill within the scope of practice of emergency medicine.

Resolution 51(05) Emergency Physician Autonomy in the Performance and Interpretation of Diagnostic Imaging Studies adopted. Called for the College to work with the house of medicine and other certification and standard setting bodies to reaffirm and promote appropriate training and education standards for all physicians who perform and interpret diagnostic imaging and to oppose any MedPac recommendation that would limit any physician other than a radiologist to provide diagnostic imaging.

Amended Resolution 15(03) Granting Clinical Privileges adopted. Directed the College 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 emergency department's physicians with respect to the clinical privileges granted to that physician.

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted. This resolution called for the College to open dialogue with the American Hospital Association, third party payers, and accreditation entities regarding the inappropriate use of ACLS and similar courses for credentialing of board-certified emergency physicians.

Amended Resolution 14(98) Merit Badge Medicine referred to the Board. This resolution called for the College policy on "Merit Badge Medicine" to read as follows: The ACEP believes that certification of knowledge and skills in emergency medicine can result only from successful completion of examinations administered by a recognized board in emergency medicine. The successful completion of any course, or series of courses, or a specified number of CME hours in a sub-area of emergency medicine, may serve as evidence of knowledge and skill of a certain sub-area of medicine. However, the completion of such does not serve as an acceptable substitute for certification of knowledge

and skills to practice emergency medicine. Therefore, ACEP opposes the use of certificates of completion of courses such as ATLS, ACLS, PALS, BTLS or a specified number of CME hours in a sub-area of emergency medicine as requirements for credentialing or employment of any physician certified in emergency medicine by the ABEM or the AOBEM.

Substitute Resolution 9(91) Merit Badge Medicine adopted. The resolution called for the College to request ABEM provide a statement that board certification supersedes successful completion of courses taught in ACLS, ATLS, APLS, etc., and that ACEP disseminate its current policy on “Merit Badge Medicine” with recommendations on methods for their use by membership.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted. This resolution called for the College to develop appropriate language that can be incorporated into legislation and regulations that would reflect the College's position opposing the use of certificates of completion of short courses in special areas relating to emergency medicine as criteria for employment, staff appointment, licensure, or facility designations when such physicians are board certified in emergency medicine.

Prior Board Action

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), Society for Academic Emergency Medicine (SAEM).

January 2022, approved the revised policy statement, “[Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment](#)” revised and approved January 2016 and April 2012; reaffirmed September 2005; Revised in June 1999, June 1997, August 1992; originally approved January 1984 titled “Certification in Emergency Medicine.

June 2018, approved the revised policy statement “[Emergency Medicine Training, Competency, and Professional Practice Principles;](#)” reaffirmed April 2012; revised and approved January 2006; originally approved November 2001.

August 2017, reviewed the Policy Resource & Education Paper (PREP) “[Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine;](#)” originally reviewed June 2006. This PREP is an adjunct to the policy statement “Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine

April 2017, approved the revised policy statement “[Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;](#)” revised and approved October 2014, June 2006, and June 2004; reaffirmed October 1999; Revised with current title September 1995 and June 1991; originally approved April 1985 titled, “Guidelines for Delineation of Clinical Privileges in Emergency Medicine.”

Amended Resolution 43(15) Required CME Burden adopted.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted.

Resolution 21(09) Opposition to Credentialing, Certification, or "Signing -Off Processes by Other Specialties adopted.

Resolution 51(05) Emergency Physician Autonomy in the Performance and Interpretation of Diagnostic Imaging Studies adopted.

Amended Resolution 15(03) Granting Clinical Privileges adopted.

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted.

Substitute Resolution 9(91) Merit Badge Medicine adopted.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

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



RESOLUTION: 55(23)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Government Services Chapter

SUBJECT: Uncompensated Required Training

PURPOSE: 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 explore opportunities to partner with other like-minded organizations to reduce unnecessary or redundant annual or onboarding training for physician employment.

FISCAL IMPACT: Unbudgeted staff resources and unbudgeted funds of approximately \$10,000 for an in-person task force meeting for 10 people and approximately \$20,000 to conduct a survey.

1 WHEREAS, There is an increasing amount of pre-employment and annual training required of board-certified
2 emergency physicians by various hospitals, organizations, and entities; and
3

4 WHEREAS, Many emergency physicians are independent contractors and compensated on an hourly basis;
5 and
6

7 WHEREAS, Most emergency physicians are required to complete institution-specific training required for
8 employment or other privileges; and
9

10 WHEREAS, Employed emergency physicians frequently are uncompensated for time completing such
11 training; and
12

13 WHEREAS, Training required by institutions is often reported to be redundant and less rigorous than required
14 continued medical education for medical licensure, board certification, maintenance of certification, and examinations
15 for emergency physicians; therefore be it
16

17 RESOLVED, That ACEP convene a working group to evaluate supporting fair compensation for required
18 training, including accurate estimates of the time to completion, time to completion is fairly compensated, and in
19 employed physician compensation models, the appropriate time is protected to allow for training without requiring
20 completion during off hours; and be it further
21

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

Background

This resolution calls for ACEP to convene a working group to evaluate 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. In addition it asks that ACEP partner with other organizations to reduce annual or onboarding training for physician employment.

ACEP has a number of existing policies regarding required CME and short courses. The policy statement "[CME Burden](#)" discusses the increasing burden of required courses. The policy states:

"The American College of Emergency Physicians (ACEP) believes that continuous board certification by the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, skills, and current understanding in the practice of emergency medicine regardless of any additional CME mandated or obtained."

ACEP's policy statement "[Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment](#)" states:

"The American College of Emergency Physicians (ACEP) believes that board certification by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, knowledge, and skill in the practice of emergency medicine." It goes on to say that ACEP strongly opposes required completion of courses such as "Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), and Basic Trauma Life Support (BTLS), or a specified number of CME hours in a sub-area of emergency medicine, as conditions for privileges, renewal of privileges, employment, qualification by hospitals, government agencies, or any other credentialing organization's standards to provide care for designated disease entities."

ACEP provides a set of personalized cards that attest that they are currently board certified by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and have expertise in procedural sedation, cardiac resuscitation, and trauma. ABEM also offers a personalized letter attesting to these same areas of expertise.

ACEP also is a CME partner for an ABEM MyEMCert module on resuscitation, for which physicians receive a certificate of completion.

Regarding the second resolved, ACEP is heavily involved with other emergency medicine organizations opposing such requirements, particularly when the material is already part of emergency medicine certification/maintenance of certification. In early the Coalition Opposing Medical Merit Badges (COMMB, now called COBCEP – the Coalition of Board Certified Emergency Physicians) was formed with the following members: American Academy of Emergency Medicine (AAEM), AAEM/RSA, ABEM, ACEP, Association of Academic Chairs in Emergency Medicine (AACEM), Council of Residency Directors in Emergency Medicine (CORD), Emergency Medicine Residents' Association (EMRA), and the Society for Academic Emergency Medicine (SAEM). SAEM/RAMS has subsequently joined the coalition. The purpose of the coalition states:

"Board-certified emergency physicians who actively maintain their board certification should not be required to complete short-course certification in advanced resuscitation, trauma care, stroke care, cardiovascular care, or pediatric care in order to obtain or maintain medical staff privileges to work in an emergency department. Similarly, mandatory targeted continuing medical education (CME) requirements do not offer any meaningful value for the public or for the emergency physician who has achieved and maintained board certification. Such requirements are often promulgated by others who incompletely understand the foundation of knowledge and skills acquired by successfully completing an Accreditation Council for Graduate Medical Education–accredited Emergency Medicine residency program. These "merit badges" add no additional value for board-certified emergency physicians. Instead, they devalue the board certification process, failing to recognize the rigor of the ABEM Maintenance of Certification (MOC) Program. In essence, medical merit badges set a lower bar than a diplomate's education, training, and ongoing learning, as measured by initial board certification and maintenance of certification. **The Coalition finds no rational justification to require medical merit badges for board-certified emergency physicians who maintain their board certification.** Our committed professional organizations provide the best opportunities for

continuous professional development and medical merit badges dismiss the quality of those educational efforts.”

The coalition has met at least quarterly since 2017. Through the years the group has created the aforementioned letter from ABEM and cards from ACEP and AAEM, worked to clarify the requirements of The Joint Commission (TJC), worked with the American College of Surgeons Committee on Trauma (ACS-COT) which ultimately removed the requirement for Advanced Trauma Life Support (ATLS) for ABEM/AOBEM certified emergency physicians, worked with the VA hospital and American Society of Anesthesiology on a procedural sedation policy, clarification of the Pediatric Emergency Care Coordinator as part of the Pediatric Readiness Project, sent multiple letters and personal contacts regarding the NY State requirement for Pediatric Advanced Life Support/Advanced Pediatric Life Support (PALS/APLS), created a letter regarding a waiver of required CLIA competency assessments for point of care testing, and opposed Pennsylvania Department of Health requirement for Basic Cardiac Life Support (BCLS) training. In 2019, COMMB changed its name to the Coalition of Board Certified Emergency Physicians (COBCEP) and they continue to work on the military requirement for Basic Life Support (BLS) and requirements for BLS, ACLS, and PALS for emergency physicians who practice in Puerto Rico. The group is currently working on the impact of state required physician education. After ACEP assisted with pilot testing through the Emergency Medicine Practice Research Network, ABEM sent a survey to their diplomates regarding the types of courses required, the estimated time to complete these requirements, the estimated cost of meeting these requirements, and the usefulness of the material required. Several thousand individuals completed the survey and the results are currently being analyzed.

In addition, there have been numerous resolutions submitted to the American Medical Association (AMA) regarding required continuing medical education (CME). For example, current AMA policy “supports physician autonomy by partnering with relevant organizations to encourage medical organizations or institutions that employ physicians and offer financial support towards continuing medical education (CME) to avoid prioritizing institutional goals over individual physician educational needs in the choice of CME coursework.” Another AMA policy states that “the medical profession alone has the responsibility for setting standards and determining curricula in continuing medical education. State medical societies in states which already have a content-specific CME requirement should consider appropriate ways of rescinding or amending the mandate.”

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

Unbudgeted staff resources and unbudgeted funds of approximately \$10,000 for an in-person task force meeting for 10 people and approximately \$20,000 to conduct a survey.

Prior Council Action

Amended Resolution 43(15) Required CME Burden adopted. Called for the College to address annual requirements for CME in specific areas that could lead to reduced ongoing education in other clinical area and work with other organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to care for all ED patients.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted. Directed ACEP to adopt a position that board certification in emergency medicine through the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, and/or sub-board on Pediatric Emergency Medicine of the American Board of Pediatrics, along with participation in Maintenance of Certification programs currently required by these Boards is sufficient for practicing emergency physicians to maintain hospital privileges, health plan participation and medical group inclusion, and Maintenance of Licensure, and requiring additional

certifications beyond board certification for emergency physicians, such as Basic Life Support, Advanced Cardiac Life Support, Advanced Trauma Life Support, and Pediatric Advanced Life Support, and other maintenance programs is redundant and unnecessary.

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted. This resolution called for the College to open dialogue with the American Hospital Association, third party payers, and accreditation entities regarding the inappropriate use of ACLS and similar courses for credentialing of board-certified emergency physicians.

Amended Resolution 14(98) Merit Badge Medicine referred to the Board. This resolution called for the College policy on "Merit Badge Medicine" to read as follows: The ACEP believes that certification of knowledge and skills in emergency medicine can result only from successful completion of examinations administered by a recognized board in emergency medicine. The successful completion of any course, or series of courses, or a specified number of CME hours in a sub-area of emergency medicine, may serve as evidence of knowledge and skill of a certain sub-area of medicine. However, the completion of such does not serve as an acceptable substitute for certification of knowledge and skills to practice emergency medicine. Therefore, ACEP opposes the use of certificates of completion of courses such as ATLS, ACLS, PALS, BTLS or a specified number of CME hours in a sub-area of emergency medicine as requirements for credentialing or employment of any physician certified in emergency medicine by the ABEM or the AOBEM.

Substitute Resolution 9(91) Merit Badge Medicine adopted. The resolution called for the College to request ABEM provide a statement that board certification supersedes successful completion of courses taught in ACLS, ATLS, APLS, etc., and that ACEP disseminate its current policy on "Merit Badge Medicine" with recommendations on methods for their use by membership.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted. This resolution called for the College to develop appropriate language that can be incorporated into legislation and regulations that would reflect the College's position opposing the use of certificates of completion of short courses in special areas relating to emergency medicine as criteria for employment, staff appointment, licensure, or facility designations when such physicians are board certified in emergency medicine.

Prior Board Action

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), Society for Academic Emergency Medicine (SAEM).

January 2022, approved the revised policy statement, "[Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment.](#)" revised and approved January 2016 and April 2012; Reaffirmed September 2005; Revised in June 1999, June 1997, August 1992 and originally approved January 1984 titled "Certification in Emergency Medicine.

January 2022, approved the revised policy statement, "[CME Burden.](#)" originally approved April 2016.

June 2019, approved the policy statement, "[Compensated Time for Faculty Academic Administration and Teaching Involvement.](#)"

June 2018, approved the revised policy statement "[Emergency Medicine Training, Competency, and Professional Practice Principles.](#)" reaffirmed April 2012; revised and approved January 2006; originally approved November 2001.

August 2017, reviewed the Policy Resource & Education Paper (PREP) "[Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine.](#)" originally reviewed June 2006. This PREP is an adjunct to the policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine

April 2017, approved the revised policy statement “[Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine](#).” revised and approved October 2014, June 2006, and June 2004; reaffirmed October 1999; Revised with current title September 1995 and June 1991; originally approved April 1985 titled, “Guidelines for Delineation of Clinical Privileges in Emergency Medicine.”

Amended Resolution 43(15) Required CME Burden adopted.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted.
Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted.

Substitute Resolution 9(91) Merit Badge Medicine adopted.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

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



Late Resolution

RESOLUTION: 56(23)
SUBMITTED BY: Indiana Chapter
SUBJECT: In Memory of William A. Nice, MD

1 WHEREAS, Emergency medicine lost a beloved leader of our specialty in the passing of William A. Nice,
2 MD, who died March 4, 2023; and
3

4 WHEREAS, Dr. Nice earned his medical degree from Indiana University School of Medicine in 1968 and
5 was vice-president of the Christian Medical Society chapter and he then completed a transitional year at South Bend
6 Memorial Hospital; and
7

8 WHEREAS, After completing his transitional year, Dr. Nice went to Rhodesia (now Zimbabwe) and was the
9 only physician at Chidamoyo Christian Hospital in the bush of the north part of the country for three years; and
10

11 WHEREAS, Dr. Nice returned to the U.S. and settled in Bloomington, Indiana, in early 1973 and began his
12 practice of emergency medicine more than six years before emergency medicine was a specialty; and
13

14 WHEREAS, Dr. Nice was a founding member of Unity Physician Group and the Director of the Emergency
15 Department at the Bloomington Hospital for over 25 years, as well as being on staff at several other Indiana hospitals
16 and immediate care centers; and
17

18 WHEREAS, Dr. Nice was one of the first emergency physicians certified by the American Board of
19 Emergency Medicine and soon became an oral examiner for the Board; and
20

21 WHEREAS, Dr. Nice was an early member of the American College of Emergency Physicians and was
22 President of the Indiana Chapter in the mid-1970s and he was instrumental in hiring the first two executive directors
23 of the Indiana Chapter; and
24

25 WHEREAS, Dr. Nice was an active councillor from Indiana for many years in the 1970s and 1980s and
26 served on the Tellers, Credentials, & Elections Committee for several of those years; and
27

28 WHEREAS, Dr. Nice is a legacy physician in Indiana and on behalf of emergency medicine at the national
29 level; therefore be it
30

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



Late Resolution

RESOLUTION: 57(23)

SUBMITTED BY: Angela Cornelius MD, MA, FACEP
D. Mark Courtney, MD, FACEP
Angela F. Gardner, MD, FACEP
Jeffrey M. Goodloe MD, FACEP
Andrew Hogan, MD
S. Marshal Isaacs, MD, FACEP
Jeff Jarvis MD, MS, FACEP
Jeffery C. Metzger, MD, MBA, FACEP
Brian L. Miller MD, FACEP
Brandon Morshedi, MD, DPT, FACEP
Kathy Rinnert, MD, MPH, FACEP
John J. Rogers MD, FACEP
Gilberto A. Salazar, MD, FACEP
Robert E. Suter, DO, MHA, FACEP
Raymond E. Swienton, MD, FACEP
Dustin Williams, MD, FACEP
Georgia College of Emergency Physicians
Texas College of Emergency Physicians

SUBJECT: Commendation for Raymond L. Fowler, MD, FACEP, FAEMS

1 WHEREAS, Raymond Logan Fowler, MD, FACEP, FAEMS, has practiced for a half century as an
2 enthusiastic and beloved frontline emergency physician and is a talented educator of paramedics, nurses, medical
3 students, and residents; and
4

5 WHEREAS, For the last two decades, Dr. Fowler has served as a highly published Professor of Emergency
6 Medicine and Chief of the Emergency Medical Services/Disaster/Global Health Division at UT Southwestern Medical
7 Center, and a brilliant attending in the nation's busiest emergency department, Parkland Hospital in Dallas, TX; and
8

9 WHEREAS, Dr. Fowler served as the president of the Georgia Chapter of ACEP and president of the
10 National Association of EMS Physicians and he has received numerous awards including ACEP's Award for
11 Outstanding Contribution in EMS in 2012; and
12

13 WHEREAS, Dr. Fowler is the author of numerous articles and textbooks including serving as one of the
14 Editors in Chief for the text *Emergency Medical Services: Clinical Practice and Systems Oversight*; and
15

16 WHEREAS, Dr. Fowler served as the inaugural Program Director for the ACEP-affiliated International
17 Trauma Life Support Course; therefore be it
18

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



Late Resolution

RESOLUTION: 58(23)
SUBMITTED BY: New York Chapter
SUBJECT: In Memory of Bradley Middleton, MD

1 WHEREAS, The specialty of emergency medicine lost a beloved colleague who was just starting a promising career
2 and was entering a post-graduate ultrasound fellowship when Bradley Middleton, MD, passed away on June 26, 2023 at the
3 age of 34; and
4

5 WHEREAS, Dr. Middleton completed his medical school training at SUNY Upstate and his residency training in
6 emergency medicine at the same institution; and
7

8 WHEREAS, Dr. Middleton was one of the kindest and most compassionate physicians with an entire career ahead of
9 him; and
10

11 WHEREAS, Dr. Middleton was a highly sought after educator, clinician, emergency medicine team member,
12 husband, father, and a member of the extended emergency medicine family; therefore be it
13

14 RESOLVED, That the American College of Emergency Physicians cherishes the memory of Bradley Middleton,
15 MD, whose short career touched many lives; and be it further
16

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

Memorandum

To: 2023 Council

From: Sonja Montgomery, CAE
Governance Operations Director

Date: October 3, 2023

Subj: ACEP Composition Annual Report

The 2019 Council adopted Amended Resolution 12 ACEP Composition Annual Report:

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

The reports contain the demographic information that was requested in the resolution.

Although ACEP's membership system has the ability to capture the information, the data is limited to the extent that members provide the information in their membership profile and how often the information is updated. Many members choose not to answer the profile questions. The term "no value" in any of the reports indicates that the information was not provided by the member.

Currently, members are asked to provide the profile information when joining ACEP and there are periodic reminders to update or complete the profile information. Staff are exploring ways to encourage members to provide their demographic information. The membership profile questionnaire was updated last year include additional demographic information.

HEADQUARTERS

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Vice Speaker

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Susan E. Sedory, MA, CAE

ACEP Composition Age Demographics

All Members

| delegation | age Group | |
|------------|---------------|-------|
| All | | 37032 |
| | 20 to 30 | 7568 |
| | 31 to 40 | 11065 |
| | 41 to 50 | 6846 |
| | 51 to 60 | 4390 |
| | 61 to 70 | 2756 |
| | GreaterThan70 | 1297 |
| | No Value | 3110 |

ACEP Composition Age Demographics

Councillors And Alternate Councillors

| delegation | age Group | |
|------------|---------------|-----|
| All | | 517 |
| | 20 to 30 | 15 |
| | 31 to 40 | 152 |
| | 41 to 50 | 172 |
| | 51 to 60 | 96 |
| | 61 to 70 | 57 |
| | GreaterThan70 | 24 |
| | No Value | 1 |

ACEP Composition Age Demographics

Councillors And Alternate Councillors

| delegation | age Group | |
|---------------------------------------|---------------|----|
| AACEM | | 1 |
| | 61 to 70 | 1 |
| AAWEP Section | | 1 |
| | 31 to 40 | 1 |
| Air Medical Transport Section | | 2 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| Alabama Chapter | | 3 |
| | 31 to 40 | 2 |
| | 51 to 60 | 1 |
| Alaska Chapter | | 1 |
| | 41 to 50 | 1 |
| Arizona Chapter | | 8 |
| | 31 to 40 | 3 |
| | 41 to 50 | 1 |
| | 51 to 60 | 3 |
| | 61 to 70 | 1 |
| Arkansas Chapter | | 4 |
| | 31 to 40 | 1 |
| | 41 to 50 | 1 |
| | 51 to 60 | 2 |
| California Chapter | | 41 |
| | 31 to 40 | 14 |
| | 41 to 50 | 8 |
| | 51 to 60 | 14 |
| | 61 to 70 | 3 |
| | GreaterThan70 | 2 |
| Careers in Emergency Medicine Section | | 1 |
| | GreaterThan70 | 1 |
| Colorado Chapter | | 10 |
| | 31 to 40 | 2 |
| | 41 to 50 | 5 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 2 |

| delegation | age Group | |
|--|------------------|----|
| Connecticut Chapter | | 6 |
| | 20 to 30 | 1 |
| | 41 to 50 | 2 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 1 |
| CORD | | 1 |
| | 51 to 60 | 1 |
| Critical Care Medicine Section | | 1 |
| | 31 to 40 | 1 |
| Cruise Ship Medicine Section | | 1 |
| | 41 to 50 | 1 |
| Delaware Chapter | | 3 |
| | 31 to 40 | 2 |
| | 41 to 50 | 1 |
| Democratic Group Practice Section | | 1 |
| | 41 to 50 | 1 |
| Disaster Medicine Section | | 1 |
| | 31 to 40 | 1 |
| District of Columbia Chapter | | 3 |
| | 31 to 40 | 2 |
| | 61 to 70 | 1 |
| Diversity & Inclusion Section | | 1 |
| | 51 to 60 | 1 |
| Dual Training Section | | 2 |
| | 31 to 40 | 1 |
| | 51 to 60 | 1 |
| EM Practice Mgmt and Health Policy Section | | 1 |
| | 61 to 70 | 1 |
| Emergency Medical Informatics Section | | 2 |
| | 31 to 40 | 1 |
| | 61 to 70 | 1 |
| Emergency Medicine Locum Tenens Section | | 1 |
| | 51 to 60 | 1 |
| Emergency Medicine Residents' Association | | 14 |
| | 20 to 30 | 4 |
| | 31 to 40 | 9 |
| | 41 to 50 | 1 |

| delegation | age Group | |
|--------------------------------------|------------------|----|
| Emergency Medicine Workforce Section | | 1 |
| | GreaterThan70 | 1 |
| Emergency Telehealth Section | | 2 |
| | 41 to 50 | 1 |
| | 61 to 70 | 1 |
| Emergency Ultrasound Section | | 2 |
| | 41 to 50 | 2 |
| EMS-Prehospital Care Section | | 1 |
| | 31 to 40 | 1 |
| Event Medicine Section | | 1 |
| | 31 to 40 | 1 |
| Florida Chapter | | 17 |
| | 31 to 40 | 6 |
| | 41 to 50 | 3 |
| | 51 to 60 | 5 |
| | 61 to 70 | 3 |
| Forensic Medicine Section | | 1 |
| | 51 to 60 | 1 |
| Freestanding Emergency Centers | | 1 |
| | 51 to 60 | 1 |
| Georgia Chapter | | 8 |
| | 31 to 40 | 1 |
| | 41 to 50 | 3 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 2 |
| Geriatric Emergency Medicine Section | | 2 |
| | 31 to 40 | 1 |
| | 41 to 50 | 1 |
| Govt Services Chapter | | 11 |
| | 20 to 30 | 1 |
| | 31 to 40 | 6 |
| | 41 to 50 | 2 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| Hawaii Chapter | | 2 |
| | 41 to 50 | 2 |
| Idaho Chapter | | 2 |
| | 31 to 40 | 1 |

| delegation | age Group | |
|--|---------------|----|
| | 61 to 70 | 1 |
| Illinois Chapter | | 12 |
| | 31 to 40 | 1 |
| | 41 to 50 | 4 |
| | 51 to 60 | 4 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 1 |
| Indiana Chapter | | 9 |
| | 31 to 40 | 5 |
| | 41 to 50 | 1 |
| | 51 to 60 | 2 |
| | GreaterThan70 | 1 |
| International Emergency Medicine Section | | 1 |
| | 41 to 50 | 1 |
| Iowa Chapter | | 4 |
| | 31 to 40 | 2 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| Kansas Chapter | | 4 |
| | 41 to 50 | 3 |
| | 61 to 70 | 1 |
| Kentucky Chapter | | 4 |
| | 31 to 40 | 1 |
| | 41 to 50 | 1 |
| | 51 to 60 | 2 |
| Louisiana Chapter | | 7 |
| | 41 to 50 | 3 |
| | 51 to 60 | 1 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 1 |
| Maine Chapter | | 5 |
| | 41 to 50 | 2 |
| | 51 to 60 | 2 |
| | 61 to 70 | 1 |
| Maryland Chapter | | 7 |
| | 41 to 50 | 3 |
| | 51 to 60 | 4 |
| Massachusetts Chapter | | 10 |
| | 31 to 40 | 1 |

| delegation | age Group | |
|----------------------------|---------------|----|
| | 41 to 50 | 2 |
| | 51 to 60 | 5 |
| | 61 to 70 | 2 |
| Medical Directors Section | | 2 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| Medical Humanities Section | | 2 |
| | 41 to 50 | 1 |
| | 61 to 70 | 1 |
| Michigan Chapter | | 25 |
| | 31 to 40 | 7 |
| | 41 to 50 | 11 |
| | 51 to 60 | 3 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 2 |
| Minnesota Chapter | | 9 |
| | 31 to 40 | 1 |
| | 41 to 50 | 5 |
| | 51 to 60 | 2 |
| | GreaterThan70 | 1 |
| Mississippi Chapter | | 3 |
| | 31 to 40 | 1 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| Missouri Chapter | | 8 |
| | 31 to 40 | 3 |
| | 41 to 50 | 3 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| Montana Chapter | | 2 |
| | 41 to 50 | 1 |
| | 61 to 70 | 1 |
| Nebraska Chapter | | 2 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| Nevada Chapter | | 4 |
| | 41 to 50 | 3 |
| | 51 to 60 | 1 |

| delegation | age Group | |
|------------------------------|------------------|----|
| New Hampshire Chapter | | 1 |
| | 61 to 70 | 1 |
| New Jersey Chapter | | 12 |
| | 20 to 30 | 2 |
| | 31 to 40 | 4 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| | 61 to 70 | 3 |
| | GreaterThan70 | 1 |
| New Mexico Chapter | | 4 |
| | 31 to 40 | 3 |
| | 51 to 60 | 1 |
| New York Chapter | | 31 |
| | 20 to 30 | 1 |
| | 31 to 40 | 12 |
| | 41 to 50 | 9 |
| | 51 to 60 | 5 |
| | 61 to 70 | 3 |
| | GreaterThan70 | 1 |
| North Carolina Chapter | | 14 |
| | 31 to 40 | 2 |
| | 41 to 50 | 8 |
| | 51 to 60 | 4 |
| North Dakota Chapter | | 1 |
| | 41 to 50 | 1 |
| Observation Services Section | | 1 |
| | 41 to 50 | 1 |
| Ohio Chapter | | 23 |
| | 20 to 30 | 1 |
| | 31 to 40 | 7 |
| | 41 to 50 | 9 |
| | 51 to 60 | 2 |
| | 61 to 70 | 3 |
| | GreaterThan70 | 1 |
| Oklahoma Chapter | | 5 |
| | 31 to 40 | 1 |
| | 41 to 50 | 2 |
| | 51 to 60 | 2 |

| delegation | age Group | |
|---|------------------|----|
| Oregon Chapter | | 4 |
| | 31 to 40 | 1 |
| | 51 to 60 | 1 |
| | GreaterThan70 | 1 |
| | No Value | 1 |
| Pain Management Section | | 1 |
| | 31 to 40 | 1 |
| Palliative Medicine Section | | 1 |
| | 31 to 40 | 1 |
| Pediatric Emergency Medicine Section | | 1 |
| | 41 to 50 | 1 |
| Pennsylvania Chapter | | 23 |
| | 20 to 30 | 1 |
| | 31 to 40 | 6 |
| | 41 to 50 | 11 |
| | 51 to 60 | 4 |
| | 61 to 70 | 1 |
| Puerto Rico Chapter | | 2 |
| | 41 to 50 | 2 |
| Quality Improvement and Patient Safety Section | | 1 |
| | 31 to 40 | 1 |
| Research, Scholarly Activity and Innovation Section | | 1 |
| | 31 to 40 | 1 |
| Rhode Island Chapter | | 3 |
| | 41 to 50 | 2 |
| | GreaterThan70 | 1 |
| Rural Emergency Medicine Section | | 1 |
| | 41 to 50 | 1 |
| Social Emergency Medicine Section | | 1 |
| | 31 to 40 | 1 |
| Society of Academic Emergency Medicine | | 1 |
| | 61 to 70 | 1 |
| South Carolina Chapter | | 7 |
| | 31 to 40 | 1 |
| | 41 to 50 | 4 |
| | 51 to 60 | 2 |
| South Dakota Chapter | | 2 |
| | 41 to 50 | 2 |

| delegation | age Group | |
|--|------------------|----|
| Sports Medicine Section | | 1 |
| | 31 to 40 | 1 |
| Tennessee Chapter | | 5 |
| | 41 to 50 | 2 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 1 |
| Texas Chapter | | 37 |
| | 20 to 30 | 2 |
| | 31 to 40 | 12 |
| | 41 to 50 | 13 |
| | 51 to 60 | 3 |
| | 61 to 70 | 6 |
| | GreaterThan70 | 1 |
| Toxicology Section | | 1 |
| | 41 to 50 | 1 |
| Trauma & Injury Prevention Section | | 1 |
| | 61 to 70 | 1 |
| Undersea & Hyperbaric Medicine Section | | 1 |
| | 31 to 40 | 1 |
| Utah Chapter | | 6 |
| | 20 to 30 | 2 |
| | 41 to 50 | 2 |
| | GreaterThan70 | 2 |
| Vermont Chapter | | 3 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| Virginia Chapter | | 9 |
| | 31 to 40 | 5 |
| | 41 to 50 | 3 |
| | 51 to 60 | 1 |
| Washington Chapter | | 13 |
| | 31 to 40 | 2 |
| | 41 to 50 | 8 |
| | 61 to 70 | 3 |
| Wellness Section | | 3 |
| | 51 to 60 | 2 |
| | 61 to 70 | 1 |

| delegation | age Group | |
|-----------------------------|------------------|---|
| West Virginia Chapter | | 3 |
| | 31 to 40 | 3 |
| Wilderness Medicine Section | | 2 |
| | 31 to 40 | 2 |
| Wisconsin Chapter | | 6 |
| | 31 to 40 | 1 |
| | 41 to 50 | 4 |
| | 51 to 60 | 1 |
| Wyoming Chapter | | 1 |
| | 31 to 40 | 1 |
| Young Physicians Section | | 3 |
| | 31 to 40 | 3 |

ACEP Composition Age Demographics

All Committees

| delegation | age Group | |
|---|---------------|----|
| Academic Affairs Committee | | 57 |
| | 20 to 30 | 1 |
| | 31 to 40 | 17 |
| | 41 to 50 | 29 |
| | 51 to 60 | 7 |
| | 61 to 70 | 3 |
| Audit Committee | | 8 |
| | 41 to 50 | 5 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 1 |
| Awards Committee | | 12 |
| | 41 to 50 | 3 |
| | 51 to 60 | 4 |
| | 61 to 70 | 4 |
| | GreaterThan70 | 1 |
| Bylaws Committee | | 21 |
| | 20 to 30 | 1 |
| | 31 to 40 | 5 |
| | 41 to 50 | 5 |
| | 51 to 60 | 4 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 4 |
| CEDR - Clinical Emergency Data Registry Committee | | 38 |
| | 20 to 30 | 4 |
| | 31 to 40 | 11 |
| | 41 to 50 | 6 |
| | 51 to 60 | 9 |
| | 61 to 70 | 6 |
| | GreaterThan70 | 2 |
| Clinical Policies Committee | | 28 |
| | 31 to 40 | 3 |
| | 41 to 50 | 8 |
| | 51 to 60 | 14 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 2 |
| Clinical Resources Review Committee | | 25 |
| | 31 to 40 | 1 |
| | 41 to 50 | 13 |

| | | |
|---|---------------|------------|
| | 51 to 60 | 8 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 1 |
| Coding and Nomenclature Advisory Committee | | 43 |
| | 31 to 40 | 12 |
| | 41 to 50 | 12 |
| | 51 to 60 | 14 |
| | 61 to 70 | 3 |
| | GreaterThan70 | 2 |
| Communications Committee | | 34 |
| | 31 to 40 | 10 |
| | 41 to 50 | 11 |
| | 51 to 60 | 4 |
| | 61 to 70 | 7 |
| | GreaterThan70 | 1 |
| | No Value | 1 |
| Compensation Committee | | 6 |
| | 41 to 50 | 1 |
| | 51 to 60 | 2 |
| | 61 to 70 | 3 |
| Disaster Preparedness & Response Committee | | 49 |
| | 20 to 30 | 1 |
| | 31 to 40 | 18 |
| | 41 to 50 | 16 |
| | 51 to 60 | 6 |
| | 61 to 70 | 5 |
| | GreaterThan70 | 3 |
| Diversity, Equity, and Inclusion Committee | | 33 |
| | 20 to 30 | 1 |
| | 31 to 40 | 7 |
| | 41 to 50 | 14 |
| | 51 to 60 | 6 |
| | 61 to 70 | 4 |
| | GreaterThan70 | 1 |
| Education Committee | | 115 |
| | 20 to 30 | 4 |
| | 31 to 40 | 39 |
| | 41 to 50 | 41 |
| | 51 to 60 | 21 |
| | 61 to 70 | 7 |
| | GreaterThan70 | 3 |
| Emergency Medical Services (EMS) Committee | | 44 |
| | 20 to 30 | 1 |
| | 31 to 40 | 14 |

| | | |
|--|---------------|----|
| | 41 to 50 | 16 |
| | 51 to 60 | 8 |
| | 61 to 70 | 5 |
| Emergency Medicine Practice Committee | | 57 |
| | 20 to 30 | 5 |
| | 31 to 40 | 20 |
| | 41 to 50 | 15 |
| | 51 to 60 | 7 |
| | 61 to 70 | 8 |
| | GreaterThan70 | 1 |
| | No Value | 1 |
| Ethics Committee | | 41 |
| | 20 to 30 | 2 |
| | 31 to 40 | 9 |
| | 41 to 50 | 12 |
| | 51 to 60 | 8 |
| | 61 to 70 | 6 |
| | GreaterThan70 | 4 |
| Federal Government Affairs Committee | | 44 |
| | 20 to 30 | 2 |
| | 31 to 40 | 9 |
| | 41 to 50 | 13 |
| | 51 to 60 | 2 |
| | 61 to 70 | 13 |
| | GreaterThan70 | 5 |
| Finance Committee | | 19 |
| | 31 to 40 | 3 |
| | 41 to 50 | 9 |
| | 51 to 60 | 2 |
| | 61 to 70 | 3 |
| | GreaterThan70 | 2 |
| Health Innovation Technology Committee | | 47 |
| | 20 to 30 | 3 |
| | 31 to 40 | 14 |
| | 41 to 50 | 13 |
| | 51 to 60 | 10 |
| | 61 to 70 | 7 |
| International Emergency Medicine Committee | | 25 |
| | 20 to 30 | 1 |
| | 31 to 40 | 7 |
| | 41 to 50 | 8 |
| | 51 to 60 | 4 |
| | 61 to 70 | 4 |
| | GreaterThan70 | 1 |

| | | |
|--|---------------|----|
| Medical-Legal Committee | | 40 |
| | 20 to 30 | 2 |
| | 31 to 40 | 6 |
| | 41 to 50 | 10 |
| | 51 to 60 | 10 |
| | 61 to 70 | 5 |
| | GreaterThan70 | 7 |
| Membership Committee | | 22 |
| | 31 to 40 | 6 |
| | 41 to 50 | 11 |
| | 51 to 60 | 2 |
| | 61 to 70 | 2 |
| | No Value | 1 |
| National Chapter Relations Committee | | 16 |
| | 31 to 40 | 4 |
| | 41 to 50 | 9 |
| | 51 to 60 | 3 |
| Pediatric Emergency Medicine Committee | | 53 |
| | 31 to 40 | 15 |
| | 41 to 50 | 18 |
| | 51 to 60 | 13 |
| | 61 to 70 | 7 |
| Public Health Committee | | 41 |
| | 20 to 30 | 3 |
| | 31 to 40 | 12 |
| | 41 to 50 | 17 |
| | 51 to 60 | 7 |
| | 61 to 70 | 2 |
| Quality and Patient Safety Committee | | 83 |
| | 20 to 30 | 3 |
| | 31 to 40 | 30 |
| | 41 to 50 | 30 |
| | 51 to 60 | 14 |
| | 61 to 70 | 5 |
| | GreaterThan70 | 1 |
| Reimbursement Committee | | 76 |
| | 20 to 30 | 1 |
| | 31 to 40 | 20 |
| | 41 to 50 | 21 |
| | 51 to 60 | 16 |
| | 61 to 70 | 9 |
| | GreaterThan70 | 8 |
| | No Value | 1 |
| Research Committee | | 73 |

| | | |
|---|---------------|-----------|
| | 20 to 30 | 2 |
| | 31 to 40 | 22 |
| | 41 to 50 | 28 |
| | 51 to 60 | 14 |
| | 61 to 70 | 5 |
| | GreaterThan70 | 2 |
| State Legislative/Regulatory Committee | | 72 |
| | 20 to 30 | 3 |
| | 31 to 40 | 26 |
| | 41 to 50 | 25 |
| | 51 to 60 | 8 |
| | 61 to 70 | 6 |
| Well-Being Committee | | 50 |
| | 20 to 30 | 4 |
| | 31 to 40 | 13 |
| | 41 to 50 | 13 |
| | 51 to 60 | 12 |
| | 61 to 70 | 5 |
| | GreaterThan70 | 3 |

ACEP Composition Age Demographics

Committees Chairs

| delegation | age Group | |
|---|---------------|---|
| Academic Affairs Committee | | 2 |
| | 41 to 50 | 2 |
| Audit Committee | | 2 |
| | 41 to 50 | 1 |
| | 61 to 70 | 1 |
| Bylaws Committee | | 2 |
| | 41 to 50 | 1 |
| | GreaterThan70 | 1 |
| CEDR - Clinical Emergency Data Registry Committee | | 1 |
| | GreaterThan70 | 1 |
| Clinical Policies Committee | | 1 |
| | 51 to 60 | 1 |
| Clinical Resources Review Committee | | 1 |
| | 41 to 50 | 1 |
| Coding and Nomenclature Advisory Committee | | 1 |
| | 51 to 60 | 1 |
| Compensation Committee | | 1 |
| | 51 to 60 | 1 |
| Disaster Preparedness & Response Committee | | 1 |
| | 41 to 50 | 1 |
| Diversity, Equity, and Inclusion Committee | | 1 |
| | 51 to 60 | 1 |
| Education Committee | | 2 |
| | 51 to 60 | 2 |
| Emergency Medical Services (EMS) Committee | | 1 |
| | 51 to 60 | 1 |
| Emergency Medicine Practice Committee | | 1 |
| | 61 to 70 | 1 |
| Ethics Committee | | 1 |
| | 41 to 50 | 1 |
| Federal Government Affairs Committee | | 2 |
| | 41 to 50 | 2 |
| Finance Committee | | 1 |
| | 41 to 50 | 1 |
| Health Innovation Technology Committee | | 1 |
| | 41 to 50 | 1 |
| International Emergency Medicine Committee | | 2 |
| | 41 to 50 | 1 |

| | | |
|--|----------|---|
| | 51 to 60 | 1 |
| Medical-Legal Committee | | 1 |
| | 41 to 50 | 1 |
| Membership Committee | | 2 |
| | 41 to 50 | 2 |
| National Chapter Relations Committee | | 1 |
| | 51 to 60 | 1 |
| Pediatric Emergency Medicine Committee | | 2 |
| | 51 to 60 | 2 |
| Public Health Committee | | 1 |
| | 41 to 50 | 1 |
| Quality and Patient Safety Committee | | 1 |
| | 51 to 60 | 1 |
| Reimbursement Committee | | 2 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| Research Committee | | 1 |
| | 31 to 40 | 1 |
| State Legislative/Regulatory Committee | | 2 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| Well-Being Committee | | 1 |
| | 31 to 40 | 1 |

ACEP Composition Age Demographics

Section Leaders

| delegation | age Group | |
|--|---------------|----|
| Air Medical Transport Section | | 8 |
| | 41 to 50 | 6 |
| | 51 to 60 | 2 |
| American Association of Women Emergency Physicians Section | | 10 |
| | 20 to 30 | 3 |
| | 31 to 40 | 2 |
| | 41 to 50 | 5 |
| Careers in Emergency Medicine Section | | 6 |
| | 41 to 50 | 1 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 4 |
| Critical Care Medicine Section | | 7 |
| | 31 to 40 | 5 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| Cruise Ship Medicine Section | | 5 |
| | 41 to 50 | 2 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 1 |
| Democratic Group Practice Section | | 9 |
| | 31 to 40 | 1 |
| | 41 to 50 | 4 |
| | 51 to 60 | 3 |
| | GreaterThan70 | 1 |
| Disaster Medicine Section | | 10 |
| | 31 to 40 | 2 |
| | 41 to 50 | 3 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 3 |
| Diversity, Inclusion and Health Equity Section | | 9 |
| | 41 to 50 | 3 |
| | 51 to 60 | 3 |
| | GreaterThan70 | 3 |
| Dual Training Section | | 7 |
| | 31 to 40 | 2 |
| | 41 to 50 | 1 |
| | 51 to 60 | 2 |

| | | |
|--|---------------|----|
| | GreaterThan70 | 1 |
| | No Value | 1 |
| Emergency Medical Informatics Section | | 5 |
| | 31 to 40 | 2 |
| | 41 to 50 | 2 |
| | 61 to 70 | 1 |
| Emergency Medical Services-Prehospital Care Section | | 11 |
| | 31 to 40 | 1 |
| | 41 to 50 | 6 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 2 |
| Emergency Medicine Practice Management and Health Policy Section | | 6 |
| | 31 to 40 | 3 |
| | 41 to 50 | 1 |
| | 61 to 70 | 2 |
| Emergency Medicine Workforce Section | | 11 |
| | 31 to 40 | 1 |
| | 41 to 50 | 1 |
| | 51 to 60 | 5 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 2 |
| Emergency Ultrasound Section | | 9 |
| | 31 to 40 | 3 |
| | 41 to 50 | 3 |
| | 51 to 60 | 2 |
| | GreaterThan70 | 1 |
| Event Medicine Section | | 10 |
| | 41 to 50 | 4 |
| | 51 to 60 | 2 |
| | 61 to 70 | 3 |
| | GreaterThan70 | 1 |
| Exploring Retirement Section | | 4 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 3 |
| Forensic Medicine Section | | 6 |
| | 31 to 40 | 1 |
| | 41 to 50 | 1 |
| | 51 to 60 | 4 |
| Freestanding Emergency Centers Section | | 10 |
| | 51 to 60 | 4 |
| | 61 to 70 | 4 |

| | | |
|---|---------------|----|
| | GreaterThan70 | 2 |
| Geriatric Emergency Medicine Section | | 6 |
| | 31 to 40 | 2 |
| | 41 to 50 | 2 |
| | 51 to 60 | 1 |
| | GreaterThan70 | 1 |
| International Emergency Medicine Section | | 9 |
| | 20 to 30 | 1 |
| | 31 to 40 | 4 |
| | 41 to 50 | 4 |
| Locum Tenens Section | | 3 |
| | 41 to 50 | 1 |
| | 51 to 60 | 2 |
| Medical Directors Section | | 11 |
| | 31 to 40 | 1 |
| | 41 to 50 | 4 |
| | 51 to 60 | 3 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 2 |
| Medical Humanities Section | | 6 |
| | 31 to 40 | 1 |
| | 41 to 50 | 1 |
| | 51 to 60 | 1 |
| | 61 to 70 | 3 |
| Observation Medicine Section | | 7 |
| | 31 to 40 | 2 |
| | 41 to 50 | 4 |
| | 51 to 60 | 1 |
| Pain Management & Addiction Medicine Section | | 7 |
| | 31 to 40 | 3 |
| | 41 to 50 | 2 |
| | 51 to 60 | 2 |
| Palliative Medicine Section | | 5 |
| | 31 to 40 | 3 |
| | 41 to 50 | 2 |
| Pediatric Emergency Medicine Section | | 8 |
| | 31 to 40 | 4 |
| | 41 to 50 | 3 |
| | 51 to 60 | 1 |
| Quality Improvement and Patient Safety Section | | 9 |
| | 31 to 40 | 7 |
| | 41 to 50 | 2 |
| Research, Scholarly Activity and Innovation Section | | 10 |

| | | |
|--|---------------|-----------|
| | 31 to 40 | 2 |
| | 41 to 50 | 3 |
| | 51 to 60 | 2 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 2 |
| Rural Emergency Medicine Section | | 8 |
| | 31 to 40 | 2 |
| | 41 to 50 | 2 |
| | 51 to 60 | 1 |
| | 61 to 70 | 2 |
| | GreaterThan70 | 1 |
| Social Emergency Medicine Section | | 8 |
| | 31 to 40 | 3 |
| | 41 to 50 | 5 |
| Sports Medicine Section | | 8 |
| | 31 to 40 | 4 |
| | 41 to 50 | 2 |
| | 51 to 60 | 1 |
| | GreaterThan70 | 1 |
| Tactical and Law Enforcement Medicine Section | | 10 |
| | 31 to 40 | 2 |
| | 41 to 50 | 2 |
| | 51 to 60 | 4 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 1 |
| Telehealth Section | | 9 |
| | 31 to 40 | 1 |
| | 41 to 50 | 5 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 1 |
| Toxicology Section | | 9 |
| | 31 to 40 | 3 |
| | 41 to 50 | 3 |
| | 51 to 60 | 3 |
| Trauma and Injury Prevention Section | | 4 |
| | 41 to 50 | 2 |
| | 51 to 60 | 1 |
| | 61 to 70 | 1 |
| Undersea & Hyperbaric Medicine Section | | 7 |
| | 31 to 40 | 2 |
| | 41 to 50 | 4 |
| | 51 to 60 | 1 |
| Wellness Section | | 6 |

| | | |
|-----------------------------|---------------|---|
| | 31 to 40 | 2 |
| | 51 to 60 | 2 |
| | 61 to 70 | 1 |
| | GreaterThan70 | 1 |
| Wilderness Medicine Section | | 6 |
| | 31 to 40 | 2 |
| | 41 to 50 | 3 |
| | 51 to 60 | 1 |
| Young Physicians Section | | 6 |
| | 31 to 40 | 5 |
| | 51 to 60 | 1 |

Council Gender Demographics

All Members

| delegation | Gender | |
|------------|-------------|-------|
| All | | 37040 |
| | Female | 11712 |
| | Male | 21432 |
| | No Value | 3866 |
| | Other | 27 |
| | Transgender | 3 |

Council Gender Demographics

Councillors And Alternate Councillors

| delegation | Gender | |
|-------------------|---------------|-----|
| All | | 517 |
| | Female | 191 |
| | Male | 305 |
| | No Value | 21 |

Council Gender Demographics

Councillors And Alternate Councillors

| delegation | Gender | |
|---------------------------------------|----------|----|
| AACEM | | 1 |
| | Male | 1 |
| AAWEP Section | | 1 |
| | Female | 1 |
| Air Medical Transport Section | | 2 |
| | Female | 1 |
| | Male | 1 |
| Alabama Chapter | | 3 |
| | Female | 1 |
| | Male | 2 |
| Alaska Chapter | | 1 |
| | Female | 1 |
| Arizona Chapter | | 8 |
| | Female | 4 |
| | Male | 3 |
| | No Value | 1 |
| Arkansas Chapter | | 4 |
| | Male | 3 |
| | No Value | 1 |
| California Chapter | | 41 |
| | Female | 17 |
| | Male | 23 |
| | No Value | 1 |
| Careers in Emergency Medicine Section | | 1 |
| | Female | 1 |
| Colorado Chapter | | 10 |
| | Female | 5 |
| | Male | 5 |
| Connecticut Chapter | | 6 |
| | Female | 1 |
| | Male | 4 |
| | No Value | 1 |
| CORD | | 1 |
| | Male | 1 |

| delegation | Gender | |
|--|---------------|----|
| Critical Care Medicine Section | | 1 |
| | Male | 1 |
| Cruise Ship Medicine Section | | 1 |
| | Male | 1 |
| Delaware Chapter | | 3 |
| | Female | 2 |
| | Male | 1 |
| Democratic Group Practice Section | | 1 |
| | Male | 1 |
| Disaster Medicine Section | | 1 |
| | Female | 1 |
| District of Columbia Chapter | | 3 |
| | Female | 1 |
| | Male | 2 |
| Diversity & Inclusion Section | | 1 |
| | Male | 1 |
| Dual Training Section | | 2 |
| | Female | 1 |
| | Male | 1 |
| EM Practice Mgmt and Health Policy Section | | 1 |
| | Male | 1 |
| Emergency Medical Informatics Section | | 2 |
| | Male | 2 |
| Emergency Medicine Locum Tenens Section | | 1 |
| | Female | 1 |
| Emergency Medicine Residents' Association | | 14 |
| | Female | 7 |
| | Male | 7 |
| Emergency Medicine Workforce Section | | 1 |
| | Male | 1 |
| Emergency Telehealth Section | | 2 |
| | Female | 2 |
| Emergency Ultrasound Section | | 2 |
| | Female | 1 |
| | Male | 1 |
| EMS-Prehospital Care Section | | 1 |
| | Male | 1 |
| Event Medicine Section | | 1 |
| | Male | 1 |

| delegation | Gender | |
|--|---------------|----|
| Florida Chapter | | 17 |
| | Female | 6 |
| | Male | 11 |
| Forensic Medicine Section | | 1 |
| | Female | 1 |
| Freestanding Emergency Centers | | 1 |
| | Male | 1 |
| Georgia Chapter | | 8 |
| | Male | 8 |
| Geriatric Emergency Medicine Section | | 2 |
| | Female | 1 |
| | Male | 1 |
| Govt Services Chapter | | 11 |
| | Female | 7 |
| | Male | 3 |
| | No Value | 1 |
| Hawaii Chapter | | 2 |
| | Female | 1 |
| | Male | 1 |
| Idaho Chapter | | 2 |
| | Female | 1 |
| | Male | 1 |
| Illinois Chapter | | 12 |
| | Female | 4 |
| | Male | 8 |
| Indiana Chapter | | 9 |
| | Female | 4 |
| | Male | 4 |
| | No Value | 1 |
| International Emergency Medicine Section | | 1 |
| | Female | 1 |
| Iowa Chapter | | 4 |
| | Female | 2 |
| | Male | 2 |
| Kansas Chapter | | 4 |
| | Male | 4 |
| Kentucky Chapter | | 4 |
| | Female | 1 |
| | Male | 3 |

| delegation | Gender | |
|----------------------------|---------------|----|
| Louisiana Chapter | | 7 |
| | Female | 2 |
| | Male | 5 |
| Maine Chapter | | 5 |
| | Male | 5 |
| Maryland Chapter | | 7 |
| | Female | 3 |
| | Male | 4 |
| Massachusetts Chapter | | 10 |
| | Female | 3 |
| | Male | 6 |
| | No Value | 1 |
| Medical Directors Section | | 2 |
| | Male | 2 |
| Medical Humanities Section | | 2 |
| | Female | 2 |
| Michigan Chapter | | 25 |
| | Female | 12 |
| | Male | 12 |
| | No Value | 1 |
| Minnesota Chapter | | 9 |
| | Female | 1 |
| | Male | 7 |
| | No Value | 1 |
| Mississippi Chapter | | 3 |
| | Female | 1 |
| | Male | 2 |
| Missouri Chapter | | 8 |
| | Male | 7 |
| | No Value | 1 |
| Montana Chapter | | 2 |
| | Male | 2 |
| Nebraska Chapter | | 2 |
| | Female | 2 |
| Nevada Chapter | | 4 |
| | Male | 4 |
| New Hampshire Chapter | | 1 |
| | Female | 1 |

| delegation | Gender | |
|--------------------------------------|---------------|----|
| New Jersey Chapter | | 12 |
| | Female | 5 |
| | Male | 5 |
| | No Value | 2 |
| New Mexico Chapter | | 4 |
| | Female | 1 |
| | Male | 3 |
| New York Chapter | | 31 |
| | Female | 8 |
| | Male | 23 |
| North Carolina Chapter | | 14 |
| | Female | 3 |
| | Male | 11 |
| North Dakota Chapter | | 1 |
| | Male | 1 |
| Observation Services Section | | 1 |
| | Male | 1 |
| Ohio Chapter | | 23 |
| | Female | 9 |
| | Male | 12 |
| | No Value | 2 |
| Oklahoma Chapter | | 5 |
| | Female | 1 |
| | Male | 4 |
| Oregon Chapter | | 4 |
| | Female | 1 |
| | Male | 3 |
| Pain Management Section | | 1 |
| | Male | 1 |
| Palliative Medicine Section | | 1 |
| | Female | 1 |
| Pediatric Emergency Medicine Section | | 1 |
| | No Value | 1 |
| Pennsylvania Chapter | | 23 |
| | Female | 12 |
| | Male | 10 |
| | No Value | 1 |
| Puerto Rico Chapter | | 2 |
| | Female | 1 |

| delegation | Gender | |
|---|----------|----|
| | Male | 1 |
| Quality Improvement and Patient Safety Section | | 1 |
| | Male | 1 |
| Research, Scholarly Activity and Innovation Section | | 1 |
| | Male | 1 |
| Rhode Island Chapter | | 3 |
| | Female | 1 |
| | Male | 2 |
| Rural Emergency Medicine Section | | 1 |
| | Male | 1 |
| Social Emergency Medicine Section | | 1 |
| | Female | 1 |
| Society of Academic Emergency Medicine | | 1 |
| | Female | 1 |
| South Carolina Chapter | | 7 |
| | Female | 4 |
| | Male | 2 |
| | No Value | 1 |
| South Dakota Chapter | | 2 |
| | Male | 2 |
| Sports Medicine Section | | 1 |
| | Female | 1 |
| Tennessee Chapter | | 5 |
| | Male | 5 |
| Texas Chapter | | 37 |
| | Female | 16 |
| | Male | 19 |
| | No Value | 2 |
| Toxicology Section | | 1 |
| | Female | 1 |
| Trauma & Injury Prevention Section | | 1 |
| | No Value | 1 |
| Undersea & Hyperbaric Medicine Section | | 1 |
| | Female | 1 |
| Utah Chapter | | 6 |
| | Female | 2 |
| | Male | 4 |
| Vermont Chapter | | 3 |
| | Female | 1 |

| delegation | Gender | |
|-----------------------------|---------------|----|
| | Male | 2 |
| Virginia Chapter | | 9 |
| | Female | 4 |
| | Male | 4 |
| | No Value | 1 |
| Washington Chapter | | 13 |
| | Female | 6 |
| | Male | 7 |
| Wellness Section | | 3 |
| | Female | 3 |
| West Virginia Chapter | | 3 |
| | Female | 1 |
| | Male | 2 |
| Wilderness Medicine Section | | 2 |
| | Male | 2 |
| Wisconsin Chapter | | 6 |
| | Female | 1 |
| | Male | 5 |
| Wyoming Chapter | | 1 |
| | Male | 1 |
| Young Physicians Section | | 3 |
| | Female | 1 |
| | Male | 2 |

Council Gender Demographics

All Committees

| delegation | Gender | |
|---|---------------|----|
| Academic Affairs Committee | | 57 |
| | Female | 27 |
| | Male | 30 |
| Audit Committee | | 8 |
| | Female | 1 |
| | Male | 7 |
| Awards Committee | | 12 |
| | Female | 4 |
| | Male | 8 |
| Bylaws Committee | | 21 |
| | Female | 7 |
| | Male | 14 |
| CEDR - Clinical Emergency Data Registry Committee | | 38 |
| | Female | 8 |
| | Male | 26 |
| | No Value | 4 |
| Clinical Policies Committee | | 28 |
| | Female | 6 |
| | Male | 21 |
| | No Value | 1 |
| Clinical Resources Review Committee | | 25 |
| | Female | 7 |
| | Male | 18 |
| Coding and Nomenclature Advisory Committee | | 43 |
| | Female | 12 |
| | Male | 30 |
| | No Value | 1 |
| Communications Committee | | 34 |
| | Female | 12 |
| | Male | 21 |
| | No Value | 1 |
| Compensation Committee | | 6 |
| | Female | 1 |
| | Male | 5 |
| Disaster Preparedness & Response Committee | | 49 |
| | Female | 17 |
| | Male | 31 |
| | No Value | 1 |

| | | |
|--|----------|-----|
| Diversity, Equity, and Inclusion Committee | | 33 |
| | Female | 19 |
| | Male | 12 |
| | No Value | 2 |
| Education Committee | | 115 |
| | Female | 47 |
| | Male | 67 |
| | No Value | 1 |
| Emergency Medical Services (EMS) Committee | | 44 |
| | Female | 5 |
| | Male | 39 |
| Emergency Medicine Practice Committee | | 57 |
| | Female | 19 |
| | Male | 37 |
| | No Value | 1 |
| Ethics Committee | | 41 |
| | Female | 20 |
| | Male | 20 |
| | No Value | 1 |
| Federal Government Affairs Committee | | 44 |
| | Female | 15 |
| | Male | 28 |
| | No Value | 1 |
| Finance Committee | | 19 |
| | Female | 7 |
| | Male | 12 |
| Government Services | | 2 |
| | Female | 1 |
| | Male | 1 |
| Health Innovation Technology Committee | | 47 |
| | Female | 12 |
| | Male | 33 |
| | No Value | 2 |
| International Emergency Medicine Committee | | 25 |
| | Female | 11 |
| | Male | 13 |
| | No Value | 1 |
| Medical-Legal Committee | | 40 |
| | Female | 7 |
| | Male | 31 |
| | No Value | 2 |
| Membership Committee | | 22 |
| | Female | 6 |
| | Male | 15 |

| | | |
|--|----------|----|
| | No Value | 1 |
| National Chapter Relations Committee | | 16 |
| | Female | 6 |
| | Male | 9 |
| | No Value | 1 |
| Pediatric Emergency Medicine Committee | | 53 |
| | Female | 30 |
| | Male | 23 |
| Public Health Committee | | 41 |
| | Female | 21 |
| | Male | 19 |
| | No Value | 1 |
| Quality and Patient Safety Committee | | 83 |
| | Female | 29 |
| | Male | 52 |
| | No Value | 2 |
| Reimbursement Committee | | 76 |
| | Female | 16 |
| | Male | 59 |
| | No Value | 1 |
| Research Committee | | 73 |
| | Female | 23 |
| | Male | 49 |
| | No Value | 1 |
| State Legislative/Regulatory Committee | | 72 |
| | Female | 27 |
| | Male | 43 |
| | No Value | 2 |
| Well-Being Committee | | 50 |
| | Female | 33 |
| | Male | 17 |

Council Gender Demographics

Committees Chairs

| delegation | Gender | |
|---|--------|---|
| Academic Affairs Committee | | 2 |
| | Female | 1 |
| | Male | 1 |
| Audit Committee | | 2 |
| | Male | 2 |
| Bylaws Committee | | 2 |
| | Male | 2 |
| CEDR - Clinical Emergency Data Registry Committee | | 1 |
| | Male | 1 |
| Clinical Policies Committee | | 1 |
| | Female | 1 |
| Clinical Resources Review Committee | | 1 |
| | Male | 1 |
| Coding and Nomenclature Advisory Committee | | 1 |
| | Male | 1 |
| Compensation Committee | | 1 |
| | Male | 1 |
| Disaster Preparedness & Response Committee | | 1 |
| | Female | 1 |
| Diversity, Equity, and Inclusion Committee | | 1 |
| | Male | 1 |
| Education Committee | | 2 |
| | Male | 2 |
| Emergency Medical Services (EMS) Committee | | 1 |
| | Male | 1 |
| Emergency Medicine Practice Committee | | 1 |
| | Male | 1 |
| Ethics Committee | | 1 |
| | Male | 1 |
| Federal Government Affairs Committee | | 2 |
| | Female | 1 |
| | Male | 1 |
| Finance Committee | | 1 |
| | Male | 1 |

| delegation | Gender | |
|--|---------------|---|
| Health Innovation Technology Committee | | 1 |
| | Female | 1 |
| International Emergency Medicine Committee | | 2 |
| | Female | 1 |
| | Male | 1 |
| Leadership Development Advisory Committee (LDAC) | | 1 |
| | Male | 1 |
| Medical-Legal Committee | | 1 |
| | Female | 1 |
| Membership Committee | | 2 |
| | Female | 1 |
| | Male | 1 |
| National Chapter Relations Committee | | 1 |
| | Female | 1 |
| Pediatric Emergency Medicine Committee | | 2 |
| | Male | 2 |
| Public Health Committee | | 1 |
| | Male | 1 |
| Quality and Patient Safety Committee | | 1 |
| | Female | 1 |
| Reimbursement Committee | | 2 |
| | Male | 2 |
| Research Committee | | 1 |
| | Female | 1 |
| State Legislative/Regulatory Committee | | 2 |
| | Male | 2 |
| Well-Being Committee | | 1 |
| | Female | 1 |

Council Gender Demographics

Section Leaders

| delegation | Gender | |
|--|----------|----|
| Air Medical Transport Section | | 8 |
| | Female | 3 |
| | Male | 5 |
| American Association of Women Emergency Physicians Section | | 10 |
| | Female | 9 |
| | No Value | 1 |
| Careers in Emergency Medicine Section | | 6 |
| | Female | 3 |
| | Male | 3 |
| Critical Care Medicine Section | | 7 |
| | Female | 4 |
| | Male | 3 |
| Cruise Ship Medicine Section | | 5 |
| | Female | 1 |
| | Male | 4 |
| Democratic Group Practice Section | | 9 |
| | Female | 2 |
| | Male | 7 |
| Disaster Medicine Section | | 10 |
| | Female | 5 |
| | Male | 5 |
| Diversity, Inclusion and Health Equity Section | | 9 |
| | Female | 5 |
| | Male | 4 |
| Dual Training Section | | 7 |
| | Female | 2 |
| | Male | 4 |
| | No Value | 1 |
| Emergency Medical Informatics Section | | 5 |
| | Female | 2 |
| | Male | 3 |
| Emergency Medical Services-Prehospital Care Section | | 11 |
| | Female | 4 |
| | Male | 7 |
| Emergency Medicine Informatics Section Leadership | | 4 |
| | Female | 1 |

| | | |
|--|--------|----|
| | Male | 3 |
| Emergency Medicine Practice Management and Health Policy Section | | 6 |
| | Female | 1 |
| | Male | 5 |
| Emergency Medicine Workforce Section | | 11 |
| | Female | 5 |
| | Male | 6 |
| Emergency Ultrasound Section | | 9 |
| | Female | 5 |
| | Male | 4 |
| Event Medicine Section | | 10 |
| | Female | 2 |
| | Male | 8 |
| Exploring Retirement Section | | 4 |
| | Female | 2 |
| | Male | 2 |
| Forensic Medicine Section | | 6 |
| | Female | 6 |
| Freestanding Emergency Centers Section | | 10 |
| | Female | 3 |
| | Male | 7 |
| Geriatric Emergency Medicine Section | | 6 |
| | Female | 5 |
| | Male | 1 |
| International Emergency Medicine Section | | 9 |
| | Female | 3 |
| | Male | 6 |
| Locum Tenens Section | | 3 |
| | Female | 3 |
| Medical Directors Section | | 11 |
| | Female | 5 |
| | Male | 6 |
| Medical Humanities Section | | 6 |
| | Female | 1 |
| | Male | 5 |
| Observation Medicine Section | | 7 |
| | Female | 1 |
| | Male | 6 |
| Pain Management & Addiction Medicine Section | | 7 |
| | Male | 7 |
| Palliative Medicine Section | | 5 |
| | Female | 4 |
| | Male | 1 |

| | | |
|---|----------|----|
| Pediatric Emergency Medicine Section | | 8 |
| | Female | 3 |
| | Male | 3 |
| | No Value | 2 |
| Quality Improvement and Patient Safety Section | | 9 |
| | Female | 2 |
| | Male | 7 |
| Research, Scholarly Activity and Innovation Section | | 10 |
| | Female | 1 |
| | Male | 9 |
| Rural Emergency Medicine Section | | 8 |
| | Female | 2 |
| | Male | 6 |
| Social Emergency Medicine Section | | 8 |
| | Female | 6 |
| | Male | 2 |
| Sports Medicine Section | | 8 |
| | Female | 2 |
| | Male | 6 |
| Tactical and Law Enforcement Medicine Section | | 10 |
| | Female | 1 |
| | Male | 9 |
| Telehealth Section | | 9 |
| | Female | 8 |
| | Male | 1 |
| Toxicology Section | | 9 |
| | Female | 4 |
| | Male | 5 |
| Trauma and Injury Prevention Section | | 4 |
| | Male | 3 |
| | No Value | 1 |
| Undersea & Hyperbaric Medicine Section | | 7 |
| | Female | 3 |
| | Male | 4 |
| Wellness Section | | 6 |
| | Female | 3 |
| | Male | 3 |
| Wilderness Medicine Section | | 6 |
| | Female | 2 |
| | Male | 4 |
| Young Physicians Section | | 6 |
| | Female | 3 |
| | Male | 3 |

ACEP Composition Ethnicity Demographics

All Members

| delegation | Ethnicity | |
|------------|---|-------|
| All | | 37042 |
| | Asian | 2051 |
| | Black or African American | 948 |
| | Hispanic or Latino | 1299 |
| | I Prefer Not to Answer | 131 |
| | Middle Eastern/North African | 103 |
| | More Than One/Multiracial | 515 |
| | Native American or Alaska Native | 59 |
| | Native Hawaiian or Other Pacific Islander | 19 |
| | No Value | 12004 |
| | Other/Not Listed | 6049 |
| | White | 13864 |

ACEP Composition Ethnicity Demographics

Councillors And Alternate Councillors

| delegation | Ethnicity | |
|------------|---|-----|
| All | | 517 |
| | Asian | 33 |
| | Black or African American | 11 |
| | Hispanic or Latino | 9 |
| | I Prefer Not to Answer | 23 |
| | Middle Eastern/North African | 1 |
| | More Than One/Multiracial | 13 |
| | Native American or Alaska Native | 2 |
| | Native Hawaiian or Other Pacific Islander | 1 |
| | No Value | 46 |
| | Other/Not Listed | 57 |
| | White | 321 |

ACEP Composition Ethnicity Demographics

Councillors And Alternate Councillors

| delegation | Ethnicity | |
|---------------------------------------|------------------------------|----|
| AACEM | | 1 |
| | White | 1 |
| AAWEP Section | | 1 |
| | White | 1 |
| Air Medical Transport Section | | 2 |
| | White | 2 |
| Alabama Chapter | | 3 |
| | White | 3 |
| Alaska Chapter | | 1 |
| | White | 1 |
| Arizona Chapter | | 8 |
| | I Prefer Not to Answer | 2 |
| | Other/Not Listed | 1 |
| | White | 5 |
| Arkansas Chapter | | 4 |
| | I Prefer Not to Answer | 1 |
| | No Value | 1 |
| | Other/Not Listed | 1 |
| | White | 1 |
| California Chapter | | 41 |
| | Asian | 4 |
| | Black or African American | 1 |
| | Hispanic or Latino | 1 |
| | I Prefer Not to Answer | 2 |
| | Middle Eastern/North African | 1 |
| | More Than One/Multiracial | 1 |
| | Other/Not Listed | 5 |
| | White | 26 |
| Careers in Emergency Medicine Section | | 1 |
| | More Than One/Multiracial | 1 |
| Colorado Chapter | | 10 |
| | No Value | 1 |
| | Other/Not Listed | 2 |
| | White | 7 |

| delegation | Ethnicity | |
|--|---------------------------|----|
| Connecticut Chapter | | 6 |
| | No Value | 1 |
| | Other/Not Listed | 1 |
| | White | 4 |
| CORD | | 1 |
| | Other/Not Listed | 1 |
| Critical Care Medicine Section | | 1 |
| | White | 1 |
| Cruise Ship Medicine Section | | 1 |
| | No Value | 1 |
| Delaware Chapter | | 3 |
| | White | 3 |
| Democratic Group Practice Section | | 1 |
| | Other/Not Listed | 1 |
| Disaster Medicine Section | | 1 |
| | No Value | 1 |
| District of Columbia Chapter | | 3 |
| | White | 3 |
| Diversity & Inclusion Section | | 1 |
| | Black or African American | 1 |
| Dual Training Section | | 2 |
| | Asian | 1 |
| | More Than One/Multiracial | 1 |
| EM Practice Mgmt and Health Policy Section | | 1 |
| | White | 1 |
| Emergency Medical Informatics Section | | 2 |
| | White | 2 |
| Emergency Medicine Locum Tenens Section | | 1 |
| | White | 1 |
| Emergency Medicine Residents' Association | | 14 |
| | Asian | 1 |
| | No Value | 4 |
| | Other/Not Listed | 2 |
| | White | 7 |
| Emergency Medicine Workforce Section | | 1 |
| | White | 1 |
| Emergency Telehealth Section | | 2 |
| | Other/Not Listed | 1 |
| | White | 1 |

| delegation | Ethnicity | |
|--------------------------------------|---|----|
| Emergency Ultrasound Section | | 2 |
| | Asian | 1 |
| | White | 1 |
| EMS-Prehospital Care Section | | 1 |
| | White | 1 |
| Event Medicine Section | | 1 |
| | No Value | 1 |
| Florida Chapter | | 17 |
| | Black or African American | 1 |
| | Native Hawaiian or Other Pacific Islander | 1 |
| | No Value | 1 |
| | Other/Not Listed | 1 |
| | White | 13 |
| Forensic Medicine Section | | 1 |
| | Other/Not Listed | 1 |
| Freestanding Emergency Centers | | 1 |
| | White | 1 |
| Georgia Chapter | | 8 |
| | Asian | 1 |
| | Other/Not Listed | 1 |
| | White | 6 |
| Geriatric Emergency Medicine Section | | 2 |
| | Asian | 1 |
| | White | 1 |
| Govt Services Chapter | | 11 |
| | Black or African American | 1 |
| | I Prefer Not to Answer | 1 |
| | More Than One/Multiracial | 1 |
| | White | 8 |
| Hawaii Chapter | | 2 |
| | White | 2 |
| Idaho Chapter | | 2 |
| | White | 2 |
| Illinois Chapter | | 12 |
| | Asian | 3 |
| | More Than One/Multiracial | 1 |
| | No Value | 1 |
| | White | 7 |

| delegation | Ethnicity | |
|--|---------------------------|----|
| Indiana Chapter | | 9 |
| | I Prefer Not to Answer | 1 |
| | No Value | 1 |
| | Other/Not Listed | 1 |
| | White | 6 |
| International Emergency Medicine Section | | 1 |
| | Asian | 1 |
| Iowa Chapter | | 4 |
| | White | 4 |
| Kansas Chapter | | 4 |
| | Asian | 1 |
| | Other/Not Listed | 1 |
| | White | 2 |
| Kentucky Chapter | | 4 |
| | White | 4 |
| Louisiana Chapter | | 7 |
| | Asian | 1 |
| | I Prefer Not to Answer | 1 |
| | White | 5 |
| Maine Chapter | | 5 |
| | White | 5 |
| Maryland Chapter | | 7 |
| | More Than One/Multiracial | 1 |
| | Other/Not Listed | 1 |
| | White | 5 |
| Massachusetts Chapter | | 10 |
| | I Prefer Not to Answer | 1 |
| | No Value | 1 |
| | Other/Not Listed | 4 |
| | White | 4 |
| Medical Directors Section | | 2 |
| | Other/Not Listed | 1 |
| | White | 1 |
| Medical Humanities Section | | 2 |
| | More Than One/Multiracial | 1 |
| | White | 1 |
| Michigan Chapter | | 25 |
| | Asian | 2 |
| | I Prefer Not to Answer | 1 |

| delegation | Ethnicity | |
|-----------------------|----------------------------------|----|
| | No Value | 2 |
| | White | 20 |
| Minnesota Chapter | | 9 |
| | Asian | 1 |
| | Native American or Alaska Native | 1 |
| | No Value | 1 |
| | Other/Not Listed | 4 |
| | White | 2 |
| Mississippi Chapter | | 3 |
| | Black or African American | 1 |
| | White | 2 |
| Missouri Chapter | | 8 |
| | Hispanic or Latino | 1 |
| | No Value | 1 |
| | White | 6 |
| Montana Chapter | | 2 |
| | White | 2 |
| Nebraska Chapter | | 2 |
| | White | 2 |
| Nevada Chapter | | 4 |
| | Other/Not Listed | 3 |
| | White | 1 |
| New Hampshire Chapter | | 1 |
| | White | 1 |
| New Jersey Chapter | | 12 |
| | Asian | 1 |
| | Black or African American | 1 |
| | I Prefer Not to Answer | 1 |
| | No Value | 3 |
| | White | 6 |
| New Mexico Chapter | | 4 |
| | No Value | 1 |
| | White | 3 |
| New York Chapter | | 31 |
| | Asian | 3 |
| | Hispanic or Latino | 2 |
| | No Value | 2 |
| | Other/Not Listed | 6 |

| delegation | Ethnicity | |
|--------------------------------------|----------------------------------|----|
| | White | 18 |
| North Carolina Chapter | | 14 |
| | Asian | 2 |
| | No Value | 1 |
| | Other/Not Listed | 4 |
| | White | 7 |
| North Dakota Chapter | | 1 |
| | White | 1 |
| Observation Services Section | | 1 |
| | Other/Not Listed | 1 |
| Ohio Chapter | | 23 |
| | Asian | 1 |
| | Black or African American | 1 |
| | I Prefer Not to Answer | 3 |
| | No Value | 2 |
| | White | 16 |
| Oklahoma Chapter | | 5 |
| | Hispanic or Latino | 1 |
| | More Than One/Multiracial | 1 |
| | Native American or Alaska Native | 1 |
| | No Value | 1 |
| | White | 1 |
| Oregon Chapter | | 4 |
| | No Value | 1 |
| | White | 3 |
| Pain Management Section | | 1 |
| | Other/Not Listed | 1 |
| Palliative Medicine Section | | 1 |
| | Hispanic or Latino | 1 |
| Pediatric Emergency Medicine Section | | 1 |
| | I Prefer Not to Answer | 1 |
| Pennsylvania Chapter | | 23 |
| | Asian | 2 |
| | Black or African American | 2 |
| | I Prefer Not to Answer | 3 |
| | More Than One/Multiracial | 2 |
| | White | 14 |

| delegation | Ethnicity | |
|---|---------------------------|----|
| Puerto Rico Chapter | | 2 |
| | Hispanic or Latino | 2 |
| Quality Improvement and Patient Safety Section | | 1 |
| | White | 1 |
| Research, Scholarly Activity and Innovation Section | | 1 |
| | White | 1 |
| Rhode Island Chapter | | 3 |
| | Asian | 1 |
| | White | 2 |
| Rural Emergency Medicine Section | | 1 |
| | No Value | 1 |
| Social Emergency Medicine Section | | 1 |
| | White | 1 |
| Society of Academic Emergency Medicine | | 1 |
| | White | 1 |
| South Carolina Chapter | | 7 |
| | I Prefer Not to Answer | 1 |
| | No Value | 1 |
| | Other/Not Listed | 1 |
| | White | 4 |
| South Dakota Chapter | | 2 |
| | Other/Not Listed | 2 |
| Sports Medicine Section | | 1 |
| | No Value | 1 |
| Tennessee Chapter | | 5 |
| | More Than One/Multiracial | 1 |
| | White | 4 |
| Texas Chapter | | 37 |
| | Asian | 3 |
| | Black or African American | 2 |
| | More Than One/Multiracial | 1 |
| | No Value | 7 |
| | Other/Not Listed | 3 |
| | White | 21 |
| Toxicology Section | | 1 |
| | White | 1 |
| Trauma & Injury Prevention Section | | 1 |
| | I Prefer Not to Answer | 1 |

| delegation | Ethnicity | |
|--|---------------------------|----|
| Undersea & Hyperbaric Medicine Section | | 1 |
| | White | 1 |
| Utah Chapter | | 6 |
| | I Prefer Not to Answer | 1 |
| | No Value | 1 |
| | White | 4 |
| Vermont Chapter | | 3 |
| | White | 3 |
| Virginia Chapter | | 9 |
| | Asian | 1 |
| | I Prefer Not to Answer | 1 |
| | No Value | 2 |
| | Other/Not Listed | 2 |
| | White | 3 |
| Washington Chapter | | 13 |
| | Hispanic or Latino | 1 |
| | No Value | 1 |
| | Other/Not Listed | 4 |
| | White | 7 |
| Wellness Section | | 3 |
| | I Prefer Not to Answer | 1 |
| | White | 2 |
| West Virginia Chapter | | 3 |
| | White | 3 |
| Wilderness Medicine Section | | 2 |
| | No Value | 1 |
| | White | 1 |
| Wisconsin Chapter | | 6 |
| | More Than One/Multiracial | 1 |
| | No Value | 1 |
| | White | 4 |
| Wyoming Chapter | | 1 |
| | No Value | 1 |
| Young Physicians Section | | 3 |
| | Asian | 1 |
| | White | 2 |

ACEP Composition Ethnicity Demographics

All Committees

| delegation | Ethnicity | |
|---|---|----|
| Academic Affairs Committee | | 57 |
| | Asian | 6 |
| | Black or African American | 3 |
| | Hispanic or Latino | 1 |
| | More Than One/Multiracial | 2 |
| | Native Hawaiian or Other Pacific Islander | 1 |
| | No Value | 7 |
| | Other/Not Listed | 12 |
| | White | 25 |
| Administration and Operations | | 1 |
| | Asian | 1 |
| Audit Committee | | 8 |
| | Other/Not Listed | 3 |
| | White | 5 |
| Awards Committee | | 12 |
| | Asian | 1 |
| | Black or African American | 1 |
| | White | 10 |
| Bylaws Committee | | 21 |
| | Asian | 1 |
| | Black or African American | 1 |
| | Hispanic or Latino | 1 |
| | Middle Eastern/North African | 1 |
| | More Than One/Multiracial | 1 |
| | Other/Not Listed | 1 |
| | White | 15 |
| CEDR - Clinical Emergency Data Registry Committee | | 38 |
| | Asian | 4 |
| | Black or African American | 1 |
| | I Prefer Not to Answer | 2 |
| | Middle Eastern/North African | 1 |
| | No Value | 7 |
| | Other/Not Listed | 10 |
| | White | 13 |
| Clinical Policies Committee | | 28 |
| | Asian | 2 |

| | | |
|---|------------------------------|------------|
| | Hispanic or Latino | 1 |
| | I Prefer Not to Answer | 2 |
| | More Than One/Multiracial | 1 |
| | No Value | 2 |
| | Other/Not Listed | 10 |
| | White | 10 |
| Clinical Resources Review Committee | | 25 |
| | Asian | 4 |
| | Hispanic or Latino | 1 |
| | I Prefer Not to Answer | 1 |
| | Other/Not Listed | 2 |
| | White | 17 |
| Coding and Nomenclature Advisory Committee | | 43 |
| | Asian | 5 |
| | Black or African American | 4 |
| | Hispanic or Latino | 1 |
| | I Prefer Not to Answer | 1 |
| | No Value | 5 |
| | Other/Not Listed | 9 |
| | White | 18 |
| Communications Committee | | 34 |
| | No Value | 6 |
| | Other/Not Listed | 5 |
| | White | 23 |
| Compensation Committee | | 6 |
| | Asian | 1 |
| | White | 5 |
| Disaster Preparedness & Response Committee | | 49 |
| | Asian | 3 |
| | Hispanic or Latino | 1 |
| | I Prefer Not to Answer | 1 |
| | No Value | 6 |
| | Other/Not Listed | 17 |
| | White | 21 |
| Diversity, Equity, and Inclusion Committee | | 33 |
| | Black or African American | 14 |
| | Hispanic or Latino | 4 |
| | Middle Eastern/North African | 1 |
| | No Value | 3 |
| | Other/Not Listed | 3 |
| | White | 8 |
| Education Committee | | 115 |
| | Asian | 8 |

| | | |
|---|---------------------------|-----------|
| | Black or African American | 2 |
| | Hispanic or Latino | 4 |
| | I Prefer Not to Answer | 2 |
| | More Than One/Multiracial | 4 |
| | No Value | 23 |
| | Other/Not Listed | 24 |
| | White | 48 |
| Emergency Medical Services (EMS) Committee | | 44 |
| | Asian | 1 |
| | I Prefer Not to Answer | 1 |
| | More Than One/Multiracial | 1 |
| | No Value | 7 |
| | Other/Not Listed | 6 |
| | White | 28 |
| Emergency Medicine Practice Committee | | 57 |
| | Asian | 5 |
| | Hispanic or Latino | 4 |
| | I Prefer Not to Answer | 1 |
| | More Than One/Multiracial | 1 |
| | No Value | 13 |
| | Other/Not Listed | 12 |
| | White | 21 |
| Ethics Committee | | 41 |
| | Asian | 2 |
| | Hispanic or Latino | 1 |
| | I Prefer Not to Answer | 1 |
| | More Than One/Multiracial | 1 |
| | No Value | 4 |
| | Other/Not Listed | 7 |
| | White | 25 |
| Federal Government Affairs Committee | | 44 |
| | Asian | 5 |
| | Black or African American | 1 |
| | Hispanic or Latino | 1 |
| | No Value | 4 |
| | Other/Not Listed | 3 |
| | White | 30 |
| Finance Committee | | 19 |
| | Asian | 1 |
| | Black or African American | 1 |
| | No Value | 2 |
| | Other/Not Listed | 2 |
| | White | 13 |
| Government Services | | 2 |

| | | |
|--|---------------------------|----|
| | More Than One/Multiracial | 1 |
| | No Value | 1 |
| Health Innovation Technology Committee | | 47 |
| | Asian | 4 |
| | Black or African American | 2 |
| | I Prefer Not to Answer | 1 |
| | No Value | 10 |
| | Other/Not Listed | 11 |
| | White | 19 |
| International Emergency Medicine Committee | | 25 |
| | Hispanic or Latino | 1 |
| | I Prefer Not to Answer | 1 |
| | No Value | 9 |
| | Other/Not Listed | 3 |
| | White | 11 |
| Medical-Legal Committee | | 40 |
| | Asian | 1 |
| | Hispanic or Latino | 2 |
| | More Than One/Multiracial | 1 |
| | No Value | 6 |
| | Other/Not Listed | 6 |
| | White | 24 |
| Membership Committee | | 22 |
| | Asian | 4 |
| | Black or African American | 1 |
| | No Value | 1 |
| | Other/Not Listed | 6 |
| | White | 10 |
| National Chapter Relations Committee | | 16 |
| | Asian | 1 |
| | Black or African American | 1 |
| | No Value | 2 |
| | Other/Not Listed | 1 |
| | White | 11 |
| Pediatric Emergency Medicine Committee | | 53 |
| | Asian | 6 |
| | Black or African American | 2 |
| | I Prefer Not to Answer | 1 |
| | More Than One/Multiracial | 2 |
| | No Value | 7 |
| | Other/Not Listed | 12 |
| | White | 23 |
| Public Health Committee | | 41 |
| | Asian | 4 |

| | | |
|---|------------------------------|-----------|
| | Black or African American | 1 |
| | Hispanic or Latino | 2 |
| | More Than One/Multiracial | 2 |
| | No Value | 8 |
| | Other/Not Listed | 8 |
| | White | 16 |
| Quality and Patient Safety Committee | | 83 |
| | Asian | 11 |
| | Black or African American | 1 |
| | Middle Eastern/North African | 2 |
| | No Value | 18 |
| | Other/Not Listed | 18 |
| | White | 33 |
| Reimbursement Committee | | 76 |
| | Asian | 3 |
| | Black or African American | 2 |
| | More Than One/Multiracial | 1 |
| | No Value | 9 |
| | Other/Not Listed | 15 |
| | White | 46 |
| Research Committee | | 73 |
| | Asian | 11 |
| | Black or African American | 5 |
| | No Value | 14 |
| | Other/Not Listed | 15 |
| | White | 28 |
| State Legislative/Regulatory Committee | | 72 |
| | Asian | 3 |
| | Black or African American | 1 |
| | Hispanic or Latino | 1 |
| | No Value | 11 |
| | Other/Not Listed | 11 |
| | White | 45 |
| Well-Being Committee | | 50 |
| | Asian | 4 |
| | Black or African American | 1 |
| | Hispanic or Latino | 3 |
| | I Prefer Not to Answer | 1 |
| | More Than One/Multiracial | 3 |
| | No Value | 8 |
| | Other/Not Listed | 12 |
| | White | 18 |

ACEP Composition Ethnicity Demographics

Committees Chairs

| delegation | Ethnicity | |
|---|---------------------------|---|
| Academic Affairs Committee | | 2 |
| | Asian | 1 |
| | Other/Not Listed | 1 |
| Audit Committee | | 2 |
| | Other/Not Listed | 1 |
| | White | 1 |
| Bylaws Committee | | 2 |
| | White | 2 |
| CEDR - Clinical Emergency Data Registry Committee | | 1 |
| | Asian | 1 |
| Clinical Policies Committee | | 1 |
| | White | 1 |
| Clinical Resources Review Committee | | 1 |
| | White | 1 |
| Coding and Nomenclature Advisory Committee | | 1 |
| | Other/Not Listed | 1 |
| Compensation Committee | | 1 |
| | White | 1 |
| Disaster Preparedness & Response Committee | | 1 |
| | White | 1 |
| Diversity, Equity, and Inclusion Committee | | 1 |
| | Black or African American | 1 |
| Education Committee | | 2 |
| | White | 2 |
| Emergency Medical Services (EMS) Committee | | 1 |
| | White | 1 |
| Emergency Medicine Practice Committee | | 1 |
| | Hispanic or Latino | 1 |
| Ethics Committee | | 1 |
| | White | 1 |
| Federal Government Affairs Committee | | 2 |
| | White | 2 |
| Finance Committee | | 1 |
| | White | 1 |

| delegation | Ethnicity | |
|--|------------------|---|
| Health Innovation Technology Committee | | 1 |
| | Other/Not Listed | 1 |
| International Emergency Medicine Committee | | 2 |
| | Other/Not Listed | 1 |
| | White | 1 |
| Leadership Development Advisory Committee (LDAC) | | 1 |
| | White | 1 |
| Medical-Legal Committee | | 1 |
| | White | 1 |
| Membership Committee | | 2 |
| | Asian | 1 |
| | White | 1 |
| National Chapter Relations Committee | | 1 |
| | White | 1 |
| Pediatric Emergency Medicine Committee | | 2 |
| | Asian | 1 |
| | White | 1 |
| Public Health Committee | | 1 |
| | White | 1 |
| Quality and Patient Safety Committee | | 1 |
| | White | 1 |
| Reimbursement Committee | | 2 |
| | White | 2 |
| Research Committee | | 1 |
| | Asian | 1 |
| State Legislative/Regulatory Committee | | 2 |
| | Other/Not Listed | 1 |
| | White | 1 |
| Well-Being Committee | | 1 |
| | White | 1 |

ACEP Composition Ethnicity Demographics

Section Leaders

| delegation | Ethnicity | |
|--|------------------------------|----|
| Air Medical Transport Section | | 8 |
| | No Value | 1 |
| | Other/Not Listed | 2 |
| | White | 5 |
| American Association of Women Emergency Physicians Section | | 10 |
| | Asian | 2 |
| | Black or African American | 1 |
| | Hispanic or Latino | 1 |
| | I Prefer Not to Answer | 1 |
| | No Value | 2 |
| | Other/Not Listed | 1 |
| | White | 2 |
| Careers in Emergency Medicine Section | | 6 |
| | More Than One/Multiracial | 2 |
| | White | 4 |
| Critical Care Medicine Section | | 7 |
| | No Value | 1 |
| | White | 6 |
| Cruise Ship Medicine Section | | 5 |
| | Black or African American | 1 |
| | I Prefer Not to Answer | 1 |
| | No Value | 2 |
| | White | 1 |
| Democratic Group Practice Section | | 9 |
| | Asian | 1 |
| | Hispanic or Latino | 1 |
| | Other/Not Listed | 3 |
| | White | 4 |
| Disaster Medicine Section | | 10 |
| | No Value | 4 |
| | Other/Not Listed | 2 |
| | White | 4 |
| Diversity, Inclusion and Health Equity Section | | 9 |
| | Black or African American | 4 |
| | Middle Eastern/North African | 1 |
| | Other/Not Listed | 2 |
| | White | 2 |

| | | |
|--|---------------------------|----|
| Dual Training Section | | 7 |
| | Asian | 2 |
| | More Than One/Multiracial | 1 |
| | No Value | 2 |
| | White | 2 |
| Emergency Medical Informatics Section | | 5 |
| | More Than One/Multiracial | 1 |
| | White | 4 |
| Emergency Medical Services-Prehospital Care Section | | 11 |
| | Other/Not Listed | 1 |
| | White | 10 |
| Emergency Medicine Informatics Section Leadership | | 4 |
| | More Than One/Multiracial | 1 |
| | Other/Not Listed | 1 |
| | White | 2 |
| Emergency Medicine Practice Management and Health Policy Section | | 6 |
| | I Prefer Not to Answer | 1 |
| | No Value | 3 |
| | Other/Not Listed | 1 |
| | White | 1 |
| Emergency Medicine Workforce Section | | 11 |
| | Asian | 2 |
| | Black or African American | 1 |
| | No Value | 1 |
| | White | 7 |
| Emergency Ultrasound Section | | 9 |
| | Asian | 3 |
| | More Than One/Multiracial | 1 |
| | No Value | 2 |
| | Other/Not Listed | 2 |
| | White | 1 |
| Event Medicine Section | | 10 |
| | Hispanic or Latino | 1 |
| | More Than One/Multiracial | 1 |
| | Other/Not Listed | 2 |
| | White | 6 |
| Exploring Retirement Section | | 4 |
| | White | 4 |
| Forensic Medicine Section | | 6 |
| | More Than One/Multiracial | 1 |
| | No Value | 1 |
| | Other/Not Listed | 2 |

| | | |
|--|---------------------------|----|
| | White | 2 |
| Freestanding Emergency Centers Section | | 10 |
| | More Than One/Multiracial | 1 |
| | Other/Not Listed | 2 |
| | White | 7 |
| Geriatric Emergency Medicine Section | | 6 |
| | Asian | 1 |
| | Other/Not Listed | 2 |
| | White | 3 |
| International Emergency Medicine Section | | 9 |
| | Asian | 1 |
| | Hispanic or Latino | 2 |
| | No Value | 2 |
| | White | 4 |
| Locum Tenens Section | | 3 |
| | Black or African American | 2 |
| | More Than One/Multiracial | 1 |
| Medical Directors Section | | 11 |
| | I Prefer Not to Answer | 1 |
| | Other/Not Listed | 3 |
| | White | 7 |
| Medical Humanities Section | | 6 |
| | Black or African American | 1 |
| | No Value | 1 |
| | White | 4 |
| Observation Medicine Section | | 7 |
| | Hispanic or Latino | 1 |
| | No Value | 1 |
| | Other/Not Listed | 3 |
| | White | 2 |
| Pain Management & Addiction Medicine Section | | 7 |
| | Other/Not Listed | 3 |
| | White | 4 |
| Palliative Medicine Section | | 5 |
| | Black or African American | 1 |
| | Hispanic or Latino | 2 |
| | No Value | 1 |
| | White | 1 |
| Pediatric Emergency Medicine Section | | 8 |
| | Asian | 1 |
| | I Prefer Not to Answer | 1 |
| | No Value | 2 |
| | Other/Not Listed | 2 |
| | White | 2 |

| | | |
|---|---|-----|
| Quality Improvement and Patient Safety Section | | 9 |
| | Middle Eastern/North African | 1 |
| | No Value | 3 |
| | Other/Not Listed | 1 |
| | White | 4 |
| Research, Scholarly Activity and Innovation Section | | 10 |
| | Other/Not Listed | 2 |
| | White | 8 |
| Rural Emergency Medicine Section | | 8 |
| | No Value | 2 |
| | Other/Not Listed | 1 |
| | White | 5 |
| Section Leaders | | 209 |
| | Asian | 11 |
| | Black or African American | 9 |
| | Hispanic or Latino | 6 |
| | I Prefer Not to Answer | 4 |
| | Middle Eastern/North African | 1 |
| | More Than One/Multiracial | 7 |
| | Native Hawaiian or Other Pacific Islander | 1 |
| | No Value | 40 |
| | Other/Not Listed | 39 |
| | White | 91 |
| Social EM Section: Education Workgroup | | 11 |
| | Hispanic or Latino | 1 |
| | No Value | 4 |
| | White | 6 |
| Social Emergency Medicine Section | | 8 |
| | Asian | 1 |
| | Black or African American | 1 |
| | No Value | 3 |
| | White | 3 |
| Sports Medicine Section | | 8 |
| | Asian | 1 |
| | More Than One/Multiracial | 1 |
| | No Value | 2 |
| | Other/Not Listed | 2 |
| | White | 2 |
| Tactical and Law Enforcement Medicine Section | | 10 |
| | More Than One/Multiracial | 2 |
| | No Value | 1 |

| | | |
|--|---|---|
| | White | 7 |
| Telehealth Section | | 9 |
| | Other/Not Listed | 4 |
| | White | 5 |
| Toxicology Section | | 9 |
| | Asian | 1 |
| | No Value | 1 |
| | White | 7 |
| Trauma and Injury Prevention Section | | 4 |
| | I Prefer Not to Answer | 1 |
| | Other/Not Listed | 1 |
| | White | 2 |
| Undersea & Hyperbaric Medicine Section | | 7 |
| | No Value | 1 |
| | Other/Not Listed | 2 |
| | White | 4 |
| Wellness Section | | 6 |
| | No Value | 2 |
| | White | 4 |
| Wilderness Medicine Section | | 6 |
| | No Value | 2 |
| | White | 4 |
| Young Physicians Section | | 6 |
| | Asian | 1 |
| | Native Hawaiian or Other Pacific Islander | 1 |
| | No Value | 1 |
| | Other/Not Listed | 1 |
| | White | 2 |

ACEP Composition Education Demographics

All Members

| delegation | Education | |
|-------------------|------------------|-------|
| All | | 37040 |
| | Fellowship | 3968 |
| | MedSchool | 3780 |
| | No Value | 628 |
| | Residency | 28664 |

ACEP Composition Education Demographics

Councillors And Alternate Councillors

| delegation | Education | |
|------------|------------|-----|
| All | | 517 |
| | Fellowship | 80 |
| | MedSchool | 18 |
| | No Value | 3 |
| | Residency | 416 |

ACEP Composition Education Demographics

Councillors And Alternate Councillors

| delegation | Education | |
|---------------------------------------|------------|----|
| AACEM | | 1 |
| | Residency | 1 |
| AAWEP Section | | 1 |
| | Residency | 1 |
| Air Medical Transport Section | | 2 |
| | Residency | 2 |
| Alabama Chapter | | 3 |
| | Fellowship | 1 |
| | Residency | 2 |
| Alaska Chapter | | 1 |
| | Residency | 1 |
| Arizona Chapter | | 8 |
| | Fellowship | 3 |
| | Residency | 5 |
| Arkansas Chapter | | 4 |
| | Residency | 4 |
| California Chapter | | 41 |
| | Fellowship | 11 |
| | MedSchool | 2 |
| | No Value | 1 |
| | Residency | 27 |
| Careers in Emergency Medicine Section | | 1 |
| | Residency | 1 |
| Colorado Chapter | | 10 |
| | Fellowship | 1 |
| | MedSchool | 2 |
| | Residency | 7 |
| Connecticut Chapter | | 6 |
| | Residency | 6 |
| CORD | | 1 |
| | Residency | 1 |
| Critical Care Medicine Section | | 1 |
| | Fellowship | 1 |
| Cruise Ship Medicine Section | | 1 |
| | Residency | 1 |

| delegation | Education | |
|--|------------------|----|
| Delaware Chapter | | 3 |
| | Fellowship | 2 |
| | Residency | 1 |
| Democratic Group Practice Section | | 1 |
| | Residency | 1 |
| Disaster Medicine Section | | 1 |
| | Fellowship | 1 |
| District of Columbia Chapter | | 3 |
| | Fellowship | 2 |
| | Residency | 1 |
| Diversity & Inclusion Section | | 1 |
| | Residency | 1 |
| Dual Training Section | | 2 |
| | Fellowship | 1 |
| | Residency | 1 |
| EM Practice Mgmt and Health Policy Section | | 1 |
| | Residency | 1 |
| Emergency Medical Informatics Section | | 2 |
| | Fellowship | 1 |
| | Residency | 1 |
| Emergency Medicine Locum Tenens Section | | 1 |
| | Residency | 1 |
| Emergency Medicine Residents' Association | | 14 |
| | Fellowship | 8 |
| | Residency | 6 |
| Emergency Medicine Workforce Section | | 1 |
| | Residency | 1 |
| Emergency Telehealth Section | | 2 |
| | Residency | 2 |
| Emergency Ultrasound Section | | 2 |
| | Fellowship | 1 |
| | Residency | 1 |
| EMS-Prehospital Care Section | | 1 |
| | Residency | 1 |
| Event Medicine Section | | 1 |
| | Fellowship | 1 |
| Florida Chapter | | 17 |
| | Fellowship | 4 |
| | MedSchool | 1 |

| delegation | Education | |
|--|------------------|----|
| | Residency | 12 |
| Forensic Medicine Section | | 1 |
| | Residency | 1 |
| Freestanding Emergency Centers | | 1 |
| | Residency | 1 |
| Georgia Chapter | | 8 |
| | No Value | 1 |
| | Residency | 7 |
| Geriatric Emergency Medicine Section | | 2 |
| | Residency | 2 |
| Govt Services Chapter | | 11 |
| | Fellowship | 1 |
| | Residency | 10 |
| Hawaii Chapter | | 2 |
| | Residency | 2 |
| Idaho Chapter | | 2 |
| | Residency | 2 |
| Illinois Chapter | | 12 |
| | Residency | 12 |
| Indiana Chapter | | 9 |
| | Fellowship | 2 |
| | MedSchool | 1 |
| | Residency | 6 |
| International Emergency Medicine Section | | 1 |
| | Fellowship | 1 |
| Iowa Chapter | | 4 |
| | Residency | 4 |
| Kansas Chapter | | 4 |
| | MedSchool | 1 |
| | Residency | 3 |
| Kentucky Chapter | | 4 |
| | Residency | 4 |
| Louisiana Chapter | | 7 |
| | Fellowship | 1 |
| | MedSchool | 1 |
| | Residency | 5 |
| Maine Chapter | | 5 |
| | Fellowship | 1 |
| | Residency | 4 |

| delegation | Education | |
|----------------------------|------------------|----|
| Maryland Chapter | | 7 |
| | Residency | 7 |
| Massachusetts Chapter | | 10 |
| | Fellowship | 1 |
| | MedSchool | 1 |
| | Residency | 8 |
| Medical Directors Section | | 2 |
| | Residency | 2 |
| Medical Humanities Section | | 2 |
| | Fellowship | 1 |
| | Residency | 1 |
| Michigan Chapter | | 25 |
| | Fellowship | 2 |
| | MedSchool | 1 |
| | Residency | 22 |
| Minnesota Chapter | | 9 |
| | Fellowship | 1 |
| | MedSchool | 1 |
| | Residency | 7 |
| Mississippi Chapter | | 3 |
| | Fellowship | 1 |
| | Residency | 2 |
| Missouri Chapter | | 8 |
| | Fellowship | 2 |
| | MedSchool | 1 |
| | Residency | 5 |
| Montana Chapter | | 2 |
| | Residency | 2 |
| Nebraska Chapter | | 2 |
| | Residency | 2 |
| Nevada Chapter | | 4 |
| | Residency | 4 |
| New Hampshire Chapter | | 1 |
| | Residency | 1 |
| New Jersey Chapter | | 12 |
| | Fellowship | 2 |
| | MedSchool | 1 |
| | Residency | 9 |

| delegation | Education | |
|---|------------------|----|
| New Mexico Chapter | | 4 |
| | Residency | 4 |
| New York Chapter | | 31 |
| | Fellowship | 4 |
| | Residency | 27 |
| North Carolina Chapter | | 14 |
| | Residency | 14 |
| North Dakota Chapter | | 1 |
| | Residency | 1 |
| Observation Services Section | | 1 |
| | Residency | 1 |
| Ohio Chapter | | 23 |
| | Fellowship | 1 |
| | Residency | 22 |
| Oklahoma Chapter | | 5 |
| | Fellowship | 3 |
| | Residency | 2 |
| Oregon Chapter | | 4 |
| | Residency | 4 |
| Pain Management Section | | 1 |
| | Residency | 1 |
| Palliative Medicine Section | | 1 |
| | Fellowship | 1 |
| Pediatric Emergency Medicine Section | | 1 |
| | Fellowship | 1 |
| Pennsylvania Chapter | | 23 |
| | Fellowship | 3 |
| | Residency | 20 |
| Puerto Rico Chapter | | 2 |
| | Residency | 2 |
| Quality Improvement and Patient Safety Section | | 1 |
| | Fellowship | 1 |
| Research, Scholarly Activity and Innovation Section | | 1 |
| | Fellowship | 1 |
| Rhode Island Chapter | | 3 |
| | Residency | 3 |
| Rural Emergency Medicine Section | | 1 |
| | Residency | 1 |

| delegation | Education | |
|--|------------------|----|
| Social Emergency Medicine Section | | 1 |
| | Residency | 1 |
| Society of Academic Emergency Medicine | | 1 |
| | Residency | 1 |
| South Carolina Chapter | | 7 |
| | Fellowship | 1 |
| | Residency | 6 |
| South Dakota Chapter | | 2 |
| | Residency | 2 |
| Sports Medicine Section | | 1 |
| | Residency | 1 |
| Tennessee Chapter | | 5 |
| | No Value | 1 |
| | Residency | 4 |
| Texas Chapter | | 37 |
| | Fellowship | 6 |
| | MedSchool | 3 |
| | Residency | 28 |
| Toxicology Section | | 1 |
| | Fellowship | 1 |
| Trauma & Injury Prevention Section | | 1 |
| | Residency | 1 |
| Undersea & Hyperbaric Medicine Section | | 1 |
| | Residency | 1 |
| Utah Chapter | | 6 |
| | MedSchool | 2 |
| | Residency | 4 |
| Vermont Chapter | | 3 |
| | Residency | 3 |
| Virginia Chapter | | 9 |
| | Residency | 9 |
| Washington Chapter | | 13 |
| | Residency | 13 |
| Wellness Section | | 3 |
| | Residency | 3 |
| West Virginia Chapter | | 3 |
| | Residency | 3 |
| Wilderness Medicine Section | | 2 |
| | Fellowship | 1 |

| delegation | Education | |
|--------------------------|------------|---|
| | Residency | 1 |
| Wisconsin Chapter | | 6 |
| | Residency | 6 |
| Wyoming Chapter | | 1 |
| | Residency | 1 |
| Young Physicians Section | | 3 |
| | Fellowship | 2 |
| | Residency | 1 |

ACEP Composition Education Demographics

All Committees

| delegation | Education | |
|---|------------|----|
| Academic Affairs Committee | | 57 |
| | Fellowship | 12 |
| | Residency | 45 |
| Audit Committee | | 8 |
| | MedSchool | 1 |
| | Residency | 7 |
| Awards Committee | | 12 |
| | Fellowship | 1 |
| | Residency | 11 |
| Bylaws Committee | | 21 |
| | Fellowship | 5 |
| | MedSchool | 3 |
| | Residency | 13 |
| CEDR - Clinical Emergency Data Registry Committee | | 38 |
| | Fellowship | 12 |
| | MedSchool | 3 |
| | Residency | 23 |
| Clinical Policies Committee | | 28 |
| | Fellowship | 11 |
| | MedSchool | 1 |
| | Residency | 16 |
| Clinical Resources Review Committee | | 25 |
| | Fellowship | 3 |
| | MedSchool | 1 |
| | Residency | 21 |
| Coding and Nomenclature Advisory Committee | | 43 |
| | Fellowship | 6 |
| | MedSchool | 1 |
| | No Value | 2 |
| | Residency | 34 |
| Communications Committee | | 34 |
| | Fellowship | 4 |
| | Residency | 30 |
| Compensation Committee | | 6 |
| | Fellowship | 1 |
| | Residency | 5 |
| Disaster Preparedness & Response Committee | | 49 |
| | Fellowship | 21 |

| | | |
|--|------------|-----|
| | MedSchool | 4 |
| | Residency | 24 |
| Diversity, Equity, and Inclusion Committee | | 33 |
| | Fellowship | 4 |
| | MedSchool | 1 |
| | Residency | 28 |
| Education Committee | | 115 |
| | Fellowship | 42 |
| | MedSchool | 3 |
| | No Value | 1 |
| | Residency | 69 |
| Emergency Medical Services (EMS) Committee | | 44 |
| | Fellowship | 18 |
| | MedSchool | 1 |
| | Residency | 25 |
| Emergency Medicine Practice Committee | | 57 |
| | Fellowship | 8 |
| | MedSchool | 1 |
| | Residency | 48 |
| Ethics Committee | | 41 |
| | Fellowship | 6 |
| | No Value | 1 |
| | Residency | 34 |
| Federal Government Affairs Committee | | 44 |
| | Fellowship | 5 |
| | MedSchool | 2 |
| | Residency | 37 |
| Finance Committee | | 19 |
| | Fellowship | 3 |
| | MedSchool | 1 |
| | No Value | 1 |
| | Residency | 14 |
| Health Innovation Technology Committee | | 47 |
| | Fellowship | 10 |
| | Residency | 37 |
| International Emergency Medicine Committee | | 25 |
| | Fellowship | 5 |
| | MedSchool | 2 |
| | Residency | 18 |
| Medical-Legal Committee | | 40 |
| | Fellowship | 5 |
| | MedSchool | 5 |
| | No Value | 1 |
| | Residency | 29 |

| | | |
|--|------------|----|
| Membership Committee | | 22 |
| | Fellowship | 5 |
| | MedSchool | 1 |
| | Residency | 16 |
| National Chapter Relations Committee | | 16 |
| | Fellowship | 1 |
| | Residency | 15 |
| Pediatric EM | | 1 |
| | Residency | 1 |
| Pediatric Emergency Medicine Committee | | 53 |
| | Fellowship | 37 |
| | MedSchool | 2 |
| | No Value | 3 |
| | Residency | 11 |
| Public Health Committee | | 41 |
| | Fellowship | 16 |
| | Residency | 25 |
| Quality and Patient Safety Committee | | 83 |
| | Fellowship | 26 |
| | MedSchool | 1 |
| | Residency | 56 |
| Reimbursement Committee | | 76 |
| | Fellowship | 9 |
| | MedSchool | 8 |
| | No Value | 2 |
| | Residency | 57 |
| Research Committee | | 73 |
| | Fellowship | 29 |
| | MedSchool | 2 |
| | No Value | 2 |
| | Residency | 40 |
| State Legislative/Regulatory Committee | | 72 |
| | Fellowship | 7 |
| | MedSchool | 3 |
| | Residency | 62 |
| Well-Being Committee | | 50 |
| | Fellowship | 8 |
| | MedSchool | 2 |
| | No Value | 1 |
| | Residency | 39 |

ACEP Composition Education Demographics

Committees Chairs

| delegation | Education | |
|---|-----------|---|
| Academic Affairs Committee | | 2 |
| | Residency | 2 |
| Audit Committee | | 2 |
| | Residency | 2 |
| Bylaws Committee | | 2 |
| | MedSchool | 1 |
| | Residency | 1 |
| CEDR - Clinical Emergency Data Registry Committee | | 1 |
| | MedSchool | 1 |
| Clinical Policies Committee | | 1 |
| | Residency | 1 |
| Clinical Resources Review Committee | | 1 |
| | Residency | 1 |
| Coding and Nomenclature Advisory Committee | | 1 |
| | Residency | 1 |
| Compensation Committee | | 1 |
| | Residency | 1 |
| Disaster Preparedness & Response Committee | | 1 |
| | Residency | 1 |
| Diversity, Equity, and Inclusion Committee | | 1 |
| | Residency | 1 |
| Education Committee | | 2 |
| | Residency | 2 |
| Emergency Medical Services (EMS) Committee | | 1 |
| | Residency | 1 |
| Emergency Medicine Practice Committee | | 1 |
| | Residency | 1 |
| Ethics Committee | | 1 |
| | Residency | 1 |
| Federal Government Affairs Committee | | 2 |
| | Residency | 2 |
| Finance Committee | | 1 |
| | Residency | 1 |

| delegation | Education | |
|--|------------------|---|
| Health Innovation Technology Committee | | 1 |
| | Residency | 1 |
| International Emergency Medicine Committee | | 2 |
| | Residency | 2 |
| Leadership Development Advisory Committee (LDAC) | | 1 |
| | Residency | 1 |
| Medical-Legal Committee | | 1 |
| | Residency | 1 |
| Membership Committee | | 2 |
| | Residency | 2 |
| National Chapter Relations Committee | | 1 |
| | Residency | 1 |
| Pediatric Emergency Medicine Committee | | 2 |
| | Fellowship | 2 |
| Public Health Committee | | 1 |
| | Residency | 1 |
| Quality and Patient Safety Committee | | 1 |
| | Fellowship | 1 |
| Reimbursement Committee | | 2 |
| | Residency | 2 |
| Research Committee | | 1 |
| | Residency | 1 |
| State Legislative/Regulatory Committee | | 2 |
| | Residency | 2 |
| Well-Being Committee | | 1 |
| | Residency | 1 |

ACEP Composition Education Demographics

Section Leaders

| delegation | Education | |
|--|------------|----|
| Air Medical Transport Section | | 8 |
| | Fellowship | 3 |
| | Residency | 5 |
| American Association of Women Emergency Physicians Section | | 10 |
| | Fellowship | 3 |
| | Residency | 7 |
| Careers in Emergency Medicine Section | | 6 |
| | MedSchool | 1 |
| | No Value | 2 |
| | Residency | 3 |
| Critical Care Medicine Section | | 7 |
| | Fellowship | 5 |
| | Residency | 2 |
| Cruise Ship Medicine Section | | 5 |
| | Residency | 5 |
| Democratic Group Practice Section | | 9 |
| | MedSchool | 1 |
| | Residency | 8 |
| Disaster Medicine Section | | 10 |
| | Fellowship | 4 |
| | MedSchool | 2 |
| | Residency | 4 |
| Diversity, Inclusion and Health Equity Section | | 9 |
| | MedSchool | 3 |
| | Residency | 6 |
| Dual Training Section | | 7 |
| | Fellowship | 1 |
| | MedSchool | 1 |
| | Residency | 5 |
| Emergency Medical Informatics Section | | 5 |
| | Fellowship | 1 |
| | Residency | 4 |
| Emergency Medical Services-Prehospital Care Section | | 11 |
| | Fellowship | 3 |
| | MedSchool | 3 |
| | Residency | 5 |

| | | |
|--|------------|----|
| Emergency Medicine Practice Management and Health Policy Section | | 6 |
| | Fellowship | 1 |
| | Residency | 5 |
| Emergency Medicine Workforce Section | | 11 |
| | Fellowship | 1 |
| | MedSchool | 4 |
| | Residency | 6 |
| Emergency Ultrasound Section | | 9 |
| | Fellowship | 6 |
| | MedSchool | 1 |
| | Residency | 2 |
| Event Medicine Section | | 10 |
| | Fellowship | 1 |
| | MedSchool | 2 |
| | Residency | 7 |
| Exploring Retirement Section | | 4 |
| | MedSchool | 1 |
| | Residency | 3 |
| Forensic Medicine Section | | 6 |
| | Residency | 6 |
| Freestanding Emergency Centers Section | | 10 |
| | MedSchool | 3 |
| | No Value | 1 |
| | Residency | 6 |
| Geriatric Emergency Medicine Section | | 6 |
| | Fellowship | 3 |
| | MedSchool | 1 |
| | Residency | 2 |
| International Emergency Medicine Section | | 9 |
| | Fellowship | 3 |
| | Residency | 6 |
| Locum Tenens Section | | 3 |
| | Residency | 3 |
| Medical Directors Section | | 11 |
| | Fellowship | 2 |
| | MedSchool | 2 |
| | Residency | 7 |
| Medical Humanities Section | | 6 |
| | Fellowship | 1 |
| | MedSchool | 2 |
| | Residency | 3 |
| Observation Medicine Section | | 7 |
| | Residency | 7 |

| | | |
|---|------------|-----|
| Pain Management & Addiction Medicine Section | | 7 |
| | Fellowship | 1 |
| | Residency | 6 |
| Palliative Medicine Section | | 5 |
| | Fellowship | 3 |
| | Residency | 2 |
| Pediatric Emergency Medicine Section | | 8 |
| | Fellowship | 8 |
| Quality Improvement and Patient Safety Section | | 9 |
| | Fellowship | 6 |
| | Residency | 3 |
| Research, Scholarly Activity and Innovation Section | | 10 |
| | Fellowship | 1 |
| | MedSchool | 1 |
| | Residency | 8 |
| Rural Emergency Medicine Section | | 8 |
| | MedSchool | 2 |
| | Residency | 6 |
| Section Leaders | | 209 |
| | Fellowship | 69 |
| | MedSchool | 10 |
| | No Value | 3 |
| | Residency | 127 |
| Social Emergency Medicine Section | | 8 |
| | Residency | 8 |
| Sports Medicine Section | | 8 |
| | Fellowship | 6 |
| | MedSchool | 1 |
| | Residency | 1 |
| Tactical and Law Enforcement Medicine Section | | 10 |
| | Fellowship | 4 |
| | MedSchool | 1 |
| | No Value | 1 |
| | Residency | 4 |
| Telehealth Section | | 9 |
| | MedSchool | 1 |
| | Residency | 8 |
| Toxicology Section | | 9 |
| | Fellowship | 6 |
| | Residency | 3 |
| Trauma and Injury Prevention Section | | 4 |
| | Fellowship | 1 |
| | Residency | 3 |

| | | |
|--|------------|---|
| Undersea & Hyperbaric Medicine Section | | 7 |
| | Fellowship | 3 |
| | Residency | 4 |
| Wellness Section | | 6 |
| | Residency | 6 |
| Wilderness Medicine Section | | 6 |
| | Fellowship | 5 |
| | Residency | 1 |
| Young Physicians Section | | 6 |
| | Fellowship | 1 |
| | Residency | 5 |

ACEP Composition Certification Demographics

All Members

| delegation | Certification | |
|------------|---------------|-------|
| All | | 37040 |
| | Certified | 15459 |
| | Not Certified | 21581 |

ACEP Composition Certification Demographics

Councillors And Alternate Councillors

| delegation | Certification | |
|------------|---------------|-----|
| All | | 517 |
| | Certified | 380 |
| | Not Certified | 137 |

ACEP Composition Certification Demographics

Councillors And Alternate Councillors

| delegation | Certification | |
|---------------------------------------|---------------|----|
| AACEM | | 1 |
| | Certified | 1 |
| AAWEP Section | | 1 |
| | Certified | 1 |
| Air Medical Transport Section | | 2 |
| | Certified | 2 |
| Alabama Chapter | | 3 |
| | Certified | 2 |
| | Not Certified | 1 |
| Alaska Chapter | | 1 |
| | Certified | 1 |
| Arizona Chapter | | 8 |
| | Certified | 5 |
| | Not Certified | 3 |
| Arkansas Chapter | | 4 |
| | Certified | 4 |
| California Chapter | | 41 |
| | Certified | 33 |
| | Not Certified | 8 |
| Careers in Emergency Medicine Section | | 1 |
| | Not Certified | 1 |
| Colorado Chapter | | 10 |
| | Certified | 9 |
| | Not Certified | 1 |
| Connecticut Chapter | | 6 |
| | Certified | 2 |
| | Not Certified | 4 |
| CORD | | 1 |
| | Certified | 1 |
| Critical Care Medicine Section | | 1 |
| | Certified | 1 |
| Cruise Ship Medicine Section | | 1 |
| | Not Certified | 1 |
| Delaware Chapter | | 3 |
| | Certified | 3 |

| delegation | Certification | |
|--|----------------------|----|
| Democratic Group Practice Section | | 1 |
| | Not Certified | 1 |
| Disaster Medicine Section | | 1 |
| | Certified | 1 |
| District of Columbia Chapter | | 3 |
| | Certified | 2 |
| | Not Certified | 1 |
| Diversity & Inclusion Section | | 1 |
| | Certified | 1 |
| Dual Training Section | | 2 |
| | Certified | 2 |
| EM Practice Mgmt and Health Policy Section | | 1 |
| | Certified | 1 |
| Emergency Medical Informatics Section | | 2 |
| | Certified | 2 |
| Emergency Medicine Locum Tenens Section | | 1 |
| | Certified | 1 |
| Emergency Medicine Residents' Association | | 14 |
| | Certified | 5 |
| | Not Certified | 9 |
| Emergency Medicine Workforce Section | | 1 |
| | Not Certified | 1 |
| Emergency Telehealth Section | | 2 |
| | Certified | 1 |
| | Not Certified | 1 |
| Emergency Ultrasound Section | | 2 |
| | Certified | 2 |
| EMS-Prehospital Care Section | | 1 |
| | Certified | 1 |
| Event Medicine Section | | 1 |
| | Certified | 1 |
| Florida Chapter | | 17 |
| | Certified | 14 |
| | Not Certified | 3 |
| Forensic Medicine Section | | 1 |
| | Certified | 1 |
| Freestanding Emergency Centers | | 1 |
| | Certified | 1 |

| delegation | Certification | |
|--|----------------------|----|
| Georgia Chapter | | 8 |
| | Certified | 4 |
| | Not Certified | 4 |
| Geriatric Emergency Medicine Section | | 2 |
| | Certified | 2 |
| Govt Services Chapter | | 11 |
| | Certified | 7 |
| | Not Certified | 4 |
| Hawaii Chapter | | 2 |
| | Certified | 2 |
| Idaho Chapter | | 2 |
| | Certified | 2 |
| Illinois Chapter | | 12 |
| | Certified | 9 |
| | Not Certified | 3 |
| Indiana Chapter | | 9 |
| | Certified | 6 |
| | Not Certified | 3 |
| International Emergency Medicine Section | | 1 |
| | Certified | 1 |
| Iowa Chapter | | 4 |
| | Certified | 3 |
| | Not Certified | 1 |
| Kansas Chapter | | 4 |
| | Certified | 3 |
| | Not Certified | 1 |
| Kentucky Chapter | | 4 |
| | Certified | 4 |
| Louisiana Chapter | | 7 |
| | Certified | 6 |
| | Not Certified | 1 |
| Maine Chapter | | 5 |
| | Certified | 4 |
| | Not Certified | 1 |
| Maryland Chapter | | 7 |
| | Certified | 7 |
| Massachusetts Chapter | | 10 |
| | Certified | 7 |
| | Not Certified | 3 |

| delegation | Certification | |
|----------------------------|----------------------|----|
| Medical Directors Section | | 2 |
| | Certified | 2 |
| Medical Humanities Section | | 2 |
| | Certified | 1 |
| | Not Certified | 1 |
| Michigan Chapter | | 25 |
| | Certified | 19 |
| | Not Certified | 6 |
| Minnesota Chapter | | 9 |
| | Certified | 7 |
| | Not Certified | 2 |
| Mississippi Chapter | | 3 |
| | Certified | 2 |
| | Not Certified | 1 |
| Missouri Chapter | | 8 |
| | Certified | 6 |
| | Not Certified | 2 |
| Montana Chapter | | 2 |
| | Certified | 1 |
| | Not Certified | 1 |
| Nebraska Chapter | | 2 |
| | Certified | 2 |
| Nevada Chapter | | 4 |
| | Certified | 4 |
| New Hampshire Chapter | | 1 |
| | Not Certified | 1 |
| New Jersey Chapter | | 12 |
| | Certified | 6 |
| | Not Certified | 6 |
| New Mexico Chapter | | 4 |
| | Certified | 3 |
| | Not Certified | 1 |
| New York Chapter | | 31 |
| | Certified | 21 |
| | Not Certified | 10 |
| North Carolina Chapter | | 14 |
| | Certified | 10 |
| | Not Certified | 4 |

| delegation | Certification | |
|---|----------------------|----|
| North Dakota Chapter | | 1 |
| | Certified | 1 |
| Observation Services Section | | 1 |
| | Certified | 1 |
| Ohio Chapter | | 23 |
| | Certified | 17 |
| | Not Certified | 6 |
| Oklahoma Chapter | | 5 |
| | Certified | 3 |
| | Not Certified | 2 |
| Oregon Chapter | | 4 |
| | Certified | 4 |
| Pain Management Section | | 1 |
| | Certified | 1 |
| Palliative Medicine Section | | 1 |
| | Certified | 1 |
| Pediatric Emergency Medicine Section | | 1 |
| | Not Certified | 1 |
| Pennsylvania Chapter | | 23 |
| | Certified | 12 |
| | Not Certified | 11 |
| Puerto Rico Chapter | | 2 |
| | Certified | 1 |
| | Not Certified | 1 |
| Quality Improvement and Patient Safety Section | | 1 |
| | Certified | 1 |
| Research, Scholarly Activity and Innovation Section | | 1 |
| | Certified | 1 |
| Rhode Island Chapter | | 3 |
| | Certified | 2 |
| | Not Certified | 1 |
| Rural Emergency Medicine Section | | 1 |
| | Certified | 1 |
| Social Emergency Medicine Section | | 1 |
| | Certified | 1 |
| Society of Academic Emergency Medicine | | 1 |
| | Not Certified | 1 |
| South Carolina Chapter | | 7 |
| | Certified | 7 |

| delegation | Certification | |
|--|----------------------|----|
| South Dakota Chapter | | 2 |
| | Certified | 2 |
| Sports Medicine Section | | 1 |
| | Certified | 1 |
| Tennessee Chapter | | 5 |
| | Certified | 3 |
| | Not Certified | 2 |
| Texas Chapter | | 37 |
| | Certified | 27 |
| | Not Certified | 10 |
| Toxicology Section | | 1 |
| | Certified | 1 |
| Trauma & Injury Prevention Section | | 1 |
| | Certified | 1 |
| Undersea & Hyperbaric Medicine Section | | 1 |
| | Certified | 1 |
| Utah Chapter | | 6 |
| | Certified | 3 |
| | Not Certified | 3 |
| Vermont Chapter | | 3 |
| | Certified | 2 |
| | Not Certified | 1 |
| Virginia Chapter | | 9 |
| | Certified | 8 |
| | Not Certified | 1 |
| Washington Chapter | | 13 |
| | Certified | 11 |
| | Not Certified | 2 |
| Wellness Section | | 3 |
| | Certified | 3 |
| West Virginia Chapter | | 3 |
| | Certified | 1 |
| | Not Certified | 2 |
| Wilderness Medicine Section | | 2 |
| | Certified | 2 |
| Wisconsin Chapter | | 6 |
| | Certified | 5 |
| | Not Certified | 1 |

| delegation | Certification | |
|--------------------------|----------------------|---|
| Wyoming Chapter | | 1 |
| | Not Certified | 1 |
| Young Physicians Section | | 3 |
| | Certified | 3 |

ACEP Composition Certification Demographics

All Committees

| delegation | Certification | |
|---|----------------------|----|
| Academic Affairs Committee | | 57 |
| | Certified | 43 |
| | Not Certified | 14 |
| Administration and Operations | | 1 |
| | Not Certified | 1 |
| Audit Committee | | 8 |
| | Certified | 6 |
| | Not Certified | 2 |
| Awards Committee | | 12 |
| | Certified | 11 |
| | Not Certified | 1 |
| Bylaws Committee | | 21 |
| | Certified | 16 |
| | Not Certified | 5 |
| CEDR - Clinical Emergency Data Registry Committee | | 38 |
| | Certified | 30 |
| | Not Certified | 8 |
| Clinical Policies Committee | | 28 |
| | Certified | 21 |
| | Not Certified | 7 |
| Clinical Resources Review Committee | | 25 |
| | Certified | 21 |
| | Not Certified | 4 |
| Coding and Nomenclature Advisory Committee | | 43 |
| | Certified | 32 |
| | Not Certified | 11 |
| Communications Committee | | 34 |
| | Certified | 25 |
| | Not Certified | 9 |
| Compensation Committee | | 6 |
| | Certified | 5 |
| | Not Certified | 1 |
| Disaster Preparedness & Response Committee | | 49 |
| | Certified | 39 |
| | Not Certified | 10 |
| Diversity, Equity, and Inclusion Committee | | 33 |
| | Certified | 22 |
| | Not Certified | 11 |

| | | |
|--|---------------|-----|
| Education Committee | | 115 |
| | Certified | 82 |
| | Not Certified | 33 |
| Emergency Medical Services (EMS) Committee | | 44 |
| | Certified | 33 |
| | Not Certified | 11 |
| Emergency Medicine Practice Committee | | 57 |
| | Certified | 44 |
| | Not Certified | 13 |
| Ethics Committee | | 41 |
| | Certified | 29 |
| | Not Certified | 12 |
| Federal Government Affairs Committee | | 44 |
| | Certified | 32 |
| | Not Certified | 12 |
| Finance Committee | | 19 |
| | Certified | 12 |
| | Not Certified | 7 |
| Government Services | | 2 |
| | Not Certified | 2 |
| Health Innovation Technology Committee | | 47 |
| | Certified | 28 |
| | Not Certified | 19 |
| International Emergency Medicine Committee | | 25 |
| | Certified | 18 |
| | Not Certified | 7 |
| Medical-Legal Committee | | 40 |
| | Certified | 27 |
| | Not Certified | 13 |
| Membership Committee | | 22 |
| | Certified | 17 |
| | Not Certified | 5 |
| National Chapter Relations Committee | | 16 |
| | Certified | 12 |
| | Not Certified | 4 |
| Pediatric Emergency Medicine Committee | | 53 |
| | Certified | 22 |
| | Not Certified | 31 |
| Public Health Committee | | 41 |
| | Certified | 27 |
| | Not Certified | 14 |
| Quality and Patient Safety Committee | | 83 |
| | Certified | 67 |
| | Not Certified | 16 |

| | | |
|--|---------------|----|
| Reimbursement Committee | | 76 |
| | Certified | 54 |
| | Not Certified | 22 |
| Research Committee | | 73 |
| | Certified | 58 |
| | Not Certified | 15 |
| State Legislative/Regulatory Committee | | 72 |
| | Certified | 54 |
| | Not Certified | 18 |
| Well-Being Committee | | 50 |
| | Certified | 35 |
| | Not Certified | 15 |

ACEP Composition Certification Demographics

Committees Chairs

| delegation | Certification | |
|---|---------------|---|
| Academic Affairs Committee | | 2 |
| | Certified | 2 |
| Audit Committee | | 2 |
| | Certified | 2 |
| Bylaws Committee | | 2 |
| | Certified | 2 |
| CEDR - Clinical Emergency Data Registry Committee | | 1 |
| | Not Certified | 1 |
| Clinical Policies Committee | | 1 |
| | Certified | 1 |
| Clinical Resources Review Committee | | 1 |
| | Certified | 1 |
| Coding and Nomenclature Advisory Committee | | 1 |
| | Not Certified | 1 |
| Compensation Committee | | 1 |
| | Not Certified | 1 |
| Disaster Preparedness & Response Committee | | 1 |
| | Certified | 1 |
| Diversity, Equity, and Inclusion Committee | | 1 |
| | Certified | 1 |
| Education Committee | | 2 |
| | Certified | 1 |
| | Not Certified | 1 |
| Emergency Medical Services (EMS) Committee | | 1 |
| | Certified | 1 |
| Emergency Medicine Practice Committee | | 1 |
| | Certified | 1 |
| Ethics Committee | | 1 |
| | Certified | 1 |
| Federal Government Affairs Committee | | 2 |
| | Certified | 2 |
| Finance Committee | | 1 |
| | Certified | 1 |
| Health Innovation Technology Committee | | 1 |
| | Certified | 1 |
| International Emergency Medicine Committee | | 2 |
| | Certified | 2 |
| Medical-Legal Committee | | 1 |

| | | |
|--|---------------|---|
| | Not Certified | 1 |
| Membership Committee | | 2 |
| | Certified | 2 |
| National Chapter Relations Committee | | 1 |
| | Certified | 1 |
| Pediatric Emergency Medicine Committee | | 2 |
| | Certified | 1 |
| | Not Certified | 1 |
| Public Health Committee | | 1 |
| | Certified | 1 |
| Quality and Patient Safety Committee | | 1 |
| | Certified | 1 |
| Reimbursement Committee | | 2 |
| | Certified | 2 |
| Research Committee | | 1 |
| | Certified | 1 |
| State Legislative/Regulatory Committee | | 2 |
| | Certified | 2 |
| Well-Being Committee | | 1 |
| | Not Certified | 1 |

ACEP Composition Certification Demographics

Section Leaders

| delegation | Certification | |
|--|---------------|----|
| Air Medical Transport Section | | 8 |
| | Certified | 6 |
| | Not Certified | 2 |
| American Association of Women Emergency Physicians Section | | 10 |
| | Certified | 7 |
| | Not Certified | 3 |
| Careers in Emergency Medicine Section | | 6 |
| | Certified | 1 |
| | Not Certified | 5 |
| Critical Care Medicine Section | | 7 |
| | Certified | 5 |
| | Not Certified | 2 |
| Cruise Ship Medicine Section | | 5 |
| | Certified | 2 |
| | Not Certified | 3 |
| Democratic Group Practice Section | | 9 |
| | Certified | 6 |
| | Not Certified | 3 |
| Disaster Medicine Section | | 10 |
| | Certified | 9 |
| | Not Certified | 1 |
| Diversity, Inclusion and Health Equity Section | | 9 |
| | Certified | 8 |
| | Not Certified | 1 |
| Dual Training Section | | 7 |
| | Certified | 6 |
| | Not Certified | 1 |
| Emergency Medical Informatics Section | | 5 |
| | Certified | 4 |
| | Not Certified | 1 |
| Emergency Medical Services-Prehospital Care Section | | 11 |
| | Certified | 8 |
| | Not Certified | 3 |
| Emergency Medicine Practice Management and Health Policy Section | | 6 |
| | Certified | 4 |
| | Not Certified | 2 |

| | | |
|--|---------------|----|
| Emergency Medicine Workforce Section | | 11 |
| | Certified | 9 |
| | Not Certified | 2 |
| Emergency Ultrasound Section | | 9 |
| | Certified | 8 |
| | Not Certified | 1 |
| Event Medicine Section | | 10 |
| | Certified | 7 |
| | Not Certified | 3 |
| Exploring Retirement Section | | 4 |
| | Certified | 1 |
| | Not Certified | 3 |
| Forensic Medicine Section | | 6 |
| | Certified | 5 |
| | Not Certified | 1 |
| Freestanding Emergency Centers Section | | 10 |
| | Certified | 5 |
| | Not Certified | 5 |
| Geriatric Emergency Medicine Section | | 6 |
| | Certified | 4 |
| | Not Certified | 2 |
| International Emergency Medicine Section | | 9 |
| | Certified | 5 |
| | Not Certified | 4 |
| Locum Tenens Section | | 3 |
| | Certified | 3 |
| Medical Directors Section | | 11 |
| | Certified | 11 |
| Medical Humanities Section | | 6 |
| | Certified | 5 |
| | Not Certified | 1 |
| Observation Medicine Section | | 7 |
| | Certified | 7 |
| Pain Management & Addiction Medicine Section | | 7 |
| | Certified | 7 |
| Palliative Medicine Section | | 5 |
| | Certified | 3 |
| | Not Certified | 2 |
| Pediatric Emergency Medicine Section | | 8 |
| | Certified | 2 |
| | Not Certified | 6 |
| Quality Improvement and Patient Safety Section | | 9 |
| | Certified | 7 |
| | Not Certified | 2 |

| | | |
|---|---------------|----|
| Research, Scholarly Activity and Innovation Section | | 10 |
| | Certified | 8 |
| | Not Certified | 2 |
| Rural Emergency Medicine Section | | 8 |
| | Certified | 8 |
| Social Emergency Medicine Section | | 8 |
| | Certified | 7 |
| | Not Certified | 1 |
| Sports Medicine Section | | 8 |
| | Certified | 8 |
| Tactical and Law Enforcement Medicine Section | | 10 |
| | Certified | 8 |
| | Not Certified | 2 |
| Telehealth Section | | 9 |
| | Certified | 6 |
| | Not Certified | 3 |
| Toxicology Section | | 9 |
| | Certified | 6 |
| | Not Certified | 3 |
| Trauma and Injury Prevention Section | | 4 |
| | Certified | 4 |
| Undersea & Hyperbaric Medicine Section | | 7 |
| | Certified | 6 |
| | Not Certified | 1 |
| Wellness Section | | 6 |
| | Certified | 6 |
| Wilderness Medicine Section | | 6 |
| | Certified | 6 |
| Young Physicians Section | | 6 |
| | Certified | 5 |
| | Not Certified | 1 |

ACEP Composition Career Demographics

All Members

| delegation | Career | |
|------------|---------------------|-------|
| All | | 37040 |
| | Academic Physician | 1014 |
| | Attending Physician | 4160 |
| | Fellow | 746 |
| | Intern | 574 |
| | Medical Student | 3229 |
| | No Value | 25420 |
| | Resident | 1897 |

ACEP Composition Career Demographics

Councillors And Alternate Councillors

| delegation | Career | |
|-------------------|---------------------|-----|
| All | | 517 |
| | Academic Physician | 50 |
| | Attending Physician | 123 |
| | Fellow | 19 |
| | Intern | 4 |
| | Medical Student | 37 |
| | No Value | 258 |
| | Resident | 26 |

ACEP Composition Career Demographics

Councillors And Alternate Councillors

| delegation | Career | |
|---------------------------------------|---------------------|----|
| AACEM | | 1 |
| | No Value | 1 |
| AAWEP Section | | 1 |
| | Resident | 1 |
| Air Medical Transport Section | | 2 |
| | No Value | 2 |
| Alabama Chapter | | 3 |
| | Attending Physician | 2 |
| | No Value | 1 |
| Alaska Chapter | | 1 |
| | No Value | 1 |
| Arizona Chapter | | 8 |
| | Attending Physician | 3 |
| | Fellow | 1 |
| | No Value | 3 |
| | Resident | 1 |
| Arkansas Chapter | | 4 |
| | Attending Physician | 1 |
| | No Value | 2 |
| | Resident | 1 |
| California Chapter | | 41 |
| | Academic Physician | 4 |
| | Attending Physician | 9 |
| | Fellow | 3 |
| | Medical Student | 2 |
| | No Value | 22 |
| | Resident | 1 |
| Careers in Emergency Medicine Section | | 1 |
| | Attending Physician | 1 |
| Colorado Chapter | | 10 |
| | Attending Physician | 2 |
| | Fellow | 1 |
| | No Value | 7 |
| Connecticut Chapter | | 6 |
| | Academic Physician | 1 |

| delegation | Career | |
|--|---------------------|----|
| | Attending Physician | 1 |
| | No Value | 4 |
| CORD | | 1 |
| | Academic Physician | 1 |
| Critical Care Medicine Section | | 1 |
| | Academic Physician | 1 |
| Cruise Ship Medicine Section | | 1 |
| | Attending Physician | 1 |
| Delaware Chapter | | 3 |
| | Academic Physician | 1 |
| | Fellow | 1 |
| | No Value | 1 |
| Democratic Group Practice Section | | 1 |
| | Attending Physician | 1 |
| Disaster Medicine Section | | 1 |
| | Medical Student | 1 |
| District of Columbia Chapter | | 3 |
| | No Value | 2 |
| | Resident | 1 |
| Diversity & Inclusion Section | | 1 |
| | Academic Physician | 1 |
| Dual Training Section | | 2 |
| | Attending Physician | 1 |
| | No Value | 1 |
| EM Practice Mgmt and Health Policy Section | | 1 |
| | No Value | 1 |
| Emergency Medical Informatics Section | | 2 |
| | No Value | 1 |
| | Resident | 1 |
| Emergency Medicine Locum Tenens Section | | 1 |
| | No Value | 1 |
| Emergency Medicine Residents' Association | | 14 |
| | Fellow | 1 |
| | Medical Student | 4 |
| | No Value | 8 |
| | Resident | 1 |
| Emergency Medicine Workforce Section | | 1 |
| | No Value | 1 |

| delegation | Career | |
|--------------------------------------|---------------------|----|
| Emergency Telehealth Section | | 2 |
| | Attending Physician | 1 |
| | No Value | 1 |
| Emergency Ultrasound Section | | 2 |
| | Fellow | 1 |
| | No Value | 1 |
| EMS-Prehospital Care Section | | 1 |
| | Fellow | 1 |
| Event Medicine Section | | 1 |
| | Intern | 1 |
| Florida Chapter | | 17 |
| | Academic Physician | 3 |
| | Attending Physician | 3 |
| | Medical Student | 2 |
| | No Value | 7 |
| | Resident | 2 |
| Forensic Medicine Section | | 1 |
| | Attending Physician | 1 |
| Freestanding Emergency Centers | | 1 |
| | No Value | 1 |
| Georgia Chapter | | 8 |
| | Academic Physician | 1 |
| | Attending Physician | 2 |
| | Medical Student | 1 |
| | No Value | 4 |
| Geriatric Emergency Medicine Section | | 2 |
| | Fellow | 1 |
| | No Value | 1 |
| Govt Services Chapter | | 11 |
| | Attending Physician | 2 |
| | Medical Student | 3 |
| | No Value | 5 |
| | Resident | 1 |
| Hawaii Chapter | | 2 |
| | Academic Physician | 1 |
| | Attending Physician | 1 |
| Idaho Chapter | | 2 |
| | Attending Physician | 1 |
| | No Value | 1 |

| delegation | Career | |
|--|---------------------|----|
| Illinois Chapter | | 12 |
| | Attending Physician | 4 |
| | No Value | 7 |
| | Resident | 1 |
| Indiana Chapter | | 9 |
| | Attending Physician | 6 |
| | No Value | 2 |
| | Resident | 1 |
| International Emergency Medicine Section | | 1 |
| | Fellow | 1 |
| Iowa Chapter | | 4 |
| | Attending Physician | 1 |
| | No Value | 3 |
| Kansas Chapter | | 4 |
| | Attending Physician | 2 |
| | No Value | 2 |
| Kentucky Chapter | | 4 |
| | Attending Physician | 1 |
| | Fellow | 1 |
| | No Value | 2 |
| Louisiana Chapter | | 7 |
| | Academic Physician | 2 |
| | Attending Physician | 3 |
| | No Value | 2 |
| Maine Chapter | | 5 |
| | No Value | 5 |
| Maryland Chapter | | 7 |
| | Academic Physician | 1 |
| | Attending Physician | 1 |
| | No Value | 5 |
| Massachusetts Chapter | | 10 |
| | Academic Physician | 2 |
| | Attending Physician | 1 |
| | Medical Student | 1 |
| | No Value | 6 |
| Medical Directors Section | | 2 |
| | Attending Physician | 2 |
| Medical Humanities Section | | 2 |
| | Attending Physician | 1 |

| delegation | Career | |
|-----------------------|---------------------|----|
| | No Value | 1 |
| Michigan Chapter | | 25 |
| | Academic Physician | 1 |
| | Attending Physician | 5 |
| | Fellow | 1 |
| | Medical Student | 1 |
| | No Value | 15 |
| | Resident | 2 |
| Minnesota Chapter | | 9 |
| | Academic Physician | 2 |
| | No Value | 7 |
| Mississippi Chapter | | 3 |
| | Academic Physician | 1 |
| | Attending Physician | 1 |
| | No Value | 1 |
| Missouri Chapter | | 8 |
| | Academic Physician | 1 |
| | Fellow | 1 |
| | Medical Student | 1 |
| | No Value | 5 |
| Montana Chapter | | 2 |
| | Attending Physician | 1 |
| | No Value | 1 |
| Nebraska Chapter | | 2 |
| | Attending Physician | 1 |
| | No Value | 1 |
| Nevada Chapter | | 4 |
| | Attending Physician | 1 |
| | No Value | 3 |
| New Hampshire Chapter | | 1 |
| | No Value | 1 |
| New Jersey Chapter | | 12 |
| | Academic Physician | 2 |
| | Attending Physician | 5 |
| | No Value | 4 |
| | Resident | 1 |
| New Mexico Chapter | | 4 |
| | Attending Physician | 1 |
| | Medical Student | 2 |

| delegation | Career | |
|--------------------------------------|---------------------|----|
| | No Value | 1 |
| New York Chapter | | 31 |
| | Academic Physician | 1 |
| | Attending Physician | 10 |
| | Fellow | 1 |
| | Intern | 1 |
| | Medical Student | 2 |
| | No Value | 14 |
| | Resident | 2 |
| North Carolina Chapter | | 14 |
| | Academic Physician | 1 |
| | Attending Physician | 3 |
| | No Value | 9 |
| | Resident | 1 |
| North Dakota Chapter | | 1 |
| | Attending Physician | 1 |
| Observation Services Section | | 1 |
| | Academic Physician | 1 |
| Ohio Chapter | | 23 |
| | Academic Physician | 1 |
| | Attending Physician | 8 |
| | Medical Student | 2 |
| | No Value | 9 |
| | Resident | 3 |
| Oklahoma Chapter | | 5 |
| | Attending Physician | 1 |
| | Medical Student | 1 |
| | No Value | 3 |
| Oregon Chapter | | 4 |
| | Medical Student | 1 |
| | No Value | 3 |
| Pain Management Section | | 1 |
| | No Value | 1 |
| Palliative Medicine Section | | 1 |
| | Fellow | 1 |
| Pediatric Emergency Medicine Section | | 1 |
| | No Value | 1 |
| Pennsylvania Chapter | | 23 |
| | Academic Physician | 3 |

| delegation | Career | |
|--|---------------------|-----------|
| | Attending Physician | 6 |
| | Intern | 1 |
| | Medical Student | 2 |
| | No Value | 10 |
| | Resident | 1 |
| Puerto Rico Chapter | | 2 |
| | Attending Physician | 1 |
| | No Value | 1 |
| Quality Improvement and Patient Safety Section | | 1 |
| | Medical Student | 1 |
| Research, Scholarly Activity and Innovation Section | | 1 |
| | No Value | 1 |
| Rhode Island Chapter | | 3 |
| | Academic Physician | 2 |
| | No Value | 1 |
| Rural Emergency Medicine Section | | 1 |
| | Attending Physician | 1 |
| Social Emergency Medicine Section | | 1 |
| | No Value | 1 |
| Society of Academic Emergency Medicine | | 1 |
| | No Value | 1 |
| South Carolina Chapter | | 7 |
| | Academic Physician | 2 |
| | Attending Physician | 3 |
| | No Value | 2 |
| South Dakota Chapter | | 2 |
| | No Value | 2 |
| Sports Medicine Section | | 1 |
| | Attending Physician | 1 |
| Tennessee Chapter | | 5 |
| | Attending Physician | 1 |
| | Intern | 1 |
| | No Value | 3 |
| Texas Chapter | | 37 |
| | Academic Physician | 6 |
| | Attending Physician | 7 |
| | Fellow | 2 |
| | Medical Student | 3 |
| | No Value | 18 |

| delegation | Career | |
|--|---------------------|----|
| | Resident | 1 |
| Toxicology Section | | 1 |
| | Academic Physician | 1 |
| Trauma & Injury Prevention Section | | 1 |
| | No Value | 1 |
| Undersea & Hyperbaric Medicine Section | | 1 |
| | No Value | 1 |
| Utah Chapter | | 6 |
| | Attending Physician | 1 |
| | No Value | 5 |
| Vermont Chapter | | 3 |
| | Academic Physician | 1 |
| | Attending Physician | 2 |
| Virginia Chapter | | 9 |
| | Academic Physician | 1 |
| | Attending Physician | 3 |
| | Medical Student | 2 |
| | No Value | 2 |
| | Resident | 1 |
| Washington Chapter | | 13 |
| | Academic Physician | 2 |
| | Attending Physician | 2 |
| | Medical Student | 1 |
| | No Value | 8 |
| Wellness Section | | 3 |
| | Attending Physician | 1 |
| | No Value | 2 |
| West Virginia Chapter | | 3 |
| | Academic Physician | 1 |
| | No Value | 1 |
| | Resident | 1 |
| Wilderness Medicine Section | | 2 |
| | Fellow | 1 |
| | Medical Student | 1 |
| Wisconsin Chapter | | 6 |
| | Medical Student | 2 |
| | No Value | 4 |
| Wyoming Chapter | | 1 |
| | Attending Physician | 1 |

| delegation | Career | |
|--------------------------|--------------------|---|
| Young Physicians Section | | 3 |
| | Academic Physician | 1 |
| | Medical Student | 1 |
| | Resident | 1 |

ACEP Composition Career Demographics

All Committees

| delegation | Career | |
|---|---------------------|----|
| Academic Affairs Committee | | 57 |
| | Academic Physician | 8 |
| | Attending Physician | 6 |
| | Fellow | 5 |
| | Intern | 1 |
| | Medical Student | 5 |
| | No Value | 28 |
| | Resident | 4 |
| Audit Committee | | 8 |
| | Academic Physician | 2 |
| | Attending Physician | 1 |
| | No Value | 5 |
| Awards Committee | | 12 |
| | Academic Physician | 6 |
| | Attending Physician | 2 |
| | Fellow | 1 |
| | No Value | 3 |
| Bylaws Committee | | 21 |
| | Academic Physician | 2 |
| | Attending Physician | 7 |
| | Intern | 1 |
| | No Value | 11 |
| CEDR - Clinical Emergency Data Registry Committee | | 38 |
| | Academic Physician | 5 |
| | Attending Physician | 5 |
| | Fellow | 1 |
| | Intern | 1 |
| | Medical Student | 5 |
| | No Value | 19 |
| | Resident | 2 |
| Clinical Policies Committee | | 28 |
| | Academic Physician | 5 |
| | Attending Physician | 2 |
| | Fellow | 2 |
| | Medical Student | 1 |
| | No Value | 18 |
| Clinical Resources Review Committee | | 25 |
| | Academic Physician | 7 |

| | | |
|---|---------------------|------------|
| | Attending Physician | 5 |
| | Fellow | 1 |
| | No Value | 12 |
| Coding and Nomenclature Advisory Committee | | 43 |
| | Academic Physician | 2 |
| | Attending Physician | 10 |
| | Fellow | 3 |
| | Medical Student | 5 |
| | No Value | 22 |
| | Resident | 1 |
| Communications Committee | | 34 |
| | Academic Physician | 3 |
| | Attending Physician | 6 |
| | Fellow | 2 |
| | Medical Student | 1 |
| | No Value | 19 |
| | Resident | 3 |
| Compensation Committee | | 6 |
| | Academic Physician | 2 |
| | No Value | 4 |
| Disaster Preparedness & Response Committee | | 49 |
| | Academic Physician | 10 |
| | Attending Physician | 4 |
| | Fellow | 5 |
| | Medical Student | 7 |
| | No Value | 20 |
| | Resident | 3 |
| Diversity, Equity, and Inclusion Committee | | 33 |
| | Academic Physician | 4 |
| | Attending Physician | 8 |
| | Fellow | 1 |
| | Medical Student | 4 |
| | No Value | 15 |
| | Resident | 1 |
| Education Committee | | 115 |
| | Academic Physician | 29 |
| | Attending Physician | 17 |
| | Fellow | 9 |
| | Intern | 1 |
| | Medical Student | 11 |
| | No Value | 43 |
| | Resident | 5 |
| Emergency Medical Services (EMS) Committee | | 44 |
| | Academic Physician | 7 |

| | | |
|--|---------------------|----|
| | Attending Physician | 8 |
| | Fellow | 3 |
| | Intern | 1 |
| | Medical Student | 3 |
| | No Value | 17 |
| | Resident | 5 |
| Emergency Medicine Practice Committee | | 57 |
| | Academic Physician | 5 |
| | Attending Physician | 16 |
| | Fellow | 3 |
| | Intern | 1 |
| | Medical Student | 1 |
| | No Value | 28 |
| | Resident | 3 |
| Ethics Committee | | 41 |
| | Academic Physician | 5 |
| | Attending Physician | 7 |
| | Fellow | 2 |
| | Medical Student | 5 |
| | No Value | 21 |
| | Resident | 1 |
| Federal Government Affairs Committee | | 44 |
| | Academic Physician | 5 |
| | Attending Physician | 9 |
| | Fellow | 2 |
| | Intern | 1 |
| | Medical Student | 2 |
| | No Value | 24 |
| | Resident | 1 |
| Finance Committee | | 19 |
| | Academic Physician | 3 |
| | Attending Physician | 4 |
| | No Value | 12 |
| Health Innovation Technology Committee | | 47 |
| | Academic Physician | 9 |
| | Attending Physician | 3 |
| | Fellow | 2 |
| | Intern | 1 |
| | Medical Student | 5 |
| | No Value | 26 |
| | Resident | 1 |
| International Emergency Medicine Committee | | 25 |
| | Academic Physician | 3 |
| | Attending Physician | 5 |

| | | |
|---|---------------------|-----------|
| | Fellow | 2 |
| | Medical Student | 4 |
| | No Value | 10 |
| | Resident | 1 |
| Medical-Legal Committee | | 40 |
| | Academic Physician | 2 |
| | Attending Physician | 7 |
| | Medical Student | 1 |
| | No Value | 28 |
| | Resident | 2 |
| Membership Committee | | 22 |
| | Academic Physician | 2 |
| | Attending Physician | 5 |
| | Fellow | 1 |
| | Medical Student | 1 |
| | No Value | 11 |
| | Resident | 2 |
| National Chapter Relations Committee | | 16 |
| | Academic Physician | 2 |
| | Attending Physician | 2 |
| | Medical Student | 1 |
| | No Value | 10 |
| | Resident | 1 |
| Pediatric Emergency Medicine Committee | | 53 |
| | Academic Physician | 8 |
| | Attending Physician | 12 |
| | Fellow | 8 |
| | Intern | 1 |
| | Medical Student | 1 |
| | No Value | 23 |
| Public Health Committee | | 41 |
| | Academic Physician | 11 |
| | Attending Physician | 11 |
| | Intern | 1 |
| | Medical Student | 4 |
| | No Value | 12 |
| | Resident | 2 |
| Quality and Patient Safety Committee | | 83 |
| | Academic Physician | 10 |
| | Attending Physician | 7 |
| | Fellow | 7 |
| | Intern | 1 |
| | Medical Student | 6 |
| | No Value | 44 |

| | | |
|---|---------------------|-----------|
| | Resident | 8 |
| Reimbursement Committee | | 76 |
| | Academic Physician | 4 |
| | Attending Physician | 13 |
| | Medical Student | 9 |
| | No Value | 49 |
| | Resident | 1 |
| Research Committee | | 73 |
| | Academic Physician | 18 |
| | Attending Physician | 6 |
| | Fellow | 4 |
| | Medical Student | 3 |
| | No Value | 39 |
| | Resident | 3 |
| State Legislative/Regulatory Committee | | 72 |
| | Academic Physician | 6 |
| | Attending Physician | 17 |
| | Fellow | 1 |
| | Intern | 2 |
| | Medical Student | 9 |
| | No Value | 35 |
| | Resident | 2 |
| Well-Being Committee | | 50 |
| | Academic Physician | 3 |
| | Attending Physician | 8 |
| | Fellow | 7 |
| | Medical Student | 2 |
| | No Value | 24 |
| | Resident | 6 |

ACEP Composition Career Demographics

Committees Chairs

| delegation | Career | |
|---|---------------------|---|
| Academic Affairs Committee | | 2 |
| | Fellow | 1 |
| | No Value | 1 |
| Audit Committee | | 2 |
| | Academic Physician | 1 |
| | No Value | 1 |
| Bylaws Committee | | 2 |
| | Attending Physician | 1 |
| | No Value | 1 |
| CEDR - Clinical Emergency Data Registry Committee | | 1 |
| | No Value | 1 |
| Clinical Policies Committee | | 1 |
| | Academic Physician | 1 |
| Clinical Resources Review Committee | | 1 |
| | No Value | 1 |
| Coding and Nomenclature Advisory Committee | | 1 |
| | No Value | 1 |
| Compensation Committee | | 1 |
| | No Value | 1 |
| Disaster Preparedness & Response Committee | | 1 |
| | Academic Physician | 1 |
| Diversity, Equity, and Inclusion Committee | | 1 |
| | Academic Physician | 1 |
| Education Committee | | 2 |
| | Academic Physician | 2 |
| Emergency Medical Services (EMS) Committee | | 1 |
| | Attending Physician | 1 |
| Emergency Medicine Practice Committee | | 1 |
| | No Value | 1 |
| Ethics Committee | | 1 |
| | No Value | 1 |
| Federal Government Affairs Committee | | 2 |
| | No Value | 2 |
| Finance Committee | | 1 |
| | No Value | 1 |
| Health Innovation Technology Committee | | 1 |
| | No Value | 1 |
| International Emergency Medicine Committee | | 2 |

| | | |
|--|---------------------|---|
| | No Value | 2 |
| Medical-Legal Committee | | 1 |
| | No Value | 1 |
| Membership Committee | | 2 |
| | Attending Physician | 1 |
| | No Value | 1 |
| National Chapter Relations Committee | | 1 |
| | Academic Physician | 1 |
| Pediatric Emergency Medicine Committee | | 2 |
| | Academic Physician | 1 |
| | Attending Physician | 1 |
| Public Health Committee | | 1 |
| | Academic Physician | 1 |
| Quality and Patient Safety Committee | | 1 |
| | No Value | 1 |
| Reimbursement Committee | | 2 |
| | Academic Physician | 1 |
| | Attending Physician | 1 |
| Research Committee | | 1 |
| | Academic Physician | 1 |
| State Legislative/Regulatory Committee | | 2 |
| | No Value | 2 |
| Well-Being Committee | | 1 |
| | Attending Physician | 1 |

ACEP Composition Career Demographics

Section Leaders

| delegation | Career | |
|--|---------------------|----|
| Air Medical Transport Section | | 8 |
| | Academic Physician | 3 |
| | Attending Physician | 2 |
| | No Value | 2 |
| | Resident | 1 |
| American Association of Women Emergency Physicians Section | | 10 |
| | Academic Physician | 4 |
| | Fellow | 1 |
| | No Value | 4 |
| | Resident | 1 |
| Careers in Emergency Medicine Section | | 6 |
| | Attending Physician | 3 |
| | No Value | 3 |
| Critical Care Medicine Section | | 7 |
| | Academic Physician | 5 |
| | Fellow | 2 |
| Cruise Ship Medicine Section | | 5 |
| | Academic Physician | 1 |
| | Attending Physician | 2 |
| | No Value | 2 |
| Democratic Group Practice Section | | 9 |
| | Academic Physician | 1 |
| | Attending Physician | 6 |
| | No Value | 2 |
| Disaster Medicine Section | | 10 |
| | Academic Physician | 3 |
| | Attending Physician | 1 |
| | Intern | 1 |
| | Medical Student | 1 |
| | No Value | 4 |
| Diversity, Inclusion and Health Equity Section | | 9 |
| | Academic Physician | 2 |
| | Attending Physician | 2 |
| | No Value | 5 |
| Dual Training Section | | 7 |
| | Attending Physician | 1 |
| | Medical Student | 1 |
| | No Value | 5 |

| | | |
|--|---------------------|----|
| Emergency Medical Informatics Section | | 5 |
| | Academic Physician | 1 |
| | No Value | 3 |
| | Resident | 1 |
| Emergency Medical Services-Prehospital Care Section | | 11 |
| | Academic Physician | 2 |
| | Attending Physician | 3 |
| | Fellow | 2 |
| | No Value | 4 |
| Emergency Medicine Practice Management and Health Policy Section | | 6 |
| | Attending Physician | 2 |
| | Medical Student | 1 |
| | No Value | 2 |
| | Resident | 1 |
| Emergency Medicine Workforce Section | | 11 |
| | Academic Physician | 1 |
| | Attending Physician | 4 |
| | Fellow | 1 |
| | No Value | 5 |
| Emergency Ultrasound Section | | 9 |
| | Academic Physician | 3 |
| | Fellow | 2 |
| | No Value | 4 |
| Event Medicine Section | | 10 |
| | Academic Physician | 1 |
| | Attending Physician | 2 |
| | Fellow | 1 |
| | No Value | 6 |
| Exploring Retirement Section | | 4 |
| | Attending Physician | 1 |
| | Fellow | 1 |
| | No Value | 2 |
| Forensic Medicine Section | | 6 |
| | Attending Physician | 1 |
| | No Value | 4 |
| | Resident | 1 |
| Freestanding Emergency Centers Section | | 10 |
| | Academic Physician | 1 |
| | Attending Physician | 2 |
| | No Value | 7 |
| Geriatric Emergency Medicine Section | | 6 |
| | Academic Physician | 3 |

| | | |
|---|---------------------|----|
| | No Value | 3 |
| International Emergency Medicine Section | | 9 |
| | Attending Physician | 3 |
| | Fellow | 1 |
| | Medical Student | 2 |
| | No Value | 2 |
| | Resident | 1 |
| Locum Tenens Section | | 3 |
| | Attending Physician | 1 |
| | Intern | 1 |
| | No Value | 1 |
| Medical Directors Section | | 11 |
| | Academic Physician | 1 |
| | Attending Physician | 5 |
| | Fellow | 1 |
| | No Value | 4 |
| Medical Humanities Section | | 6 |
| | Academic Physician | 1 |
| | Attending Physician | 3 |
| | No Value | 2 |
| Observation Medicine Section | | 7 |
| | Academic Physician | 2 |
| | Attending Physician | 2 |
| | No Value | 2 |
| | Resident | 1 |
| Pain Management & Addiction Medicine Section | | 7 |
| | Attending Physician | 2 |
| | No Value | 5 |
| Palliative Medicine Section | | 5 |
| | Academic Physician | 1 |
| | Fellow | 3 |
| | No Value | 1 |
| Pediatric Emergency Medicine Section | | 8 |
| | Academic Physician | 1 |
| | Fellow | 4 |
| | No Value | 3 |
| Quality Improvement and Patient Safety Section | | 9 |
| | Medical Student | 5 |
| | No Value | 4 |
| Research, Scholarly Activity and Innovation Section | | 10 |
| | Academic Physician | 4 |
| | Medical Student | 1 |
| | No Value | 5 |

| | | |
|---|---------------------|----|
| Rural Emergency Medicine Section | | 8 |
| | Academic Physician | 1 |
| | Attending Physician | 4 |
| | No Value | 3 |
| Social Emergency Medicine Section | | 8 |
| | Academic Physician | 2 |
| | Fellow | 1 |
| | Intern | 1 |
| | No Value | 3 |
| | Resident | 1 |
| Sports Medicine Section | | 8 |
| | Academic Physician | 2 |
| | Attending Physician | 1 |
| | Fellow | 1 |
| | Medical Student | 1 |
| | No Value | 3 |
| Tactical and Law Enforcement Medicine Section | | 10 |
| | Academic Physician | 3 |
| | No Value | 6 |
| | Resident | 1 |
| Telehealth Section | | 9 |
| | Academic Physician | 1 |
| | Attending Physician | 2 |
| | No Value | 6 |
| Toxicology Section | | 9 |
| | Academic Physician | 2 |
| | Attending Physician | 2 |
| | Fellow | 1 |
| | No Value | 3 |
| | Resident | 1 |
| Trauma and Injury Prevention Section | | 4 |
| | Attending Physician | 2 |
| | No Value | 2 |
| Undersea & Hyperbaric Medicine Section | | 7 |
| | Academic Physician | 1 |
| | Attending Physician | 2 |
| | Fellow | 1 |
| | Medical Student | 1 |
| | No Value | 2 |
| Wellness Section | | 6 |
| | Academic Physician | 1 |
| | Attending Physician | 1 |
| | No Value | 4 |
| Wilderness Medicine Section | | 6 |

| | | |
|--------------------------|---------------------|---|
| | Academic Physician | 1 |
| | Fellow | 2 |
| | Medical Student | 2 |
| | No Value | 1 |
| Young Physicians Section | | 6 |
| | Attending Physician | 1 |
| | No Value | 2 |
| | Resident | 3 |

ACEP Composition Employment Environment Demographic

All Members

| delegation | Career | |
|------------|----------|-------|
| All | | 37041 |
| | No Value | 29669 |
| | Rural | 820 |
| | Suburban | 2515 |
| | Urban | 4037 |

ACEP Composition Employment Environment Demographic Councillors And Alternate Councillors

| delegation | Career | |
|-------------------|---------------|-----|
| All | | 517 |
| | No Value | 255 |
| | Rural | 24 |
| | Suburban | 87 |
| | Urban | 151 |

ACEP Composition Employment Environment Demographic Councillors And Alternate Councillors

| delegation | Career | |
|---------------------------------------|----------|----|
| AACEM | | 1 |
| | No Value | 1 |
| AAWEP Section | | 1 |
| | No Value | 1 |
| Air Medical Transport Section | | 2 |
| | No Value | 1 |
| | Urban | 1 |
| Alabama Chapter | | 3 |
| | No Value | 1 |
| | Suburban | 1 |
| | Urban | 1 |
| Alaska Chapter | | 1 |
| | No Value | 1 |
| Arizona Chapter | | 8 |
| | No Value | 4 |
| | Suburban | 1 |
| | Urban | 3 |
| Arkansas Chapter | | 4 |
| | No Value | 2 |
| | Rural | 1 |
| | Urban | 1 |
| California Chapter | | 41 |
| | No Value | 20 |
| | Rural | 3 |
| | Suburban | 4 |
| | Urban | 14 |
| Careers in Emergency Medicine Section | | 1 |
| | Suburban | 1 |
| Colorado Chapter | | 10 |
| | No Value | 7 |
| | Urban | 3 |
| Connecticut Chapter | | 6 |
| | No Value | 3 |
| | Urban | 3 |

| delegation | Career | |
|--|---------------|----|
| CORD | | 1 |
| | Urban | 1 |
| Critical Care Medicine Section | | 1 |
| | No Value | 1 |
| Cruise Ship Medicine Section | | 1 |
| | Urban | 1 |
| Delaware Chapter | | 3 |
| | No Value | 1 |
| | Suburban | 2 |
| Democratic Group Practice Section | | 1 |
| | Urban | 1 |
| Disaster Medicine Section | | 1 |
| | No Value | 1 |
| District of Columbia Chapter | | 3 |
| | No Value | 3 |
| Diversity & Inclusion Section | | 1 |
| | Urban | 1 |
| Dual Training Section | | 2 |
| | No Value | 1 |
| | Urban | 1 |
| EM Practice Mgmt and Health Policy Section | | 1 |
| | No Value | 1 |
| Emergency Medical Informatics Section | | 2 |
| | Suburban | 1 |
| | Urban | 1 |
| Emergency Medicine Locum Tenens Section | | 1 |
| | Urban | 1 |
| Emergency Medicine Residents' Association | | 14 |
| | No Value | 13 |
| | Urban | 1 |
| Emergency Medicine Workforce Section | | 1 |
| | Suburban | 1 |
| Emergency Telehealth Section | | 2 |
| | No Value | 1 |
| | Urban | 1 |
| Emergency Ultrasound Section | | 2 |
| | No Value | 1 |
| | Urban | 1 |

| delegation | Career | |
|--|---------------|----|
| EMS-Prehospital Care Section | | 1 |
| | Urban | 1 |
| Event Medicine Section | | 1 |
| | No Value | 1 |
| Florida Chapter | | 17 |
| | No Value | 7 |
| | Suburban | 4 |
| | Urban | 6 |
| Forensic Medicine Section | | 1 |
| | Urban | 1 |
| Freestanding Emergency Centers | | 1 |
| | No Value | 1 |
| Georgia Chapter | | 8 |
| | No Value | 4 |
| | Suburban | 2 |
| | Urban | 2 |
| Geriatric Emergency Medicine Section | | 2 |
| | No Value | 2 |
| Govt Services Chapter | | 11 |
| | No Value | 8 |
| | Rural | 1 |
| | Suburban | 2 |
| Hawaii Chapter | | 2 |
| | Suburban | 1 |
| | Urban | 1 |
| Idaho Chapter | | 2 |
| | No Value | 1 |
| | Rural | 1 |
| Illinois Chapter | | 12 |
| | No Value | 7 |
| | Suburban | 1 |
| | Urban | 4 |
| Indiana Chapter | | 9 |
| | No Value | 3 |
| | Suburban | 4 |
| | Urban | 2 |
| International Emergency Medicine Section | | 1 |
| | Urban | 1 |

| delegation | Career | |
|----------------------------|---------------|----|
| Iowa Chapter | | 4 |
| | No Value | 1 |
| | Suburban | 2 |
| | Urban | 1 |
| Kansas Chapter | | 4 |
| | No Value | 2 |
| | Suburban | 1 |
| | Urban | 1 |
| Kentucky Chapter | | 4 |
| | No Value | 2 |
| | Suburban | 1 |
| | Urban | 1 |
| Louisiana Chapter | | 7 |
| | No Value | 2 |
| | Rural | 1 |
| | Suburban | 1 |
| | Urban | 3 |
| Maine Chapter | | 5 |
| | No Value | 3 |
| | Suburban | 1 |
| | Urban | 1 |
| Maryland Chapter | | 7 |
| | No Value | 4 |
| | Suburban | 1 |
| | Urban | 2 |
| Massachusetts Chapter | | 10 |
| | No Value | 3 |
| | Suburban | 2 |
| | Urban | 5 |
| Medical Directors Section | | 2 |
| | Suburban | 1 |
| | Urban | 1 |
| Medical Humanities Section | | 2 |
| | No Value | 1 |
| | Urban | 1 |
| Michigan Chapter | | 25 |
| | No Value | 14 |
| | Suburban | 6 |
| | Urban | 5 |

| delegation | Career | |
|------------------------|---------------|----|
| Minnesota Chapter | | 9 |
| | No Value | 4 |
| | Rural | 1 |
| | Suburban | 1 |
| | Urban | 3 |
| Mississippi Chapter | | 3 |
| | No Value | 1 |
| | Rural | 1 |
| | Urban | 1 |
| Missouri Chapter | | 8 |
| | No Value | 3 |
| | Suburban | 3 |
| | Urban | 2 |
| Montana Chapter | | 2 |
| | Rural | 1 |
| | Urban | 1 |
| Nebraska Chapter | | 2 |
| | No Value | 1 |
| | Rural | 1 |
| Nevada Chapter | | 4 |
| | No Value | 2 |
| | Suburban | 1 |
| | Urban | 1 |
| New Hampshire Chapter | | 1 |
| | Rural | 1 |
| New Jersey Chapter | | 12 |
| | No Value | 5 |
| | Suburban | 5 |
| | Urban | 2 |
| New Mexico Chapter | | 4 |
| | No Value | 4 |
| New York Chapter | | 31 |
| | No Value | 16 |
| | Suburban | 5 |
| | Urban | 10 |
| North Carolina Chapter | | 14 |
| | No Value | 7 |
| | Rural | 2 |
| | Suburban | 3 |

| delegation | Career | |
|---|---------------|----|
| | Urban | 2 |
| North Dakota Chapter | | 1 |
| | Suburban | 1 |
| Observation Services Section | | 1 |
| | Urban | 1 |
| Ohio Chapter | | 23 |
| | No Value | 12 |
| | Rural | 1 |
| | Suburban | 2 |
| | Urban | 8 |
| Oklahoma Chapter | | 5 |
| | No Value | 2 |
| | Suburban | 1 |
| | Urban | 2 |
| Oregon Chapter | | 4 |
| | No Value | 2 |
| | Urban | 2 |
| Pain Management Section | | 1 |
| | Suburban | 1 |
| Palliative Medicine Section | | 1 |
| | Urban | 1 |
| Pediatric Emergency Medicine Section | | 1 |
| | No Value | 1 |
| Pennsylvania Chapter | | 23 |
| | No Value | 14 |
| | Rural | 2 |
| | Suburban | 5 |
| | Urban | 2 |
| Puerto Rico Chapter | | 2 |
| | Urban | 2 |
| Quality Improvement and Patient Safety Section | | 1 |
| | No Value | 1 |
| Research, Scholarly Activity and Innovation Section | | 1 |
| | Urban | 1 |
| Rhode Island Chapter | | 3 |
| | Urban | 3 |
| Rural Emergency Medicine Section | | 1 |
| | Rural | 1 |

| delegation | Career | |
|--|---------------|----|
| Social Emergency Medicine Section | | 1 |
| | No Value | 1 |
| Society of Academic Emergency Medicine | | 1 |
| | No Value | 1 |
| South Carolina Chapter | | 7 |
| | No Value | 2 |
| | Rural | 1 |
| | Suburban | 1 |
| | Urban | 3 |
| South Dakota Chapter | | 2 |
| | No Value | 2 |
| Sports Medicine Section | | 1 |
| | Suburban | 1 |
| Tennessee Chapter | | 5 |
| | No Value | 3 |
| | Suburban | 1 |
| | Urban | 1 |
| Texas Chapter | | 37 |
| | No Value | 16 |
| | Suburban | 6 |
| | Urban | 15 |
| Toxicology Section | | 1 |
| | Suburban | 1 |
| Trauma & Injury Prevention Section | | 1 |
| | No Value | 1 |
| Undersea & Hyperbaric Medicine Section | | 1 |
| | No Value | 1 |
| Utah Chapter | | 6 |
| | No Value | 4 |
| | Urban | 2 |
| Vermont Chapter | | 3 |
| | Rural | 1 |
| | Suburban | 1 |
| | Urban | 1 |
| Virginia Chapter | | 9 |
| | No Value | 4 |
| | Suburban | 3 |
| | Urban | 2 |

| delegation | Career | |
|-----------------------------|---------------|----|
| Washington Chapter | | 13 |
| | No Value | 5 |
| | Rural | 1 |
| | Suburban | 2 |
| | Urban | 5 |
| Wellness Section | | 3 |
| | No Value | 1 |
| | Rural | 2 |
| West Virginia Chapter | | 3 |
| | Rural | 1 |
| | Suburban | 1 |
| | Urban | 1 |
| Wilderness Medicine Section | | 2 |
| | No Value | 2 |
| Wisconsin Chapter | | 6 |
| | No Value | 4 |
| | Suburban | 1 |
| | Urban | 1 |
| Wyoming Chapter | | 1 |
| | Urban | 1 |
| Young Physicians Section | | 3 |
| | No Value | 3 |

ACEP Composition Employment Environment Demographic All Committees

| delegation | Career | |
|---|---------------|----|
| Academic Affairs Committee | | 57 |
| | No Value | 35 |
| | Rural | 1 |
| | Suburban | 4 |
| | Urban | 17 |
| Audit Committee | | 8 |
| | No Value | 4 |
| | Suburban | 1 |
| | Urban | 3 |
| Awards Committee | | 12 |
| | No Value | 5 |
| | Suburban | 2 |
| | Urban | 5 |
| Bylaws Committee | | 21 |
| | No Value | 12 |
| | Suburban | 3 |
| | Urban | 6 |
| CEDR - Clinical Emergency Data Registry Committee | | 38 |
| | No Value | 22 |
| | Rural | 2 |
| | Suburban | 3 |
| | Urban | 11 |
| Clinical Policies Committee | | 28 |
| | No Value | 16 |
| | Suburban | 2 |
| | Urban | 10 |
| Clinical Resources Review Committee | | 25 |
| | No Value | 10 |
| | Rural | 2 |
| | Suburban | 6 |
| | Urban | 7 |
| Coding and Nomenclature Advisory Committee | | 43 |
| | No Value | 24 |
| | Suburban | 13 |
| | Urban | 6 |
| Communications Committee | | 34 |
| | No Value | 16 |
| | Rural | 1 |

| | | |
|--|----------|-----|
| | Suburban | 4 |
| | Urban | 13 |
| Compensation Committee | | 6 |
| | No Value | 2 |
| | Urban | 4 |
| Disaster Preparedness & Response Committee | | 49 |
| | No Value | 21 |
| | Suburban | 4 |
| | Urban | 24 |
| Diversity, Equity, and Inclusion Committee | | 33 |
| | No Value | 17 |
| | Rural | 2 |
| | Suburban | 2 |
| | Urban | 12 |
| Education Committee | | 115 |
| | No Value | 62 |
| | Suburban | 14 |
| | Urban | 39 |
| Emergency Medical Services (EMS) Committee | | 44 |
| | No Value | 25 |
| | Rural | 3 |
| | Suburban | 4 |
| | Urban | 12 |
| Emergency Medicine Practice Committee | | 57 |
| | No Value | 32 |
| | Rural | 1 |
| | Suburban | 10 |
| | Urban | 14 |
| Ethics Committee | | 41 |
| | No Value | 24 |
| | Rural | 1 |
| | Suburban | 4 |
| | Urban | 12 |
| Federal Government Affairs Committee | | 44 |
| | No Value | 20 |
| | Rural | 1 |
| | Suburban | 7 |
| | Urban | 16 |
| Finance Committee | | 19 |
| | No Value | 9 |
| | Rural | 1 |
| | Suburban | 5 |
| | Urban | 4 |
| Health Innovation Technology Committee | | 47 |

| | | |
|--|----------|----|
| | No Value | 31 |
| | Rural | 1 |
| | Suburban | 1 |
| | Urban | 14 |
| International Emergency Medicine Committee | | 25 |
| | No Value | 15 |
| | Suburban | 1 |
| | Urban | 9 |
| Medical-Legal Committee | | 40 |
| | No Value | 21 |
| | Rural | 2 |
| | Suburban | 9 |
| | Urban | 8 |
| Membership Committee | | 22 |
| | No Value | 11 |
| | Rural | 1 |
| | Suburban | 1 |
| | Urban | 9 |
| National Chapter Relations Committee | | 16 |
| | No Value | 11 |
| | Rural | 1 |
| | Suburban | 1 |
| | Urban | 3 |
| Pediatric Emergency Medicine Committee | | 53 |
| | No Value | 33 |
| | Rural | 1 |
| | Suburban | 3 |
| | Urban | 16 |
| Public Health Committee | | 41 |
| | No Value | 18 |
| | Rural | 1 |
| | Suburban | 4 |
| | Urban | 18 |
| Quality and Patient Safety Committee | | 83 |
| | No Value | 54 |
| | Rural | 2 |
| | Suburban | 6 |
| | Urban | 21 |
| Reimbursement Committee | | 76 |
| | No Value | 53 |
| | Rural | 2 |
| | Suburban | 11 |
| | Urban | 10 |
| Research Committee | | 73 |

| | | |
|--|----------|----|
| | No Value | 42 |
| | Rural | 1 |
| | Suburban | 2 |
| | Urban | 28 |
| State Legislative/Regulatory Committee | | 72 |
| | No Value | 41 |
| | Rural | 3 |
| | Suburban | 15 |
| | Urban | 13 |
| Well-Being Committee | | 50 |
| | No Value | 22 |
| | Rural | 4 |
| | Suburban | 9 |
| | Urban | 15 |

ACEP Composition Employment Environment Demographic Committees Chairs

| delegation | Career | |
|---|----------|---|
| Academic Affairs Committee | | 2 |
| | No Value | 2 |
| Audit Committee | | 2 |
| | No Value | 1 |
| | Urban | 1 |
| Bylaws Committee | | 2 |
| | No Value | 1 |
| | Urban | 1 |
| CEDR - Clinical Emergency Data Registry Committee | | 1 |
| | Rural | 1 |
| Clinical Policies Committee | | 1 |
| | Urban | 1 |
| Clinical Resources Review Committee | | 1 |
| | No Value | 1 |
| Coding and Nomenclature Advisory Committee | | 1 |
| | No Value | 1 |
| Compensation Committee | | 1 |
| | No Value | 1 |
| Disaster Preparedness & Response Committee | | 1 |
| | Urban | 1 |
| Diversity, Equity, and Inclusion Committee | | 1 |
| | Urban | 1 |
| Education Committee | | 2 |
| | No Value | 1 |
| | Urban | 1 |
| Emergency Medical Services (EMS) Committee | | 1 |
| | Suburban | 1 |
| Emergency Medicine Practice Committee | | 1 |
| | No Value | 1 |
| Ethics Committee | | 1 |
| | No Value | 1 |
| Federal Government Affairs Committee | | 2 |
| | Suburban | 1 |
| | Urban | 1 |
| Finance Committee | | 1 |
| | Urban | 1 |
| Health Innovation Technology Committee | | 1 |
| | No Value | 1 |

| | | |
|--|----------|---|
| International Emergency Medicine Committee | | 2 |
| | No Value | 2 |
| Medical-Legal Committee | | 1 |
| | No Value | 1 |
| Membership Committee | | 2 |
| | No Value | 1 |
| | Urban | 1 |
| National Chapter Relations Committee | | 1 |
| | Urban | 1 |
| Pediatric Emergency Medicine Committee | | 2 |
| | No Value | 1 |
| | Urban | 1 |
| Public Health Committee | | 1 |
| | Urban | 1 |
| Quality and Patient Safety Committee | | 1 |
| | No Value | 1 |
| Reimbursement Committee | | 2 |
| | Suburban | 1 |
| | Urban | 1 |
| Research Committee | | 1 |
| | Urban | 1 |
| State Legislative/Regulatory Committee | | 2 |
| | No Value | 1 |
| | Suburban | 1 |
| Well-Being Committee | | 1 |
| | Suburban | 1 |

ACEP Composition Employment Environment Demographic Section Leaders

| delegation | Career | |
|--|----------|----|
| Air Medical Transport Section | | 8 |
| | No Value | 2 |
| | Rural | 2 |
| | Urban | 4 |
| American Association of Women Emergency Physicians Section | | 10 |
| | No Value | 5 |
| | Suburban | 1 |
| | Urban | 4 |
| Careers in Emergency Medicine Section | | 6 |
| | No Value | 3 |
| | Suburban | 2 |
| | Urban | 1 |
| Critical Care Medicine Section | | 7 |
| | No Value | 5 |
| | Urban | 2 |
| Cruise Ship Medicine Section | | 5 |
| | Suburban | 1 |
| | Urban | 4 |
| CWO White Paper Team | | 9 |
| | No Value | 5 |
| | Rural | 1 |
| | Suburban | 2 |
| | Urban | 1 |
| Democratic Group Practice Section | | 9 |
| | No Value | 1 |
| | Suburban | 4 |
| | Urban | 4 |
| Disaster Medicine Section | | 10 |
| | No Value | 6 |
| | Urban | 4 |
| Diversity, Inclusion and Health Equity Section | | 9 |
| | No Value | 3 |
| | Suburban | 1 |
| | Urban | 5 |
| Dual Training Section | | 7 |
| | No Value | 5 |
| | Urban | 2 |
| Emergency Medical Informatics Section | | 5 |

| | | |
|--|----------|----|
| | No Value | 2 |
| | Suburban | 1 |
| | Urban | 2 |
| Emergency Medical Services-Prehospital Care Section | | 11 |
| | No Value | 4 |
| | Rural | 1 |
| | Urban | 6 |
| Emergency Medicine Practice Management and Health Policy Section | | 6 |
| | No Value | 5 |
| | Suburban | 1 |
| Emergency Medicine Workforce Section | | 11 |
| | No Value | 7 |
| | Suburban | 2 |
| | Urban | 2 |
| Emergency Ultrasound Section | | 9 |
| | No Value | 6 |
| | Rural | 1 |
| | Urban | 2 |
| Event Medicine Section | | 10 |
| | No Value | 4 |
| | Suburban | 2 |
| | Urban | 4 |
| Exploring Retirement Section | | 4 |
| | No Value | 2 |
| | Suburban | 1 |
| | Urban | 1 |
| Forensic Medicine Section | | 6 |
| | No Value | 3 |
| | Rural | 1 |
| | Urban | 2 |
| Freestanding Emergency Centers Section | | 10 |
| | No Value | 7 |
| | Rural | 1 |
| | Urban | 2 |
| Geriatric Emergency Medicine Section | | 6 |
| | No Value | 3 |
| | Urban | 3 |
| International Emergency Medicine Section | | 9 |
| | No Value | 5 |
| | Urban | 4 |
| Locum Tenens Section | | 3 |
| | No Value | 1 |

| | | |
|---|----------|----|
| | Rural | 1 |
| | Suburban | 1 |
| Medical Directors Section | | 11 |
| | No Value | 4 |
| | Suburban | 3 |
| | Urban | 4 |
| Medical Humanities Section | | 6 |
| | No Value | 1 |
| | Rural | 1 |
| | Suburban | 1 |
| | Urban | 3 |
| Observation Medicine Section | | 7 |
| | No Value | 2 |
| | Suburban | 1 |
| | Urban | 4 |
| Pain Management & Addiction Medicine Section | | 7 |
| | No Value | 3 |
| | Suburban | 2 |
| | Urban | 2 |
| Palliative Medicine Section | | 5 |
| | No Value | 1 |
| | Urban | 4 |
| Pediatric Emergency Medicine Section | | 8 |
| | No Value | 7 |
| | Urban | 1 |
| Quality Improvement and Patient Safety Section | | 9 |
| | No Value | 7 |
| | Rural | 1 |
| | Urban | 1 |
| Research, Scholarly Activity and Innovation Section | | 10 |
| | No Value | 5 |
| | Urban | 5 |
| Rural Emergency Medicine Section | | 8 |
| | No Value | 3 |
| | Rural | 2 |
| | Suburban | 1 |
| | Urban | 2 |
| Social Emergency Medicine Section | | 8 |
| | No Value | 5 |
| | Suburban | 1 |
| | Urban | 2 |
| Sports Medicine Section | | 8 |
| | No Value | 4 |

| | | |
|---|----------|----|
| | Suburban | 1 |
| | Urban | 3 |
| Tactical and Law Enforcement Medicine Section | | 10 |
| | No Value | 4 |
| | Suburban | 1 |
| | Urban | 5 |
| Telehealth Section | | 9 |
| | No Value | 6 |
| | Urban | 3 |
| Toxicology Section | | 9 |
| | No Value | 5 |
| | Suburban | 2 |
| | Urban | 2 |
| Trauma and Injury Prevention Section | | 4 |
| | No Value | 1 |
| | Suburban | 1 |
| | Urban | 2 |
| Undersea & Hyperbaric Medicine Section | | 7 |
| | No Value | 3 |
| | Suburban | 1 |
| | Urban | 3 |
| Wellness Section | | 6 |
| | No Value | 4 |
| | Rural | 1 |
| | Urban | 1 |
| Wilderness Medicine Section | | 6 |
| | No Value | 4 |
| | Urban | 2 |
| Young Physicians Section | | 6 |
| | No Value | 5 |
| | Urban | 1 |

Memorandum

To: 2023 Council

From: Sonja Montgomery, CAE
Governance Operations Director

Date: September 7, 2023

Subj: Compensation Committee Report

The Compensation Committee has not yet developed their recommendations for Board member and officer stipends for FY 2023-24. The committee will hold a conference call soon to discuss their recommendations. The committee's recommendations will be discussed by the Board at their meeting on October 6. The Compensation Committee's report will be distributed to the Council as soon as it is available. The Council will also be informed if the Board does not adopt the Compensation Committee's recommendations.

The basis for the Compensation Committee resides in the ACEP Bylaws, Article XI – Committees, Section 7 – Compensation Committee:

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

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

The current officer and non-officer stipends are:

| | |
|---------------------------|-----------|
| President | \$148,329 |
| President-Elect | \$107,865 |
| Chair | \$ 35,736 |
| Vice President | \$ 35,736 |
| Secretary-Treasurer | \$ 35,736 |
| Immediate Past President | \$ 35,736 |
| Speaker | \$ 35,736 |
| Vice Speaker | \$ 18,413 |
| Non-Officer Board Members | \$ 11,054 |

HEADQUARTERS

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Kristin B. McCabe-Kline, MD, FACEP

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Speaker

Melissa W. Costello, MD, FACEP
Vice Speaker

EXECUTIVE DIRECTOR

Susan E. Sedory, MA, CAE

Memorandum

To: Council Steering Committee
2023 Council

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

Melissa W. Costello, MD, FACEP
Council Vice Speaker

Date: September 1, 2023

Subj: Board Position and Vote on Amended Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine (*second resolved*)

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Vice Speaker

EXECUTIVE DIRECTOR

Susan E. Sedory, MA, CAE

The 2021 Council and the Board of Directors adopted Amended Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine:

RESOLVED, That ACEP support that anyone, physicians or non-physician practitioners, who engage in the practice of medicine be regulated by the respective state medical board of their respective states; and be it further

RESOLVED, That ACEP work with the AMA and submit a resolution to their house of delegates to create a universal definition of the practice of medicine to include the ordering of diagnostic tests, diagnosing clinical condition/disease, prescribing of medications, and/or ordering of treatments on human beings.

The first resolved was assigned to the State Legislative/Regulatory Committee (SLRC) to develop a policy statement. The Board adopted the policy statement “State Board of Medicine Regulation of Non-Physician Practitioners Practicing Medicine” on April 30, 2023.

The second resolved was assigned to the AMA Section Council on Emergency Medicine. The AMA Section Council on Emergency Medicine discussed the second resolved extensively and was concerned that, contrary to the seeming intent of the resolution, a universal definition of the practice of medicine could leave emergency medicine more vulnerable on scope of practice issues rather than less vulnerable. If defined too narrowly, it leaves an opening for nurse practitioners to further expand their scope of practice and if defined too broadly it could remove needed functions provided by nurse practitioners and potentially nurses as well. An overly broad definition could also introduce new complications wherein anyone offering friendly advice to someone could be construed as providing medical advice and therefore subject them to liability concerns.

Another challenge is if a universal definition is offered by emergency medicine to the AMA House of Delegates (HoD), primary care and other specialties in attendance would then propose alterations or alternative definitions more suited to their own members. This could pit emergency medicine against other specialties within the house of medicine with no guarantee that our definition would prevail, and thereby introduce risk that whatever consensus definition ultimately emerged from the HoD could be much more problematic for emergency medicine (especially given its unique nature) than any perceived issues posed by the current lack of a definition.

The Board of Directors approved the following recommendations on April 30, 2023:

1. Rescind the motion approved at the October 28, 2021, meeting to adopt the second resolved of Amended Resolution 74(21) “Regulation by State Medical Boards of All Who Engage in Practice of Medicine.
2. Overrule the second resolved of Amended Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine.

The Board also adopted a motion “that ACEP work with the American Medical Association and other stakeholders to support that anyone, physicians or non-physician practitioners, who engage in the practice of medicine be regulated by the respective state medical board of their respective states.”

The Steering Committee was informed of the recommendations to the Board at their April 30, 2023, meeting. A message regarding the Board’s decision was posted on the Council engagED on May 30, 2023.

The ACEP Bylaws, Article VIII – Council, Section 8 – Board of Directors Action on Resolutions, paragraphs one and two, state:

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.

Board of Directors Vote and Position

L. Anthony Cirillo, MD, FACEP

I voted to overrule the second resolved based on the recommendation of the AMA Section Council on Emergency Medicine with their report of conversations that did occur with other leaders within the AMA. In addition, there were specific concerns that a universal definition of the practice of medicine could leave emergency medicine more vulnerable on scope of practice issues rather than less vulnerable.

J.T. Finnell, MD, FACEP

I voted to overrule the second resolved based on the recommendation of the AMA Section Council on Emergency Medicine and the concerns that a universal definition of the practice of medicine could leave emergency medicine more vulnerable on scope of practice issues rather than less vulnerable.

Jeff Goodloe, MD, FACEP

I voted to overrule the second resolved based on the recommendation of ACEP's AMA Section Council on Emergency Medicine (represented by Dr. Stephen Epstein) with specified concerns that a universal definition of the practice of medicine could leave emergency medicine more vulnerable on scope of practice issues rather than less vulnerable.

Alison Haddock, MD, FACEP

Abstention – Dr. Haddock was temporarily out of the room when the vote was taken.

Christopher Kang, MD, FACEP

I voted to overrule the second resolved of Council Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine based on the recommendation of the AMA Section Council on Emergency Medicine and concerns regarding the feasibility, accuracy, and acceptance of a universal definition of the practice of medicine and its applicability to the current and evolving scope of practice of non-physician healthcare professions, including roles, education, licensure, credentialing, certification, and regulation at the hospital, state, and federal levels.

Gabe Kelen, MD, FACEP

I voted to overrule the second resolved based on the recommendation of the AMA Section Council on Emergency Medicine and the concerns that a universal definition of the practice of medicine could leave emergency medicine more vulnerable on scope of practice issues rather than less vulnerable.

Rami Khoury, MD, FACEP

I voted to overrule the second resolved based on the recommendation of the AMA Section Council on Emergency Medicine after a very lengthy discussion. Concerns that a universal definition of the practice of medicine could leave emergency medicine more vulnerable on scope of practice issues rather than less vulnerable which I believe to be true.

Heidi Knowles, MD, FACEP

I voted to overrule the second resolved based on the wisdom and recommendation of the AMA Section Council on Emergency Medicine and the concerns for unintended consequences that a universal definition of the practice of medicine could result in, including negatively affecting the scope of practice of APPs as well as nurses, increased liability, the potential to pit emergency medicine against other specialties, and the possibility that future definitions could be harmful to EM.

Kristin McCabe-Kline, MD, FACEP

I voted to overrule based on the recommendation from the ACEP representative to the AMA regarding the position of the AMA but in full support of further action to preserve the intent of the Council while aligning with the AMA.

Gillian Schmitz, MD, FACEP

I voted to overrule the second resolved based on the recommendation of the AMA Section Council on Emergency Medicine and the concerns that a universal definition of the practice of medicine could leave emergency medicine more vulnerable on scope of practice issues rather than less vulnerable.

James Shoemaker, Jr., MD, FACEP

I voted to overrule the 2nd resolved based on the analysis from the AMA Section Council on EM that felt a universal definition of the practice of medicine could inadvertently result in more scope creep vulnerabilities and could negatively impact nurses and nurse

practitioners. The potential liability concerns identified were also enough to overrule not to mention other specialties in the House of Medicine wanting to make changes to best fit their needs. One size does not fit all.

Ryan Stanton, MD, FACEP

I voted to overrule based on the recommendation and guidance of our colleagues representing the College with the AMA in order to promote a solution that maintains our relationships with the AMA while still providing a pathway for best achieving the intent of the resolution.

Aisha Terry, MD, FACEP

I voted to overrule the second resolved based on the recommendation of the AMA Section Council on Emergency Medicine and the concerns that a universal definition of the practice of medicine could leave emergency medicine more vulnerable on scope of practice issues rather than less vulnerable.



2023 Town Hall Meeting

Saturday, October 7, 2023
Pennsylvania Convention Center
Terrace Ballroom II-III (400 Level)
1:15 pm – 2:15 pm

What's AI Got to Do With IT? The Future of Health Care Automation

Moderator: Todd Taylor, MD, FACEP
Chief Vision Officer, ACEP Emergency Medicine Data Institute

Discussants: Michael Gillam, MD, FACEP
HealthLab, Founder & CEO

Christopher Alban, MD
Emergency Physician & Clinical Informaticist, Epic Systems Corporation

Session Format: The Town Hall Meeting is open to everyone attending the Council meeting. Seating is open without restriction to the Council floor.

Description: Artificial Intelligence, Augmented Intelligence, Large Language Models, Generative Pre-trained Transformers (GPT), ChatGPT-3 (Chatbot Generative Pre-trained Transformer), Enterprise ChatGPT-4., Neural Network Machine Learning Model, Natural Language Processing, Reinforcement Learning from Human Feedback (RLHF), Predictive Auto-Complete, on & on . . . We'll make (some) sense of all this, offer real world EM application (EPIC) and show how IT will change your world. Buckle up for a glimpse into the near future . . .

Objectives:

1. Discuss how the largest EM database in the world will change EM.
2. Illustrate how new AI technologies are being applied to common tools (EPIC EHR).
3. Demonstrate ChatGPT in real time.
4. Q&A

Memorandum

To: 2023 Council

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

Date: October 3, 2023

Subj: Action on 2022 Resolutions

The 2022 Council considered 65 resolutions: 45 were adopted, 17 were not adopted, and four were referred to the Board of Directors. There are five commendation resolutions, 10 memorial resolutions, one Bylaws resolution, and two Council Standing Rules resolutions.

Note: The first resolved of Resolution 19 was not adopted and the second resolved was adopted as amended.

The attached report summarizes the actions taken on the 2022 resolutions adopted by the Council and those that were referred to the Board of Directors. The [updated actions](#) are also available on the ACEP website (scroll to the end of the document to see amended or substituted language and to see the implementation action).

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Action on 2022 Council Resolutions

Resolution 1 Commendation for Michael L. Callaham, MD, FACEP

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

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

Action: A framed resolution was sent to Dr. Callaham.

Resolution 2 Commendation for Virginia Kennedy Palys, JD

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

Action: A framed resolution was sent to Ms. Kennedy-Palys.

Resolution 3 Commendation for Commendation Paul Pomeroy, MD, FACEP

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

Action: A framed resolution was sent to Dr. Pomeroy.

Resolution 4 Commendation for Loren Rives, MNA

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

Action: A framed resolution was sent to Ms. Rives.

Resolution 5 Commendation for Mark S. Rosenberg, MD, MBA, FACEP

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

Action: A framed resolution was presented to Dr. Rosenberg.

Resolution 6 In Memory of Carey D. Chisholm, MD

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Carey D. Chisholm, MD, to the specialty of emergency medicine, especially as an educator, and extends the College's condolences to his wife of almost 40 years, Robin Chisholm, as well as to their daughters, Kelsey and Tyler.

Action: A framed resolution was sent to Dr. Chisholm's family.

Resolution 7 In Memory of Loren A. Crown, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Loren A. Crown, MD, FACEP, and extends condolences and gratitude to his wife, Elaine Kathleen Ellis, family, and friends for his service to the specialty of emergency medicine and to patient care.

Resolution 8 In Memory of Sherill Mullenix

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

Action: A framed resolution was sent to Ms. Mullenix's family.

Resolution 9 In Memory of Adetolu "Tolu" Odufuye, MD

RESOLVED, That the American College of Emergency Physicians extends to the family of Adetolu "Tolu" Odufuye MD, FACEP, her friends, and her colleagues our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the patients and physicians of Florida and the United States.

Action: A framed resolution was sent to Dr. Odufuye's family.

Resolution 11 Establishing a Young Physician Position on the ACEP Nominating Committee

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

A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members, **at least one of which 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.

Action: The Bylaws were updated.

Resolution 15 Electronic Voting During the Council Meeting – Council Standing Rules Amendment (as amended)

RESOLVED, That the ACEP Council Standing Rules, "Election Procedures" section, paragraph one, and the "Voting on Resolutions and Motions" first paragraph be amended to read:

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot, **which may include remote communication and voting technology**. There shall be no write-in voting. **Individual connectivity issues or individual disruption of remote communication technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. 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.**

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.**

Action: The Council Standing Rules were updated.

Resolution 16 Required Candidate Campaign Materials from Floor Candidates

RESOLVED, That the ACEP Council Standing Rules, "Nominations" section, be amended to read:

Nominations

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

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

Action: The Council Standing Rules were updated.

Resolution 17 Criteria for the Location of Future National ACEP Events (as substituted)

RESOLVED, That in considering where to schedule future national level ACEP events, ACEP shall take into consideration whether that location restricts access to reproductive health care.

Action: Assigned to educational meetings staff to consider when developing recommendations for future national ACEP meetings.

Resolution 19 Due Process and Interaction with ACEP (as amended) – second resolved

RESOLVED, That ACEP create a method for members to report incidents of denial of due process, review member-submitted contractual clauses, or other methods of denying such that are of concern.

Action: Assigned to legal staff to guide the appropriate development and implementation of this reporting mechanism for members.

There are a growing number of [resources available on the ACEP website](#) dedicated to the topics of employment contracts and other practice and legal issues, including a checklist to negotiate the best contract and an on-demand course on standard contract provisions. The site also includes a list of local attorneys available to review contracts and assist with other legal matters. In addition, ACEP partnered with Resolve, a well-established physician contract review service, in March 2023, to provide all ACEP members a 20% discount on contract review services, ranging in price from \$499 to \$1,999 based on the complexity of review required. Resolve also provides insight into compensation data and the competitiveness of other terms in the contract. The service was tested by two ACEP members needing contract review for their real-life employment agreements prior to finalizing the partnership and both members had positive feedback about their experiences.

Resolution 24 Access to Reproductive Rights (as amended)

RESOLVED, That ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Action: Assigned to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP’s policy statement “[Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy](#)” and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care. Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

The Emergency Medicine Reproductive Health & Patient Safety Task Force developed a new and comprehensive policy statement “[Access to Reproductive Healthcare in the Emergency Department](#)” that includes and expands on the policy statement “Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy.” The new policy statement is intended to focus on protecting the patient-physician relationship, which will allow it to be used to serve patients throughout the United States. The policy statement was approved by the Board in June 2023. Elements of the new policy statement were used in ACEP’s response to HIPAA Privacy Rule to Support Reproductive Health Care Privacy.

Resolution 25 Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care (as amended)

RESOLVED, That ACEP affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual’s state; and 2) no physician or other professional personnel shall be required to

perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure; and be it further

RESOLVED, That ACEP support the position that the early termination of pregnancy (publicly referred to as “abortion”) is a medical procedure, and as such, involves shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients; and be it further

RESOLVED, That ACEP oppose statutory provision of criminal penalties for any medically appropriate care provided in the emergency department and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, which includes, but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss; and be it further

RESOLVED, That ACEP 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; and be it further

RESOLVED, That ACEP 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.

Action: Assigned to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP’s policy statement “[Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy](#)” and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care. Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

The Emergency Medicine Reproductive Health & Patient Safety Task Force developed a new and comprehensive policy statement “[Access to Reproductive Healthcare in the Emergency Department](#)” that includes and expands on the policy statement “Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy.” The new policy statement is intended to focus on protecting the patient-physician relationship, which will allow it to be used to serve patients throughout the United States. The policy statement was approved by the Board in June 2023. Elements of the new policy statement were used in ACEP’s response to HIPAA Privacy Rule to Support Reproductive Health Care Privacy, specifically regarding a proposed prohibition on use or disclosure of PHI, in accordance with the 3rd and 4th resolveds.

Resolution 26 Promoting Safe Reproductive Health Care for Patients (as amended)

RESOLVED, That ACEP 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; and be it further

RESOLVED, That ACEP 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 be it further.

RESOLVED, That ACEP 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.

Action: Assigned to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP’s policy statement “[Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy](#)” and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care. Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

The Emergency Medicine Reproductive Health & Patient Safety Task Force developed a new and comprehensive policy statement “[Access to Reproductive Healthcare in the Emergency Department](#)” that includes and expands on the policy statement “Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy.” The new policy statement is intended to focus on protecting the patient-physician relationship, which will allow it to be used to serve patients throughout the United States. The policy statement was approved by the Board in June 2023. Elements of the new policy statement were used in ACEP’s response to HIPAA Privacy Rule to Support Reproductive Health Care Privacy, specifically in support of legal protections in accordance with the 3rd resolved.

Resolution 27 Equitable Access to Emergency Contraception in the ED

RESOLVED, That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and be it further

RESOLVED, ACEP advocate for universal access to emergency contraception in the emergency department.

Action: Assigned first resolved to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP's policy statement "[Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy](#)" and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care. Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

The Emergency Medicine Reproductive Health & Patient Safety Task Force developed a new and comprehensive policy statement "[Access to Reproductive Healthcare in the Emergency Department](#)" that includes and expands on the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy." The new policy statement is intended to focus on protecting the patient-physician relationship, which will allow it to be used to serve patients throughout the United States. The policy statement was approved by the Board in June 2023.

Resolution 28 Billing and Collections Transparency and Interaction with ACEP (as amended)

RESOLVED, That ACEP advocate to establish the requirement that revenue cycle management entities will, upon request, directly provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide.

Action: Assigned to Advocacy & Practice Affairs staff for federal, state, and local advocacy initiatives, in accordance with ACEP's policy statement "[Emergency Physician Contractual Relationships](#)" and the associated [Policy Resource and Education Paper \(PREP\)](#) supporting the rights of an emergency physician to review what is billed and collected in their name. ACEP continues to advocate for the importance of billings and collections transparency. One of the questions employers, including revenue cycle management entities, are asked as part of ACEP's [Open Book](#) project is to identify if, and how often, physicians in their group are provided with billing and collections data.

Resolution 29 Buprenorphine is an Essential Medicine and Should be Stocked in Every ED

RESOLVED, That ACEP advocate on behalf of its patients and members that the FDA add buprenorphine to its list of essential medications; and be it further

RESOLVED, That ACEP recommend and advocate that every emergency department stock buprenorphine and medications for opioid use disorder so that patients with opioid use disorder or in opioid withdrawal may receive the best evidence-based care; and be it further

RESOLVED, That ACEP work with the American Hospital Association, American Medical Association, state agencies, and federal agencies to promote availability of medications for opioid use disorder in emergency departments and hospital settings; and be it further

RESOLVED, That ACEP support hospitals and emergency physicians in initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder to enhance best evidence-based practices in emergency medicine throughout the United States.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Administration (DEA) [issued guidance on the removal of the X-waiver](#) on January 12, 2023. This is an ACEP priority that was included in the Consolidated Appropriations Act, 2023. ACEP has advocated for years for Congress to repeal the X-waiver requirement, which was a significant barrier to the treatment of opioid use disorder and contributed to stigma around the disease. ACEP contacted SAMSHA and the DEA immediately upon the passage of the legislation to request that they issue guidance effectuating the policy change as soon as possible. As stated in the guidance, an X-waiver is no longer required to treat patients with buprenorphine for opioid use disorder. Going forward, all prescriptions for buprenorphine will only require a standard DEA registration number. There are no longer any limits or patient caps on the number of patients a prescriber may treat for opioid use disorder with buprenorphine. Existing state laws or regulations still apply. SAMHSA also will [no longer be accepting new waiver applications](#). Separately, the Consolidated Appropriations Act, 2023 also introduced new training requirements for all prescribers. These requirements were effective June 21, 2023. The DEA and SAMHSA are actively working to provide further guidance and DEA will follow up with additional information on the requirements. All physicians and other health care professionals with a regular DEA license

can now prescribe buprenorphine. ACEP developed a BUPE [point-of care tool](#) and training courses to provide best practices and the most up-to-date evidence-based protocols regarding this treatment.

ACEP submitted [a letter](#) to the Food and Drug Administration (FDA) on February 15, 2023, asking the agency to add buprenorphine to the list of essential medicines. The FDA list is often used as a reference for what EDs are required to stock, and because buprenorphine is not currently recognized as an essential medicine, many EDs do not carry it and are not required to stock buprenorphine and other medications for opioid use disorder by accrediting bodies or government agencies. Also, since buprenorphine is classified as a “suspicious order” according to current Drug Enforcement Agency (DEA) regulations, many community pharmacies are hesitant to stock it, and there is a misperception that there are limits around how much of the medication pharmacies can carry at one time. Adding buprenorphine to the list of essential medicines would help address these barriers and ensure that individuals are able to access this important medication.

ACEP advocacy resulted in an additional \$7.4 million in Substance Abuse and Mental Health Services Administration ([SAMHSA](#)) [grant funding](#) for Emergency Department Alternative to Opioids (ALTO) programs and an additional \$18.4 million for programs providing Medication-Assisted Treatment (MAT). ACEP [developed, advocated for, and secured enactment of the law](#) passed by Congress in 2018 to establish the ALTO grant program, and successfully advocated for [follow-up legislation](#) with a \$2 million funding increase to make the emergency physician-led program permanent. We also strongly supported MAT expansion – including the recent [repeal of the “X-waiver”](#) to prescribe buprenorphine.

Resolution 32 Supervised Consumption Facilities/Safe Injection Sites

RESOLVED, That ACEP support the development and implementation of Supervised Consumption Facilities/Supervised Injection Sites (SCF/SIS) in the United States that would be designed, monitored, and evaluated to include additional data to inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harm and health care costs related to injection drug use.

Action: Assigned to the Public Health & Injury Prevention Committee to develop a policy statement in support of supervised consumption facilities/supervised injection sites. The committee submitted a proposed policy statement for the Board of Directors to consider at their October 6, 2023, meeting.

Resolution 33 Telehealth Bridge Model for the Treatment of Opioid Use Disorder

RESOLVED, That ACEP support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder care; and be it further

RESOLVED, That ACEP advocate for state and federal regulatory and legislative solutions that will permit the ongoing integration of opioid use disorder treatment including medication therapy through telehealth into the continuum of addiction care.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives and consult with the Emergency Telehealth Section.

ACEP responded on March 28, 2023, to a proposed rule issued by the DEA regarding the continued use of telehealth to prescribe buprenorphine in cases where patients have never before been treated in-person by the prescriber. Comments focused on: 1) **Advocating for a 90-day instead of a 30-Day Prescription Limit:** The DEA is proposing to continue to allow the use of telemedicine to initially prescribe buprenorphine for the treatment of MOUD. However, in these circumstances, the DEA is proposing a prescription limit of 30 days (it can be multiple prescriptions as long as the total number of days does not exceed 30), after which an in-person examination would be required in order to receive refills. ACEP has concerns about the 30-day limitation for buprenorphine prescriptions. We acknowledge the DEA’s reasoning that obtaining an in-person medical appointment with a practitioner is often difficult due to the shortage of health care workers and various economic, geographical, sociological, and logistical limitations. However, these limitations are not entirely dissolved after 30 days. Many patients have transportation challenges and inflexible work schedules and must navigate finding an in-network provider that is accepting patients. It also takes significantly longer than 30 days to find an appointment in some areas. We therefore request that DEA extend the limit to 90 days so patients can more easily maneuver these logistical barriers. 2) **Opposing the PDMP Restrictions:** The DEA is requiring that prescribers consult a PDMP before writing the prescription. If they do not (even if the PDMP is down and is not the fault of the prescribers), the prescribers can only write a 7-day buprenorphine prescription (otherwise they can write up to a 30-day prescription). ACEP believes that PDMPs play an important role in addressing the opioid crisis as well as deaths related to other prescription drugs. Physicians should make good faith efforts to consult PDMPs before prescribing controlled substances. However, although instances in which a PDMP is inaccessible, such as a server outage, disconnect with the electronic medical record, or a ransomware attack, are rare, they are not impossible occurrences. Infrequent instances in which the PDMP is inaccessible should be documented but should not impede the ability to prescribe a

greater supply of buprenorphine, which may cause a disruption in care. Practitioners and patients should not be punished for something out of their control, including non-operational PDMPs. Therefore, the DEA should omit this requirement from the final rule. 3) **Pushing back against Diversion Rhetoric:** The DEA includes a discussion of buprenorphine diversion in the proposed rule. We push back against the the DEA’s assertion that “diversion of buprenorphine and other prescription opioids remains an issue across the country.” The DEA’s evidence to make its assertions around diversion are based on findings prior to the COVID-19 public health emergency (PHE), in which flexibilities in prescriptions via telemedicine were granted. Therefore, we believe more investigation is necessary to analyze the effects of telemedicine prescribing of buprenorphine on diversion and health outcomes. There are numerous other studies that demonstrate that diversion is decreasing-- and when diversion does occur, it appears from studies that individuals actually wind up using it for its intended purpose, and the only reason why it was diverted initially was because it was difficult to access through the proper channels.

Resolution 34 Emergency Department Safety

RESOLVED, That ACEP work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

ACEP helped inform and supports the “Safety from Violence for Healthcare Employees (SAVE) Act,” (H.R. 7961), bipartisan legislation re-introduced into the 118th Congress by Madeleine Dean (D-PA-04) and Larry Buschon MD (R-IN-08) in April, 2023 that would establish federal criminal penalties for violence against health care workers (as this resolution seeks to do), based on federal penalties that already exist for violence against airline and airport employees. This legislation is also supported by the American Hospital Association. ACEP president Gillian Schmitz, MD, FACEP, was quoted in the [press release](#) issued previously by the sponsors of the legislation on June 7, 2022.

The “[Safety from Violence for Healthcare Employees \(SAVE\) Act](#)” was introduced in the Senate by Senators Marco Rubio (R-FL) and Joe Manchin (D-WV). The legislation establishes federal criminal penalties for individuals who assault health care workers and is modeled after existing protections for airline employees. This bill serves as the Senate companion to the previously-introduced House bill that ACEP advocated for during Hill visits at LAC23 in May. The Senate version is essentially identical in terms of the federal penalties language and who would be covered, but there are two key differences from the House version. The Senate bill strips out the grants for hospitals, and includes a new section requiring a GAO report on the effectiveness of criminal penalties and prosecutions for violence against health care workers. ACEP’s letter of support can be found [here](#), and ACEP President Christopher Kang, MD, FACEP, was quoted in the press release.

Resolution 35 Workplace Violence Towards Health Care Workers (as amended)

RESOLVED, That ACEP 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.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

ACEP helped inform and supports the “Safety from Violence for Healthcare Employees (SAVE) Act,” (H.R. 7961), bipartisan legislation re-introduced into the 118th Congress by Madeleine Dean (D-PA-04) and Larry Buschon MD (R-IN-08) in April, 2023 that would establish federal criminal penalties for violence against health care workers (as this resolution seeks to do), based on federal penalties that already exist for violence against airline and airport employees. This legislation is also supported by the American Hospital Association. ACEP president Gillian Schmitz, MD, FACEP, was quoted in the [press release](#) issued previously by the sponsors of the legislation on June 7, 2022.

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Resolution 36 Emergency Medical Services Are Essential Services (as amended)

RESOLVED, That ACEP advocate for EMS to be considered and funded as an essential service; and be it further

RESOLVED, That ACEP 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 in this regard.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

Resolution 37 Enhance Patient Safety and Physician Wellness

RESOLVED, That ACEP support the protection of all participants in discussions of cases of potential medical error, whether Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), or any patient safety forum, from legal discovery; and be it further

RESOLVED, That ACEP encourage and support state chapters in identifying pending or existing state laws limiting free discussion of cases of potential medical error in quality assurance/quality improvement, Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), and similar environments, and in lobbying against them.

Action: Assigned first resolved to the Medical-Legal Committee to develop a policy statement. Assigned second resolved to Advocacy & Practice Affairs staff for federal and state advocacy initiatives and assist chapters with identifying pending or existing state laws.

Resolution 38 Focus on Emergency Department Patient Boarding as a Health Equity Issue (as amended)

RESOLVED, That ACEP, through legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; and be it further

RESOLVED, That ACEP publish best-practice action plans for hospitals to improve emergency department capacity; and be it further

RESOLVED, That ACEP work to define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

Assigned second and third resolves to the ED Boarding Task Force created by ACEP President Christopher Kang, MD, FACEP. Objectives also include: 1) create an agenda for a boarding summit along with recommendations for organizations to be represented; and 2) create a list of potential solutions to boarding with an emphasis on what the state/federal government can do to reduce boarding.

ACEP President Christopher Kang, MD, FACEP, met with senior officials of the Biden Administration in mid-October 2022 to discuss several issues and specifically recommended that the White House host a summit on ED boarding and workforce issues that would bring together key stakeholders from the clinician, hospital, nursing home, emergency medical services (EMS), and patient communities to discuss potential solutions. ACEP sent a letter to the White House on October 28, 2022, calling attention to the boarding problems in the U.S. and formally asked the Administration to convene a meeting of stakeholders to identify immediate and long-term solutions. Many other medical organizations signed on to the letter. ACEP also sent a letter sent to the National Governors Association on November 9, 2022, that included a copy of the White House boarding letter. A template letter was also created for ACEP chapters to share the White House letter with their individual governors. ACEP began a communications campaign in November 2022 to keep members informed of the initiatives underway to address boarding. A comprehensive [resource page](#) was created on acep.org and a [digital storybook](#) to highlight many of the stories ACEP collected.

The Emergency Medicine Practice Committee developed an ED Boarding Toolkit that will be available on the ACEP Website once it is finalized. The committee also revised the “[Boarding of Admitted and Intensive Care Patients in the Emergency Department](#)” policy statement and it was approved by the Board in February 2023.

ACEP hosted a Boarding Summit on September 27, 2023. Attendees included representatives from the Agency for Healthcare Research and Quality (AHRQ), Health & Human Services’ Administration for Strategic Preparedness & Response-Biomedical Advanced Research and Development Authority (ASPR-BARDA), nursing homes/post-acute care, hospitals, psychiatry, nursing, emergency nursing, patients, National Governors’ Association, Association for State and Territorial Health Officials, and others. The summit participants identified what they perceived as the causes of boarding, discussed barriers to overcome them, and then reached group consensus on areas to prioritize for addressing. The next steps include writing up a report of the Summit and creating a listserv for continued collaboration with the group and others, as appropriate, for advocating at the state and federal level. Information about the Summit will be publicized along with the results of public opinion polling that is being conducted.

Resolution 39 Signage at Emergency Departments With Onsite Emergency Physicians (as amended)

RESOLVED, That ACEP encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

Action: Assigned to communications staff to work with ABEM to disseminate ABEM-developed messaging and/or other tools that can be utilized by EDs to promote their staffing of board certified/board eligible emergency physicians.

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. Co-branded advertisements from this campaign will be displayed in Philadelphia, PA, concurrent with ACEP23.

Resolution 40 Support for Medicaid Expansion

RESOLVED, That ACEP develop a policy statement in support of the expansion of Medicaid to the levels allowable by federal law in recognition of the benefit of increasing health care access to eligible patients, including some of our most vulnerable, while decreasing the uncompensated care provided by emergency physicians; and be it further

RESOLVED, That ACEP develop a toolkit to assist ACEP state chapters in their efforts to advocate for such expansion of Medicaid in their states.

Action: Assigned to the State Legislative/Regulatory Committee to develop a policy statement and toolkit. The committee will continue working on this objective in the 2023-24 committee year.

Resolution 41 Addressing Stigma in the Emergency Department (as amended)

RESOLVED, That ACEP develop an educational resource on identifying and addressing stigma in the emergency department that can be provided to emergency physicians and residency programs, highlighting the role of important practices such as person-first language.

Action: Assigned to the Public Health & Injury Prevention Committee to develop an educational resource and work with the Pain Management & Addiction Medicine Section and the Social Emergency Medicine Section. Seek input from EMRA and CORD regarding the type of resource that is needed. Review the [Substance Use Disorder Emergency Medicine Residency Curriculum](#) that was developed by ACEP, ABEM, CORD, and EMRA and recommend revisions to the curriculum if needed. The SUD Emergency Medicine Residency Curriculum was reviewed, and multiple modules were updated and approved for CME for the period June 30, 2023, through June 19, 2026. The curriculum is available as a member benefit with CME in the [ACEP online learning center](#).

Resolution 43 Endorsing ED Resident Competency in Buprenorphine Initiation (as amended)

RESOLVED, That ACEP support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and be it further

RESOLVED, That ACEP coordinate with other organizations in emergency medicine (Council of Residency Directors in Emergency Medicine, Society for Academic Emergency Medicine, and the American Board of Emergency Medicine) to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency and should focus on identification of patients with opioid use disorder and initiation of buprenorphine treatment as well as sharing harm reduction information and resources.

Action: Assigned to the Academic Affairs Committee to develop strategies to address the resolution and seek input from EMRA. The committee worked with ABEM, CORD, EMRA, and SAEM to develop a policy statement and it has been submitted to the ACEP Board of Directors to consider at their October 6, 2023, meeting. The policy will be submitted to the other organizations for approval after it is approved by the ACEP Board.

Resolution 45 Onsite Supervision of Nurse Practitioners and Physician Assistants

RESOLVED, That the ACEP policy statement “Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department” [sic] be revised so that onsite emergency physician presence to supervise nurse practitioners and physician assistants is stated as the gold standard for staffing all emergency departments.

Action: Assigned to the Emergency Medicine Practice Committee to revise the policy statement. The Board of Directors approved the revised policy statement “[Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in](#)

[the Emergency Department](#)” in June 2023.

Resolution 46 Safe Staffing for Nurse Practitioner and Physician Assistant Supervision (as amended)

RESOLVED, That ACEP 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.

Action: Assigned to the Emergency Medicine Practice Committee. The committee will continue working on the resolution during the 2023-24 committee year.

Resolution 47 Independent Agency Report for Nurse Practitioner Schools (as amended)

RESOLVED, That ACEP work with the American Medical Association to provide recommendations for nurse practitioner education reform to improve the quality and standards of nurse practitioner training for the purpose of improving physician-led patient care.

Action: Assigned to the AMA Section Council on Emergency Medicine.

Resolution 50 Supporting Emergency Physicians to Work in Rural Settings (as amended)

RESOLVED, That ACEP support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; and be it further

RESOLVED, That ACEP help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work in rural settings; and be it further

RESOLVED, That ACEP 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.

Action: Assigned to the Academic Affairs Committee to develop strategies to address the resolution. The committee will continue working on the resolution during the 2023-24 committee year.

Resolution 51 Implementation of Social Determinants of Health Evaluation in the ED (as amended)

RESOLVED, That ACEP support evaluation of social determinants of health in the emergency department; and be it further

RESOLVED, That ACEP advocate for national, state, and local resources and responses to be paired with the evaluation for social determinants of health.

Action: Assigned first resolved to the Public Health & Injury Prevention Committee to work with the Social Emergency Medicine Section and review ACEP’s policy statements “[Safe Discharge from the Emergency Department](#)” and “[Social Work and Case Management in the ED](#)” to determine if revisions are needed to address the first resolved or if a separate policy statement, PREP, and/or other resources are needed. Seek input from the Emergency Medicine Practice Committee if policy revisions are recommended. Assigned second resolved to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

The Public Health & Injury Prevention Committee and the Social Emergency Medicine Section determined that the policy statement “Safe Discharge from the Emergency Department” did not require any revisions and the “Social Work and Case Management in the Emergency Department” required revisions to the content and language, including changing the title. The committee submitted a revised policy statement for the Board of Directors to consider at their October 6, 2023, meeting. The current policy statement has an accompanying Policy Resource & Education Paper (PREP) that will be reviewed by the committee to determine if additional changes are needed beyond changing the title to correspond to the policy statement.

Resolution 56 Policy Statement on the Corporate Practice of Medicine (as amended)

RESOLVED, That ACEP work with relevant experts to develop a policy statement opposing the corporate practice of medicine.

Action: Assigned to the Emergency Medicine Practice Committee to review ACEP’s “[Statement on Private Equity and Corporate Investment in Emergency Medicine](#)” and develop a policy statement as directed in the resolution. The committee developed the policy statement “[Corporate Practice of Medicine](#)” and it was approved by the Board of

Directors in June 2023. ACEP issued a [press release](#) on July 14, 2023, announcing the policy statement. A dedicated page on the topic of [Corporatization](#) was added to the ACEP website.

Resolution 57 Recognized Bodies for Emergency Physician Board Certification (as amended)

RESOLVED, That ACEP amend its policy statement “ACEP Recognized Certifying Bodies in Emergency Medicine” to reflect that no certifying organizations beyond those already listed in the policy statement are recognized by ACEP.

Action: Assigned to the Academic Affairs Committee to revise the policy statement. The Board of Directors approved the revised policy statement “[ACEP Recognized Certifying Bodies in Emergency Medicine](#)” in April 2023.

Resolution 58 Removing Intrusive Medical Exams and Questionnaires from Employment Contracts (as amended)

RESOLVED, That ACEP support the cessation of intrusive medical evaluation exams and questionnaires that may unduly and unnecessarily invade the privacy of emergency medicine physicians seeking and continuing employment beyond that necessary to confirm ability to perform duties associated with the individual’s role as hired.

Action: Assigned to the Emergency Medicine Practice Committee to determine if revisions are needed to ACEP’s policy statement “[Physician Impairment](#)” or whether a separate policy statement or other resources are needed to address the resolution. The committee will continue working on the resolution during the 2023-24 committee year.

Resolution 59 In Memory of Brian Robb, DO, MBA, FACEP

RESOLVED, That the American College of Emergency Physicians recognize and salute Brian Robb, DO, MBA, FACEP, and offer our heartfelt condolence to his wife of 43 years, Sharon, his three children, and many grandchildren.

Action: A framed resolution was sent to Dr. Robb’s family.

Resolution 60 In Memory of James R. Roberts, MD, FACEP

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of James R. Roberts, MD, FACMT, FAAEM, FACEP, who was a pioneer in the specialty and dedicated himself to his patients, to his profession, and to his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extend to his partner Lydia (Forte) to whom he was married for over 40 years, daughter Martha, son Matthew, his grandchildren Eleanor Cronin and Liam Roberts, his brother George Roberts, his sister Mary Peterlin, nieces, nephews, and family-in-law gratitude for his tremendous service as one of the pillars of emergency medicine, a consummate clinician and educator, as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Robert’s family.

Resolution 61 In Memory of Douglas D. Rockacy, MD, FACEP

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Douglas D. Rockacy, MD, FACEP, who dedicated himself to his patients, to his trainees, to his profession, and to his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extend to his wife Wendy, daughter Claire, and son Russell gratitude for his tremendous service as one of the finest emergency physicians the University of Pittsburgh has ever seen, as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Rockacy’s family.

Resolution 62 In Memory of Robert J. Teichman, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Robert J. Teichman, MD, PhD, and extends condolences and gratitude to his wife, Geri Young, MD, of Kapa’a, Kaua’i, and his sons Kurt Teichman of Brooklyn, NY and Grant Teichman of Honolulu, Hawaii, and other family members for his service to the community, his patients, his students, and the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Teichman’s family.

Resolution 63 In Memory of Jason M. White, MD, FACEP

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Jason M White, MD, FACEP, to the specialty of emergency medicine and extends the College's condolences to his wife of almost 40 years, Carol, and also to their sons and daughters, Ken, Christopher, Brittany, and Allison, and grandchildren Olivia, Finn, Rosalyn, Easton, and Cassius.

Action: A framed resolution was sent to Dr. White's family.

Resolution 64 In Memory of J. David Barry, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by J. David Barry, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of J. David Barry MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of the Department of Defense, Veteran's Affairs, and the United States.

Action: A framed resolution was sent to Dr. Barry's family.

Resolutions Referred to the Board of Directors

Resolution 10 Candidate Members in the ACEP Council – Bylaws Amendment

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

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

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

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

Action: Assigned to the Bylaws Committee to review and work with the Membership Committee to provide a recommendation to the Council Steering Committee and the Board of Directors regarding the advisability of implementing the resolution.

The Bylaws Committee reviewed the resolution and concluded that the resolution does not conflict with any other portions of the Bylaws and the resolution language is appropriate as prepared from a Bylaws standpoint. The Bylaws Committee also discussed what had been presented as a possible amendment at Reference Committee A: limiting candidate student member eligibility only to the EMRA delegation. However, without knowing the authors intent going forward, the Bylaws Committee did not believe it was within their purview to discuss the merits of a potential new resolution and deferred that determination to the Membership Committee to provide a membership prospective. The Membership Committee was asked to address whether or not resubmitting the resolution for the Council to consider is in the best interests of the membership. The Membership Committee recommended that the existing language limiting Council representation to physician members be reaffirmed. While student input on matters pertaining to the Council and the profession is always welcomed and appreciated, it was determined that since they have not yet made a commitment to emergency medicine, as evidenced by acceptance into an EM residency program, they may not be fully invested and/or reasonably informed in the outcome of decisions being made. In addition, it was expressed that they often would lack the full context necessary to understand the long-term impact. The Membership Committee encouraged EMRA to continue to involve student members in the Council process as appropriate and to create opportunities for exposure that can help guide them into future leadership pathways. The Board of Directors affirmed that no further action is needed regarding

Referred Resolution 10(22) Candidate Members in the ACEP Council based on the review by the Bylaws Committee and Membership Committee.

Resolution 20 Expert Consultation for Employee Contracts

RESOLVED, That ACEP provide, as a member benefit at no charge, legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

Action: Assigned to membership and legal staff to work with EMRA to review the resolution and provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution, including potential cost estimates.

ACEP and EMRA recognize the importance of equipping all emergency physicians, especially those new to practice, with the resources and tools needed to ensure that any potential contracts they consider include fair compensation and benefits, adequate due process, and protection for themselves and their patients during the course of medical practice. There are a growing number of [resources available on the ACEP website](#) dedicated to the topics of employment contracts and other practice and legal issues, including a checklist to negotiate the best contract and an on-demand course on standard contract provisions. The site also includes a list of local attorneys available to review contracts and assist with other legal matters. In addition, ACEP partnered with Resolve, a well-established physician contract review service, in March 2023, to provide all ACEP members a 20% discount on contract review services, ranging in price from \$499 to \$1,999 based on the complexity of review required. Resolve also provides insight into compensation data and the competitiveness of other terms in the contract. The service was tested by two ACEP members needing contract review for their real-life employment agreements prior to finalizing the partnership and both members had positive feedback about their experiences. EMRA representatives reviewed the referred resolution and concluded that the financial burden of creating and implementing a free contract review service for residents would outweigh the benefits received. While it would likely be utilized by some EMRA's members, EMRA leadership determined it is reasonable to expect that physicians will pay for this type of service. The ACEP Board of Directors affirmed in June 2023 that no further action was needed to address the referred resolution based on analysis by ACEP and EMRA staff and the new partnership with Resolve for discounted contract review.

Resolution 22 State Chapter Funding

RESOLVED, That ACEP return 10% of national dues to each chapter calculated by $0.1 \times$ number of state dues-paying members every year.

Action: Assigned to member engagement and state government relations staff to review and provide a recommendation to the Board of Directors regarding the advisability and cost implications of implementing the resolution.

The high-level fiscal impact of returning 10% of national dues revenue to state chapters for advocacy would be \$1,218,567.87 in expense added to the bottom line. This number would change slightly on an annual basis as dues revenue fluctuates. Given the wide variation between chapters, it is possible that not all chapters will have the staff and/or volunteer capacity or the knowledge to use these funds effectively toward state advocacy efforts. Additional unbudgeted staff resources would be required to administer a formal grant program or oversee accountability of spending the funds toward their dedicated purpose, as well as accounting for calculation and payment of the funds on a monthly or annual basis. ACEP has moved the state government affairs functions from the Clinical Affairs line of service to the Public Affairs line of service to ensure better alignment and coordination across ACEP's federal and state advocacy initiatives. Past state and federal advocacy efforts had, at times, been siloed and fragmented, leading to missed opportunities for stronger advocacy impact and victories. ACEP has invested in resources to increase support for chapter engagement in state advocacy with a dedicated state government relations staff member, continued budget for state public policy grants and plans to simplify the application process and increase awareness of the program, expanded grassroots efforts beyond federal actions to include state-level actions, new toolkits and advocacy resources specifically for state chapters, and financial support to the American Medical Association's Scope of Practice Partnership.

ACEP does not have purview over or approval of the member dues rates set at the chapter level. Chapters that wish to raise funds for advocacy initiatives could consider a variety of options that would allow them to allocate greater resources in that area. ACEP is willing to provide operational assistance or subject matter expertise with the establishment of PACs, volunteer committees, or other sustainable methods of increasing a chapter's ability to impact legislation. ACEP staff are available to assist chapters with implementing chapter specific financial programs such as Virginia ACEP's Statewide Action Trust (STAT) and California ACEP's California Emergency Medicine Advocacy Fund to generate non-dues related financial support for state advocacy. ACEP does not currently have the financial resources to fulfill the resolution nor does it have the staff resources to administer a formal grant program or to ensure that the funds are spent toward their dedicated purpose. ACEP will continue to provide and refine support provided to chapters to meet their state

advocacy needs. That support includes, but is not limited to:

- a dedicated staff member for chapter engagement in state advocacy
- state-level grassroots alerts
- state public policy grants
- financial support to the American Medical Association's Scope of Practice Partnership
- collaboration with the State Legislative/Regulatory Committee
- continued development of toolkits and advocacy resources specifically for chapters
- operational assistance or subject matter expertise with the establishment of:
 - PACs,
 - Advocacy Funds,
 - volunteer committees,
 - or other sustainable methods of increasing a chapter's ability to impact legislation,
- expanded educational opportunities on state policy issues and tools and tips for grassroots and political action

The Board affirmed in June 2023 that initiatives already in place meet the intention of the referred resolution.

Resolution 53 Law Enforcement and Intoxicated Patients in the ED

RESOLVED, That ACEP investigate alternative care models to evaluate patients in police custody, such as telehealth, to determine necessity of an in-person evaluation; and be it further

RESOLVED, That ACEP encourage law enforcement to stay with any patient they choose to bring to the ED who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed.

Action: Assigned to the Emergency Medicine Practice Committee to work with the Tactical Emergency Medicine Section and provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution. The committee will continue working on the resolution during the 2023-24 committee year.

Memorandum

To: 2023 Council

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

Date: October 3, 2023

Subj: Action on 2021 Resolutions

The 2021 Council considered 82 resolutions: 57 were adopted, 15 were not adopted, 10 were referred to the Board of Directors, and one was referred to the Council Steering Committee.

Note: The first two resolveds of Resolution 35 were adopted and the last three resolveds were referred to the Board of Directors. The first resolved of Resolution 47 was adopted and the third resolved was referred to the Board. The first resolved of Resolution 49 was adopted and the second resolved was referred to the Board.

The attached report summarizes the actions taken on the 2021 resolutions adopted by the Council and those that were referred to the Board and the Council Steering Committee. The [updated actions](#) are also available on the ACEP website (scroll to the end of the document to see amended or substituted language and to see the implementation action).

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Action on 2021 Council Resolutions

Resolution 1 Commendation for Vidor E. Friedman, MD, FACEP

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

Action: A framed resolution was sent to Dr. Friedman.

Resolution 2 Commendation for William P. Jaquis, MD, MSHQS, FACEP

RESOLVED, That the American College of Emergency Physicians commends William P. Jaquis, MD, MSHQS, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

Action: A framed resolution was presented to Dr. Jaquis.

Resolution 3 Commendation for Gary R. Katz, MD, MBA, FACEP

RESOLVED, That the American College of Emergency Physicians commends Gary R. Katz, MD, MBA, FACEP, for his service as Council Speaker and Council Vice Speaker, and for his enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

Action: A framed resolution was presented to Dr. Katz.

Resolution 4 Commendation for Margaret M. Montgomery, RN, MSN

RESOLVED, That the American College of Emergency Physicians commends Margaret Montgomery, RN, MSN, for her outstanding service and commitment to the College and the specialty of emergency medicine.

Action: A framed resolution was sent to Ms. Montgomery.

Resolution 5 In Memory of Catherine Agustiady-Becker, DO

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Catherine Agustiady-Becker, DO, as one of the rising stars in emergency medicine; and be it further

RESOLVED; That the American College of Emergency Physicians extends to her husband, Jacob, her sons Wyatt, Theodore, and Quentin, her extended family, colleagues, and friends our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the countless patients and physicians across the country whom she served selflessly.

Action: A framed resolution was sent to Dr. Agustiady-Becker's family.

Resolution 6 In Memory of Heide J. Lako-Adamson, MD

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

Action: A framed resolution was sent to Dr. Lako-Adamson's family.

Resolution 7 In Memory of Joseph Litner, MD, PhD, FACEP

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the magnanimous life of Joseph Litner, MD, PhD, FACEP, on the states of Washington, Mississippi, Louisiana, and the Government Services Chapter of ACEP; therefore be it

RESOLVED That the American College of Emergency Physicians and the Government Services Chapter acknowledge the huge loss and bereavement of his many colleagues and friends, but above all, extend condolences to his beloved wife of more than 40 years, Maria Hugi, MD, FACEP, and their precious children, David and Jonathan.

Action: A framed resolution was sent to Dr. Litner's family.

Resolution 8 In Memory of Paul S. Auerbach, MD, MS, FACEP

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

Action: A framed resolution was sent to Dr. Auerbach's family.

Resolution 9 In Memory of Samuel C. Slimmer, Jr., MD, FACEP

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Samuel C. Slimmer, Jr., MD, FACEP, who was a pioneer in the specialty and dedicated himself to his patients, to his profession, and to his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extend to his son Samuel J., daughter-in-law Kelly, daughter Lara, and granddaughters Ellianna and Eily gratitude for his tremendous service as one of the first emergency physicians, as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Slimmer's family.

Resolution 10 Board of Directors Action on Council Resolutions – Bylaws Amendment (as amended)

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

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

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

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

The ACEP Council Speaker and Vice Speaker or their designee shall provide to the College a written summary of the Council meeting within 14-45 calendar days of the adjournment of the Council meeting. This summary shall include:

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

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

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

Action: The Bylaws were updated.

Resolution 12 Permitting Bylaws Amendments on the Unanimous Consent Agenda – Council Standing Rules Amendment

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

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

Action: The Council Standing Rules were updated.

Resolution 14 Establishing a Young Physician Position on the ACEP Nominating Committee

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

Action: The Steering Committee discussed this resolution at their January 24, 2022, meeting and it was assigned to the Bylaws & Council Standing Rules Subcommittee to develop a resolution. The draft resolution was discussed at the May 1, 2022, Steering Committee meeting and it was approved for submission to the 2022 Council. The 2022 Council adopted the Bylaws amendment to add a young physician to the Nominating Committee.

Resolution 18 Change to ACEP Conflict of Interest Statement (as amended)

RESOLVED, That the ACEP Conflict of Interest form include all immediate family members or intimate partners as well as non-adopted children of a current spouse; and be it further

RESOLVED, That the ACEP Conflict of Interest forms be provided to all members and relevant staff and be included in the introductory materials for the project, committee, or task force; and be it further

RESOLVED, That a question be added to the College’s Conflict of Interest form to indicate if the person completing the form is related to a non-physician provider; and be it further

RESOLVED, That every candidate for the College President, Board of Directors, or Council Officer positions, including those running from the floor, complete the ACEP Conflict of Interest (COI) form and copies of those COI statements be included in election materials and available to all councillors.

Action: Assigned an objective to the Ethics Committee, working with ACEP’s General Counsel, to review and update, as appropriate, the “Conflict of Interest” (COI) policy statement. The Board of Directors approved the revised “[Conflict of Interest](#)” policy statement in April 2023.

ACEP’s General Counsel updated the COI disclosure form as directed by the resolution. ACEP’s Executive Director, Chief Operating Officer, and Senior Vice President staff members are required to complete COI statements. The Committee Manual was updated and staff liaisons instructed on how to facilitate these changes, including information about distributing the COI disclosure statements. All candidates are required to complete the updated COI disclosure form instead of the “Candidate Disclosure Form” that was used in the past. The updated disclosure form was distributed to all members and staff that are required to complete the disclosure form.

Resolution 19 Clear and Complete Conflict of Interest Disclosure at the Council Meeting (as substituted)

RESOLVED, That the Council Steering Committee develop a Conflict of Interest form to be utilized by councillors, alternate councillors, or any person providing testimony at the Council meeting and develop means for councillors to access such forms during or prior to the Council meeting.

Action: Assigned to ACEP’s General Counsel to review and update the “Conflict of Interest” (COI) disclosure form, as directed in Amended Resolution 18(21). Assigned to Governance Operations staff to work with component bodies to collect conflict of interest disclosure forms from councillors and alternate councillors and others providing testimony during the Council meeting. Assigned to Technology Services staff to develop a means for councillors to access conflict of interest forms during or prior to the Council meeting.

The updated disclosure form was distributed electronically to the Council on September 9, 2022. The completed conflict of interest disclosure forms were available as a single PDF document on the ACEP website and a direct link to the forms was provided prior to the Council meeting. Annual completion of COI disclosures for the Council is now an ongoing process. The Council area of the ACEP website includes [access to the completed COIs](#) and the ability to search for an individual COI disclosure statement.

Resolution 21 Diversity, Equity, and Inclusion

RESOLVED, That ACEP convene a summit meeting inviting the societies of emergency medicine to align efforts to address diversity, equity, and inclusion within the next year; and be it further

RESOLVED, That ACEP embed diversity, equity, and inclusion into its strategic plan and the internal and external work of ACEP; and be it further

RESOLVED, That ACEP report back to the 2022 Council meeting the outcome of the summit and have a road map created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Action: Assigned to Clinical Affairs staff and ACEP's Diversity, Equity, & Inclusion Committee that was appointed in July 2022.

In addition to being has been assigned objectives to address health equity and advocacy, data collection and monitoring, organizational accountability, and education, staff and the committee are working to develop a plan to ensure that diversity, equity, and inclusion is included in the strategic plan and the internal and external work of the College.

Because its efforts were already underway, ACEP supported the Society for Academic Emergency Medicine's "SAEM22 Consensus Conference on "Diversity, Equity, and Inclusion: Developing a Research Agenda for Addressing Racism in Emergency Medicine" that was held in person on May 10, 2022. The intent of the conference, as described by SAEM, was as follows: "The overarching goal of this Consensus Conference is to stimulate researchers and educators in our specialty to generate a research agenda around the role of racism in modern healthcare and medical education that results in disparate outcomes for our patients. The themes of the conference have been informed by national experts both within and outside our specialty and include: Education and Training; Leadership; Research, and Social Determinants of Health. The specific objectives are to: 1) Identify best practices, clarify knowledge gaps and prioritize research questions; 2) Bring together key stakeholders with varied backgrounds to develop collaborative research networks; and 3) Disseminate findings of the consensus conference through peer-reviewed publications, national meetings, policy briefs, and other venues."

One outcome from the summit was the formation of an All-EM organizations working group on diversity, equity and inclusion. ACEP is participating in this effort to further align efforts, particularly in promoting diversity, equity and inclusion across the specialty of emergency medicine.

As needed, ACEP staff and the Diversity, Equity, & Inclusion Committee may further develop a plan to convene a virtual summit meeting of emergency medicine organizations.

Resolution 22 Expanding Diversity and Inclusion in Educational Programs

RESOLVED, That ACEP survey its speakers and educational presenters and report on speaker/educator demographics; and be it further

RESOLVED, That ACEP set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Action: Assigned to the Education Committee and work with the new Diversity, Equity, & Inclusion Committee, and the Diversity, Inclusion, & Health Equity Section on the second resolved. The Education Committee discussed the resolution at their December 6, 2021, meeting began working on a plan to address the resolution. The members assigned to plan ACEP22 courses/tracks added learning objectives pertaining to diversity, inclusion, and/or healthcare disparities in all courses where appropriate. This requirement will continue for future meeting planning. Additionally, the committee formalized an annual "Leon L Haley, Jr Lecture" for *Scientific Assembly* that focuses on diversity, equity, and inclusion as well as professionalism, humanitarianism, and advocacy for the elimination of healthcare disparities. The first lecture was held at ACEP22 in San Francisco and will continue as a named lecture in future years. The committee's objectives have been updated to include: 1) developing an annual Educator and Education Committee and Subcommittees Demographics Report to increase diversity, equity, and inclusion in all ACEP education activities; 2) purposefully increase DEI within ACEP education by recruiting leading URM (Under-Represented in Medicine) educators to the committee, subcommittees, and advisory group; mentoring new URM committee and subcommittee members to successful membership and leadership roles; identifying and mentoring URM faculty to successful first and subsequent lectures; 3) ensure each track for *Scientific Assembly* includes at least one didactic session with a learning objective related to systemic racism and social determinants of health.

ACEP's Diversity, Equity, & Inclusion Committee was appointed in July 2022 and was assigned objectives to address health equity and advocacy, data collection and monitoring, organizational accountability, and education.

Starting in August 2021, ACEP has been participating in a collaboration between the Accreditation Council for Graduate Medical Education (ACGME) and the Council of Medical Specialty Societies (CMSS) called "Equity Matters." The program, as described by CMSS: "Equity Matters is an Accreditation ACGME initiative that supplies a framework for continuous learning and process improvement in the areas of diversity, equity, and inclusion (DEI) and anti-racism practices. The purpose of this initiative is to achieve health equity through increasing physician workforce diversity, and by creating clinical learning environments that are safe, inclusive, and equitable." It was hoped that ACEP's capstone project would address this resolution; while significant learning occurred with this program, the capstone effort was not fully completed due to changes in staff and volunteer availability..

Resolution 23 Media Marketing of Value of Emergency Medicine Board Certification (as amended)

RESOLVED, That ACEP focus more on marketing to and educating the public on the value of **ABEM/AOBEM emergency physician (as defined in ACEP's policy statement "Definition of an Emergency Physician")** board certification in emergency medicine, focusing on the differences in education and training that **ABEM/AOBEM** board certified emergency physicians go through compared to non-**ABEM/AOBEM** board certified emergency physicians and non-physician practitioners; and be it further

RESOLVED, That ACEP focus more resources on a local, state, and national level campaign of marketing to the public through TV, radio, newspaper, social media, and public service announcements.

Action: The Board of Directors amended the resolution during their October 28, 2022, meeting. The Steering Committee discussed this amendment during their meeting on January 24, 2022, and determined that the change did not alter the intent of the resolution. Per the Bylaws, the amended resolution was implemented without further action by the Council.

The resolution was assigned to Communications staff for implementation, in collaboration with similar efforts being done by ABEM. A meeting was held on January 31, 2022, with some patient advocacy groups to begin discussions about the difference in training between physicians and nurse practitioners and the need to educate the public on who is caring for them.

ACEP Communications staff developed a video that launched on YouTube and was released as part of a new national scope of practice public relations campaign in correlation with National Doctors Day on March 30, 2022. [Who Takes Care of You in an Emergency?](#) is specifically designed 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 shorter videos were also released on ACEP's [YouTube channel](#) to better explain the vital role of emergency physicians. This is an ongoing campaign and to date there have been 18,274 views across various platforms. A toolkit, which includes talking points, a sample op-ed and social media posts, infographics, and video content are available in the [ACEP Media Hub](#). A second video was released in October 2022. Resources for members to advocate at the state and local level on this topic can be found on the ACEP website at acep.org/scope. ACEP will continue to develop internal and external communications that highlight the importance of board certification in emergency medicine.

Throughout the fall of 2022 and 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. The campaign was successful in strengthening relationships between ABEM and local hospitals/health systems. Enduring materials from the campaign are available to diplomates and the public on the ABEM website, which includes video content provided by ACEP. Co-branded advertisements from this campaign will be displayed in Philadelphia, PA, concurrent with ACEP23. ACEP will continue to use these resources and other resources in our ongoing efforts to communicate the importance of board certification in emergency medicine and fight inappropriate scope of practice practices and legislation.

Resolution 26 Advocacy for Syringe Services Programs and Fentanyl Test Strips (as amended)

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

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

RESOLVED, That ACEP update harm reduction materials and resources available to its members to include informing patients of the risks of fentanyl analogues and other potentially harmful admixtures and the utilization and limitations of fentanyl test strips and other methods of testing for contaminants and adulterants.

Action: Assigned first and second resolved to Advocacy and Practice Affairs staff for federal and state advocacy initiatives. Assigned third resolved to the Public Health & Injury Prevention Committee to review ACEP's existing resources and update them as needed.

The Public Health & Injury Prevention Committee developed two handouts that were added to the ACEP website: 1) [physician handout on fentanyl test strips and opioid resources for patients](#); and 2) [patient handout on opioid risks and fentanyl test strip and naloxone use](#).

ACEP tracked provisions of the American Rescue Plan Act (P.L. 117-2), including Section 2706 that provided funding to the Substance Abuse and Mental Health Services Administration (SAMHSA) for overdose prevention programs, syringe services programs, and other harm reduction measures; ACEP federal advocacy staff continue to follow the implementation of those programs and monitor legislation related to syringe services programs specifically. Several bills have been introduced to eliminate or prohibit federal funding of these programs, and we continue to track those as well.

The State Legislative/Regulatory Committee identified state and local laws to be used as a model for ACEP chapters to use. Legal and logistical issues were discussed by work groups. The committee is planning to develop comprehensive advocacy materials for chapters to use.

Resolution 28 Consumer Awareness Through Classification of Emergency Departments (as substituted)

RESOLVED, That the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

Action: Assigned to the ED Accreditation Task Force.

The Board of Directors discussed the task force report on June 24, 2022, and it was distributed to the Council on July 1, 2022. As a next step, the Board approved funding up to \$50,000 to develop a business plan for an Emergency Department Accreditation Program. While the proposed initial criteria are merely that and do not establish the final standards that will be ultimately be included, the Board approved that the future Emergency Department Accreditation Program will include tiers based on staffing levels; that further delineation of these tiers in various settings may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; that Emergency Department Accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and that all tiers for the Emergency Department Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

The Board approved launching the [ED Accreditation Program \(EDAP\)](#) based on the business plan and the preliminary criteria and tiers for the program in February 2023. The Board approved the governance charter in June 2023.

Resolution 29 Downcoding (as amended)

RESOLVED, That ACEP develop strategies to assist chapters in identifying if downcoding is occurring in their state; and be it further

RESOLVED, That ACEP work with the Centers for Medicare & Medicaid Services and private insurers to prevent the practice of downcoding in state Medicaid programs and by private insurers; and be it further

RESOLVED, That ACEP work with chapters to develop specific model legislative language to require transparency when insurance companies make changes to or require additional information for a claim.

Action: Assigned to Advocacy and Practice Affairs staff for federal, regulatory, and state advocacy initiatives. Promote the availability of potential funding through the Public Policy Grant Program to assist chapters with advocacy efforts.

In November 2021, ACEP and the State Legislative/Regulatory Committee made a targeted push to encourage chapters to apply for the College's existing Public Policy Grant Program (that has existed since 2006 to assist chapters with advocacy efforts) specifically to fight downcoding and prudent layperson issues at the state level. Two chapters are currently in the process of applying for a grant to address downcoding.

ACEP Advocacy & Practice Affairs staff were [successful in strengthening](#) existing prudent layperson protections with inclusion of new language in the first interim final rule (IFR) to implement the *No Surprises Act*. While this language focused predominantly on retroactive denials, it could help strengthen our opposition to downcoding as well. ACEP Advocacy & Practice Affairs staff continued efforts to gain further protections from downcoding via regulatory channels by providing strong recommendations in comment letters on the first IFR, and in advance of the second IFR's release. The second IFR mainly focused on the federal independent dispute resolution process. ACEP, and most all physician organizations, expressed extreme concern regarding the qualified payment amount in the independent resolution process. ACEP issued a statement on October 1, 2021, opposing the IFR, and another statement on November 9, 2021, standing firmly with more than 150 bipartisan members of Congress calling on the Biden Administration to change the IFR. ACEP, the American Society of Anesthesiologists (ASA), and the American College of Radiology (ACR), filed a lawsuit against the federal government on December 22, 2021, charging that the IFR goes against the language of the *No Surprises Act* and will ultimately harm patients and access to care. Lawsuits were also filed by the American Medical Association and American Hospital Association, the Texas Medical Association, an individual in New York, an air ambulance association, and the Georgia College of Emergency Physicians. ACEP/ASA/ACR filed a motion for summary judgement in the lawsuit on February 9, 2022. A federal judge in Texas ruled on February 23, 2022, in the lawsuit filed by the Texas Medical Association, that the *No Surprises Act* implementation fails to follow the letter of the law, and that giving unequal weight to the Qualified Payment Amount (QPA) tilts the process unreasonably in favor of insurance companies. The court also determined that by skipping a customary notice and comment period while the law was being finalized, the government failed to follow its own well-established and transparent regulatory process. The federal government has appealed the Texas court ruling TMA lawsuits I through IV continue to work their way through the legal process.

ACEP and the Medical Association of Georgia were involved in litigation with Anthem/Blue Cross Blue Shield regarding retroactive denial of emergency department claims starting in July 2018. On October 22, 2020, the 11th Circuit

Court ruled in favor of the appeal filed by ACEP and the Medical Association of Georgia. The case was remanded back to the Northern District Court in Georgia. The wording of the opinion was strongly supportive of ACEP's position. It was announced on March 9, 2022, that ACEP and the Medical Association of Georgia agreed to withdraw the lawsuit in response to the discontinuation of Blue Cross Blue Shield Healthcare Plan (BCBSHP) of Georgia, Inc.'s "avoidable ER" program. The change was effective March 28, 2022.

The Federal Government Affairs Committee formed a work group to review the resolution and discuss actions that could be pursued to address these issues. ACEP continues to work in conjunction with EDPMA to analyze claims data, as well as developing a contract with an outside vendor to collect additional information about claims denials to get a better understanding of the scope of this problem. In addition to supplementing ACEP's advocacy actions with federal regulators, the results of these data collection efforts would also be helpful in ACEP's legislative efforts to persuade federal lawmakers to address this issue.

The Federal Government Affairs Committee, the Reimbursement Committee, and the State Legislative/Regulatory Committee continue to track actions by insurers to deny and downgrade claims. ACEP has sent letters protesting action by United Health Care and various Medicaid plans. ACEP met with several members of Congress in the Maryland delegation to highlight inappropriate denials by United's Optum for mental health care provided by emergency physicians in the ED in the state. ACEP has also been working with the VA chapter to resolve downcoding issues in the state with Medicaid managed care plans. In July 2022, ACEP sent [a joint letter](#) with the California Chapter to CCIIO and the entire California Congressional delegation to bring attention to payment denials by Anthem to small groups in the state. The letters have already prompted follow-up investigatory actions by several members of the delegation and the federal agencies.

The Federal Government Affairs continues to track instances of suspected/confirmed prudent layperson standard (PLS) violations and downcoding issues, including work with Sen. Cardin (D-MD) to investigate and assist with issues related to mental health services provided by emergency physicians in Maryland, as well as a joint letter from ACEP and the California Chapter to the California congressional delegation raising the issue of downcoding/nonpayment issues by Anthem in the state.

The State Legislative/Regulatory Committee worked with EDPMA to draft a model state bill "An Act to Protect Emergency Patients using the Prudent Layperson Standard" to strengthen state laws on prudent layperson transparency and protections from insurer downcoding. The model bill has been added to the ACEP website and shared with chapters.

The *No Surprises Act* final rule was issued in August 2022 and due to ACEP's advocacy, it implements the specific protections from downcoding ACEP asked for in its response to the IFRs. While there are some concerning provisions in the rule, it establishes for the first time a federally-recognized official definition of downcoding as well as a requirement that if a QPA is based on a downcoded service code or modifier, the plan must provide an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which modifiers were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded. The rule also notes that without information on what the QPA would have been had the claim not been downcoded, the provider may be at a disadvantage during open negotiation compared to the plan or issuer.

ACEP will continue to fight for its members and employ strategies to assist chapters in combating downcoding by insurers.

Resolution 30 Unfair Health Plan Payment Policies

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

RESOLVED, That ACEP advocate at the American Medical Association to promote legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

Action: Assigned first resolved to Advocacy and Practice Affairs staff. Assigned second resolved to the AMA Section Council on Emergency Medicine.

ACEP has worked with chapters and individual groups in 14 states to challenge threats to reimbursement – specifically a 40-50% reduction in payment for services by Cigna and some BCBS plans. ACEP Public Affairs staff have collected letters from these insurers threatening cuts as well as termination notices and have worked with the AMA, members of Congress, and the press to show how Cigna is weaponizing the NSA against physicians.

ACEP has worked with several congressional advocates to raise attention to unfair health plan payment policies and practices and has explored potential legislative efforts to address these issues, even despite reluctance from many in Congress to address these issues in the relatively fresh wake of the *No Surprises Act* (NSA). In response to actions by insurers in North Carolina demanding rate cuts due to the NSA, ACEP worked with Rep. Greg Murphy, MD (R-NC), who

sent letters (along with Ronny Jackson, MD (R-TX)) to Blue Cross Blue Shield, Aetna, and United Healthcare noting that these extreme rate reductions defied the congressional intent of the law and requested that the plans halt any reduction of rates until the appropriate regulations are finally in place and that any pursuant litigation is resolved. We continue working closely with Dr. Murphy's office on this issue, recently discussing similar new efforts by another NC insurer and are in the process of developing a new advocacy strategy.

ACEP also worked with the California ACEP chapter to notify the California congressional delegation about unfair payment practices by Anthem in the state. In a joint letter, ACEP and California ACEP alerted legislators to Anthem's practice of unilaterally denying payment for the highest level of ED E/M services (CPT 99285) throughout the state at different hospitals staffed by different emergency physician groups, regardless of whether they were in- or out-of-network with the plan. In response, several legislators reached out to us to gain more information and track the issue. The effort also caught the attention of Anthem's federal affairs team who reached out to us for a meeting, where we and California ACEP laid out the ongoing issue and requested appropriate resolution. ACEP also notified the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) of the issue, to which CCIIO responded that they would look into the matter.

The AMA has current policy that calls for a mechanism to address grievances and supports advocacy on behalf of patients, 11.2.3 Contracts to Deliver Health Care Services, which was last modified in 2017: [E-11.2.3 11.2.3 Contracts to Deliver Health Care Services | AMA \(ama-assn.org\)](#). A second AMA policy on Physician Negotiations says that physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations and that physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting, H-383.997 Hospital Based Physician Contracting: [H-383.997 Hospital-Based Physician Contracting | AMA \(ama-assn.org\)](#). A third AMA policy urges CMS to ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan, H-285.902 Ban on Medicare Advantage "No Cause" Network Terminations: [H-285.902 Ban on Medicare Advantage "No Cause" Network Terminations | AMA \(ama-assn.org\)](#). The AMA also has policy requiring managed care organizations to provide due process to physicians in all adverse selective contracting decisions, H-285.981 Fair Market Practices: [H-285.981 Fair Market Practices | AMA \(ama-assn.org\)](#).

As this issue impacts the greater house of medicine, ACEP staff will continue to work with AMA advocacy staff to identify opportunities to develop or promote such legislation regarding health plan contracts for enactment at both the state and federal levels.

Resolution 31 Employment Retaliation, Whistleblower, Wrongful Termination (as amended)

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

RESOLVED, That ACEP develop model legislation emulating Arizona house bill 2622 (2021) to share with chapters through mechanisms such as the State Legislative/Regulatory Committee and other membership outreach.

Action: Assigned first resolved to the AMA Section Council on Emergency Medicine. Assigned second resolved to the State Legislative/Regulatory Committee.

ACEP developed and introduced [a resolution](#) at the AMA's 2022 House of Delegates Annual Meeting calling for the AMA to develop a model state legislative template and principles for federal legislation in order to protect physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or in the government, which includes independent and third-party contractors providing patient services at said facilities. The resolution was passed by the full House and will ensure that the entire House of Medicine and the AMA's significant resources will now be fighting to ensure due process protections at the federal and state level.

The State Legislative/Regulatory Committee developed model legislation based on the Arizona legislation and it will be disseminated to the chapters.

Resolution 32 Firearm Ban in EDs Excluding Active-Duty Law Enforcement (as amended)

RESOLVED, That ACEP promote and endorse that Emergency Departments become "Firearm Free" Zones, with the exception of active duty law enforcement officers, hospital security, military police, and federal agents; and be it further

RESOLVED, That ACEP endorse and promote screening for weapons in the emergency department; and be it further

RESOLVED, That ACEP promote public education and academic research to decrease workplace violence.

Action: Assigned to the Public Health & Injury Prevention Committee to consider all types of security arrangements for emergency departments and develop a policy statement. The committee updated ACEP's policy statement "[Protection from Violence and the Threat of Violence in the Emergency Department](#)" and it was approved by the Board of Directors in June 2022.

The third resolved is addressed by current ACEP policy statements and other initiatives. ACEP's policy statement "[Firearm Safety and Injury Prevention](#)" calls for "funding, research, and protocols" to address the public health issue of injury and death from firearms. The policy lists six legislative and regulatory actions that ACEP supports, including funding for firearm injury prevention research, protecting physicians' ability to discuss firearm safety with patients, universal background checks, prohibiting high-risk and prohibited individuals from obtaining firearms, restricting the sale and ownership of weapons and munitions designed for military or law enforcement use, and prohibiting 3-D printing of firearms and their components. The policy statement "[Violence-Free Society](#)" also notes that "ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives." ACEP also supports the efforts of the American Foundation for Firearm Injury Reduction in medicine (AFFIRM) to fund medical and public health research of firearm-related violence, injury, and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on several research grants. ACEP members are represented as leaders in AFFIRM, have attended strategic planning meetings, and an ACEP staff member is also a member of their Research Council. ACEP's legislative and regulatory priorities include working with members of Congress to promote efforts that may prevent firearm-related injuries/deaths and to support public/private initiatives to fund firearm research.

In early 2022, The Joint Commission established and started enforcing [new workplace violence prevention requirements](#) to guide hospitals in developing strong workplace violence prevention programs. ACEP contributed to the development of these new requirements by participating in an expert workgroup and supplying comments.

Advocacy and Practice Affairs staff are monitoring legislative initiatives to address workplace violence and the work of a congressional committee that has been appointed. One of the main focuses of the 2022 Leadership & Advocacy Conference was protecting emergency physicians from ED violence. Emergency physicians at all career levels met with legislators about ED violence and asked legislators to establish important, common sense procedures to protect emergency physicians, health care workers, and patients from violence in the health care workplace. ACEP helped inform and supports the "Workplace Violence Prevention for Health Care and Social Service Workers," (H.R. 1195/S. 4182) ensuring that the legislation gives appropriate consideration to emergency department needs, and has advocated for this legislation for several years. The legislation, which would require OSHA to require health care employers to implement violence prevention programs, was passed in the House of Representatives in April 2021 and awaits further action in the Senate. ACEP's support for the legislation was also specifically noted during committee consideration of the bill and on the House floor during debate and final passage.

ACEP has partnered with ENA on 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 also helped inform and supports the "Safety from Violence for Healthcare Employees (SAVE) Act," (H.R. 7961), bipartisan legislation re-introduced into the 118th Congress, that would establish federal criminal penalties for violence against health care workers (as this resolution seeks to do), based on federal penalties that already exist for violence against airline and airport employees. This legislation is also supported by the American Hospital Association. ACEP president Gillian Schmitz, MD, FACEP, was quoted in the [press release](#) issued previously by the original sponsors of the legislation on June 7, 2022.

The "[Safety from Violence for Healthcare Employees \(SAVE\) Act](#)" was introduced in the Senate by Senators Marco Rubio (R-FL) and Joe Manchin (D-WV). The legislation establishes federal criminal penalties for individuals who assault health care workers and is modeled after existing protections for airline employees. This bill serves as the Senate companion to the previously-introduced House bill that ACEP advocated for during Hill visits at LAC23 in May. The Senate version is essentially identical in terms of the federal penalties language and who would be covered, but there are

two key differences from the House version. The Senate bill strips out the grants for hospitals, and includes a new section requiring a GAO report on the effectiveness of criminal penalties and prosecutions for violence against health care workers. ACEP's letter of support can be found [here](#), and ACEP President Christopher Kang, MD, FACEP, was quoted in the press release.

The ACEP website includes many resources: "[Violence in the Emergency Department: Resources for a Safer Workplace](#)," "[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](#)."

CMS released a [memo](#) on November 28, 2022, on Workplace Violence in Hospitals. The memo reminds hospital leaders of their responsibility to "provide adequate training, sufficient staffing levels, and ongoing assessment of patients and residents for aggressive behavior and indicators to adapt their care interventions and environment appropriately." The CMS memo also references an April 2020 Bureau of Labor Statistics Fact Sheet that healthcare workers accounted for 73% of all nonfatal workplace injuries and illnesses due to violence in 2018, and states that "with appropriate controls in place," workplace violence can be addressed. CMS reiterates that they "will continue to enforce the regulatory expectations that patient and staff have an environment that prioritizes their safety to ensure effective delivery of healthcare."

Resolution 33 Formation of a National Bureau for Firearm Injury Prevention

RESOLVED, That ACEP support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

Action: Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives.

In addition to ongoing federal efforts to reduce firearms injury and violence, ACEP joined a new coalition, the Gun Violence Prevention Research Roundtable (GVPRR) as a member of the Steering Committee that is focused on maximizing investments in and impact of federally-funded research to reduce firearms-related injuries and deaths. In these conversations, ACEP has raised the potential creation of a National Bureau for Firearm Injury Prevention as well as our other College priorities on the topic. Additionally, during consideration of various firearms-related legislation in the 117th Congress, ACEP advocated for this priority and others with legislators who led efforts to push related legislation through Congress.

In response to the public health crisis of firearm violence, professionals from 47 multidisciplinary medical societies and health organizations from across the country participated in a Medical Summit on Firearm Injury Prevention at the American College of Surgeons (ACS) headquarters in Chicago September 10-11, 2022. Cohosted by ACEP, ACS, American College of Physicians, American Academy of Pediatrics, and the Council of Medical Specialty Societies, this hybrid in-person and virtual meeting was the second such meeting aimed at developing firearm violence prevention recommendations. It built upon the first Medical Summit's work from 2019. The meeting provided an opportunity for an inclusive and collegial dialogue on identifying opportunities for the medical community to reach a consensus-based approach to firearm injury prevention, with a focus on understanding and addressing the root causes of firearm violence while advocating for bipartisan policy solutions to address the issue. While the summit did not specifically address the creation of a National Bureau for Firearm Injury Prevention, topics discussed included: the public health approach to firearm violence in the US; recent and potential legislative approaches related to prevention; addressing violence through community engagement; utilizing healthcare resources to influence the social determinants that contribute to violence; how effective communication on firearm violence from the healthcare sector can influence policy work and community building. 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. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.

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 representative will also serve.

ACEP's legislative and regulatory priorities continue to include working with Members of Congress to promote efforts that may prevent firearm related injuries/deaths and support increased funding for firearms injury research.

Resolution 34 Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas

RESOLVED, That ACEP engage appropriate stakeholders, including at the federal and state levels, to find innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives and obtain input from the Rural Emergency Medicine Section and the Reimbursement Committee.

ACEP has explored alternative financial models for providing care in rural areas. Specifically, ACEP advocated for increased reimbursement for clinicians, including emergency physicians, who work in Rural Emergency Hospitals (REHs). ACEP has also met with CMS to discuss the viability of incorporating elements of the [Acute Unscheduled Care Model \(AUCM\)](#) in current alternative payment models (APMs) and have stated to the Centers for Medicare & Medicaid Services (CMS) that an AUCM-like approach could help improve emergency care in rural areas.

Structured as a bundled payment model, the AUCM would improve quality and reduce costs by allowing emergency physicians to accept some financial risk for the decisions they make around discharges for certain episodes of acute unscheduled care. Initial episodes focus on patients with the following symptoms: abdominal pain, altered mental status, chest pain, and syncope. In later years, the AUCM will be expanded to include all ED conditions that have national admission rates less than 90 percent, thereby also capturing headache and back pain. The AUCM would enhance the ability of emergency physicians to reduce inpatient admissions and observation stays when appropriate through processes that support care coordination. Emergency physicians would become members of the continuum of care as the model focuses on ensuring follow up, minimizing redundant post-ED services, and avoiding post-ED discharge safety events that lead to follow-up ED visits or inpatient admissions. The model also allows waivers to promote telehealth, care coordination, and home visit services after discharge to encourage risk sharing for the cost of care and better patient outcomes.

Resolution 35 Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals – first two resolved

RESOLVED, That ACEP support the rural critical access hospital program including the conversion of struggling rural critical access hospitals to rural emergency hospitals and state and federal governments should increase rural hospital access to low-cost capital to support the conversion of these facilities and preserve access to emergency care; and be it further

RESOLVED, That ACEP support rural health services research, including financial analyses of rural hospitals to better define the optimal funding model for rural critical access hospitals and rural emergency hospitals.

Action: Assigned to Advocacy & Practice Affairs staff for federal, state, and local advocacy initiatives, including increased support for expanded rural health services research.

ACEP stated in our [response](#) to a request for information on rural emergency hospitals (REHs) that the conversion of a critical access hospital (CAH) to a REH requires significant time and capital, not only to complete all the necessary infrastructure changes and administrative work, but also to subsidize the hospital operations during this transition time when patient volumes are likely to drop and some services are permanently and temporarily unavailable. We specifically requested to the Centers for Medicare & Medicaid Services (CMS) that low-cost capital be available for conversion of these facilities including covering operating costs during the transition period.

ACEP worked with Congress on the legislative language that was included in the Consolidated Appropriations Act which created the new designation of Rural Emergency Hospitals (REHs) for these converted hospitals. ACEP was proactive in reaching out to CMS to help construct various REH requirements. ACEP submitted a [comprehensive response](#) on proposed regulations establishing conditions of participation for REHs that were released in July 2022. ACEP also submitted a [joint response](#) to the regulation with the American Academy of Family Physicians focusing on the issue of scope of practice and the importance of having physician-led teams provide the care that is delivered in REHs. We strongly recommended that physicians should supervise all care delivered by non-physician practitioners in REHs. When possible, board-certified emergency physicians should conduct that supervision, but we understand that, due to workforce issues, that is not always possible. When a board-certified emergency physician is not available, it is still critical that physicians experienced and/or trained in emergency medicine (such as family physicians) oversee care being delivered by non-physician practitioners in REHs.

Once critical access hospitals (CAHs) and small rural hospitals have the opportunity to begin converting REHs in January 2023, ACEP will likely play a role in helping to educate hospitals, including CAHs, about the possible benefits of converting to this new facility-type.

Resolution 36 Mitigating the Unintended Consequences of the CURES Act

RESOLVED, That ACEP work with appropriate stakeholders to highlight patient safety issues that may disproportionately impact the emergency department population related to implementation of the CURES Act; and be it further

RESOLVED, That ACEP develop a policy statement advocating for release of records only after the treating physician and team have had sufficient opportunity and time to review those results and discuss them with the patient.

Action: Assigned first resolved to Advocacy & Practice Affairs staff for federal advocacy initiatives. Assigned second resolved to the Emergency Medicine Practice Committee to work with the Health Innovation Technology Committee to review the “Patient Medical Records in the Emergency Department” policy statement and incorporate information about the CURES Act or determine if a separate policy statement is needed.

The Public Health & Injury Prevention Committee determined that a separate policy statement was needed to address the resolution. The Board of Directors approved the policy statement “[Mitigating the Unintended Consequences of the CURES Act](#)” in June 2022.

ACEP has been proactive in our advocacy on this issue. The data blocking requirements went into effect in April 2021 and in May of that year [ACEP members were polled](#) to gather input on the data sharing requirements. Although respondents generally supported sharing data with patients, the biggest issue flagged repeatedly in the poll was around the *timing* of the data sharing. Specifically, emergency physicians noted the significant unintended consequences associated with sharing notes and lab results immediately-before emergency physicians are able to discuss the results with their patients. Over two-thirds of respondents in the poll stated that lab results are shared immediately with patients once they are available. According to these respondents, this policy of sharing notes immediately has caused patient confusion, anger, and sadness-with some extremely compelling examples, including patients who have found out they had cancer or a miscarriage without first being able to discuss their diagnosis with a physician. Further, there are numerous examples of patients misreading or misinterpreting clinical notes and lab results, causing physicians to have to spend significant time correcting those misconceptions and consoling patients. The results were shared directly with the Office of the National Coordinator (ONC) for Health Information Technology in June 2021. In a conversation with ONC’s leadership, including its chief medical officer, we specifically requested that ONC alter regulations to allow for EDs to delay sharing lab results and clinical notes with patients for a 24-hour period or at least until the patient was discharged from the ED. Unfortunately, ONC did not accept our recommendation, and has since clarified that such a delay is unacceptable in most cases. Specifically, ONC stated that having an organizational-wide policy of delaying the release of lab results or clinical notes is considered “interfering” with data sharing. ONC also unfortunately stated that “you cannot claim that sharing results immediately with a patient will cause the patient to experience “harm,” which is one of the regulatory exceptions that ONC has granted for the data sharing requirements. ACEP disagrees with this decision, as we believe that instituting a delay in data sharing in the ED does protect patients from emotional harm and should be appropriate use of the harm exception.

ACEP is not alone in expressing disappointment over various aspects of this policy. In an [article in Medpage](#), the American Medical Association (AMA) and AMGA (formerly the *American Medical Group Association*) both stated that implementing the data sharing requirements in this way will harm patients and will cause emotional stress to already overburdened clinicians. The AMGA has also [specifically requested](#) that ONC allow clinicians to delay sharing results with patients for 24 to 72 hours so that they could deliver them in a “more compassionate way.”

During the drafting of the “CURES 2.0” legislation and after introduction in the House of Representatives in late 2021, ACEP advocated to the lead sponsors and other legislators to notify them about potential patient safety issues and urged the development of potential updates to the statute to maintain transparency while ensuring patient safety. However, the bill as introduced does not include such provisions.

ACEP will continue to push for legislative and regulatory changes to the data sharing requirements and will also work with the AMA and others to coordinate our advocacy efforts.

Resolution 38 Prehospital Oversight and Management of Patients Experiencing Hyperactive Delirium with Severe Agitation (as amended)

RESOLVED, That ACEP advocate, at both state and national levels, that ABEM/AOBEM-certified physicians serve as the highest level of medical experts on the matter of management of patients with hyperactive delirium with severe agitation in the out-of-hospital and emergency department settings; and be it further

RESOLVED, That ACEP play an active role, at both state and national levels, in advocating against any non-ABEM/AOBEM-certified specialty’s assertion to having greater expertise in the acute therapeutic (i.e., pharmacologic and non-pharmacologic) management of patients with hyperactive delirium in the out-of-hospital setting; and be it further

RESOLVED, That ACEP oppose any non-ABEM/AOBEM-certified specialty’s medical oversight of out-of-hospital medical direction, particularly when pertaining to the management of hyperactive delirium with severe agitation; and be it further

RESOLVED, That ACEP partner with the National Association of EMS Physicians (NAEMSP) to work with state and national regulators and legislators on all issues pertaining to the out-of-hospital management of hyperactive delirium with severe agitation.

Action: Assigned to the EMS Committee with support from Advocacy & Practice Affairs staff as needed for federal and state advocacy initiatives.

In June 2021, the Board of Directors approved the document titled [ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings](#). The American Medical Association has adopted a policy opposing “excited delirium” as a medical diagnosis and underscoring the importance of emergency physician-led oversight of medical emergencies in the field.

The EMS Committee shared the task force report with the EMS Section and hosted a webinar in February 2023 with experts from the task force sharing strategies and best practices for managing hyperactive delirium with severe agitation. The task force report was included as part of the materials for the webinar.

ACEP also developed the online course “[Recognition and Management of Hyperactive Delirium in Emergency Settings](#)” that is available in the online learning center.

The Clinical Policies Committee developed the draft “Clinical Policy: Critical Issues in the Evaluation and Management of Adult Prehospital or Emergency Department Patients Presenting with Severe Agitation” that has been submitted to the Board of Directors to consider at their October 6, 2023, meeting. The clinical policy compliments the work of the 2021 “ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings” by providing recommendations informed by a systematic review of critically appraised literature.

Resolution 41 Take Home Naloxone Programs in Emergency Departments (as substituted in lieu of resolutions 40 and 41).

RESOLVED, That ACEP amend the current policy statement “Naloxone Prescriptions by Emergency Physicians” to include endorsement for Take-Home Naloxone programs in emergency departments; and be it further

RESOLVED, That ACEP seek to increase the distribution of naloxone from the emergency department by researching and advocating for a standardized, lower barrier, and cost-effective take-home model for naloxone for at risk patients; and be it further

RESOLVED, That ACEP partner with other like-minded organizations to promote Take-Home Naloxone programs as a best practice for patients at risk of opioid overdose, and work to increase the number of Take-Home Naloxone programs in emergency departments; and be it further

RESOLVED, That ACEP advocate for regulatory and payment reform that would facilitate reimbursement from public and private payers, to hospitals and emergency departments for naloxone dispensed directly to patients as part of Take-Home Naloxone programs, thus removing financial disincentives for hospitals to have Take-Home Naloxone programs; and be it further

RESOLVED, That ACEP educate emergency physicians about strategies to implement Take Home Naloxone programs in their emergency department.

Action: Assigned first resolved to the Clinical Policies Committee to include in their work to revise the “Naloxone Prescriptions by Emergency Physicians” policy statement. The committee coordinated their work with the EMS Committee and the Pain Management & Addiction Medicine Section. The committee revised the policy statement “[Naloxone Access and Utilization for Suspected Opioid Overdoses](#)” and it was approved by the Board in February 2023.

Assigned to Advocacy & Practice Affairs staff for regulatory and federal advocacy initiatives. Assigned third and fourth resolved to the Pain Management & Addiction Medicine Section to develop a recommendation(s) to the Board of Directors.

ACEP has advocated to CMS to establish a reimbursement mechanism under Medicare and Medicaid for take home naloxone programs, emphasizing that it is essential for the agency to support these initiatives.

The Pain Management & Addiction Medicine Section, along with additional experts and leaders, continue to work with the CDC, SAMSHA, and the AMA to promote Take-Home Naloxone programs as a best practice for patients at risk of opioid overdose, through:

- Feedback and guidance to the AMA Opioid Task Force (including ANA Naloxone Issue Brief).
- CDC 2016 CDC Guideline for Prescribing Opioids review and feedback (including recommendations relevant to Naloxone).
- Dissemination of CDC Updated Naloxone education and training materials.

Resolution 42 Administration of COVID-19 Vaccines in the Emergency Department

RESOLVED, That ACEP advocate for the administration of vaccines against COVID-19 to qualified patients that present to the emergency department (ED); and be it further

RESOLVED, That ACEP support the development of best practices for discussing COVID-19 vaccines with patients, clinical decision making around when to administer the vaccine, building capacity to administer vaccines to emergency department patients, and integrating ED vaccination programs into larger community vaccination efforts.

Action: This resolution has been completed. ACEP supports and advocates for ED-based COVID-19 vaccination programs and has developed and continues to update and adapt education, tools, and resources for its members to enable them to establish COVID-19 vaccination programs out of their EDs, hospitals, and institutions. There are multiple open access resources that are currently available to ACEP members and anyone who is interested:

- [COVID-19 Vaccination Toolkit](#)
- [COVID-19 ED Vaccination Program Resource Center](#)
- [ACEP Toolkit for COVID-19 Emergency Department \(ED\) Vaccination Programs](#)
- [COVID-19 Vaccination Smart Phrases Now in Several Languages](#)
- [ACEP Field Guide Chapter on Vaccinations and Prevention](#)
- [COVID-19 Vaccine Resource Center](#)
- [Webinar: COVID-19 Vaccinations in the Emergency Department](#) (on demand)

ACEP has also developed numerous resources addressing vaccine hesitancy:

- [Patient Poster and Flyer from ACEP's Diversity and Inclusion Section](#)
- [Webinar: This Is Our Shot: How EM Docs Can Empower Patients to End the Pandemic](#) (on demand)
- [ACEP's Public COVID-19 Vaccine Information Center](#)
- [The Language of COVID-19 Vaccine Acceptance](#)

Resolution 44 Caring for Transgender and Gender Diverse Patients in the Emergency Department

RESOLVED, That ACEP promote the equitable, culturally competent, and knowledgeable treatment of transgender and gender diverse patients receiving care in the emergency department; and be it further

RESOLVED, That ACEP compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the emergency department; and be it further

RESOLVED, That ACEP encourage hospitals to provide adequate and appropriate education, training, and resources to all emergency department physicians on the needs and best practices related to care of transgender and gender diverse patients; and be it further

RESOLVED, That ACEP encourage emergency departments to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

Action: Assigned to the Emergency Medicine Practice Committee to work with the Diversity, Equity, & Inclusion Committee, the Diversity, Inclusion, & Health Equity Section, and the Social Emergency Medicine Section to develop a policy statement and Policy Resource & Education Paper (PREP) and/or other resources to address the resolution.

The Emergency Medicine Practice Committee and the Public Health & Injury Prevention Committee developed the policy statement “[Caring for Transgender and Gender Diverse Patients in the Emergency Department](#)” and it was approved by the Board in June 2022. The PREP has also been completed and it was submitted for publication consideration. The PREP will be available on the ACEP website after publication.

Resolution 46 Effects of EM Practice Ownership on the Costs and Quality of Emergency Care

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

Action: Assigned to Clinical Affairs staff to coordinate with the Emergency Medicine Group Ownership Task Force.

The Board of Directors approved the [ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine](#) on April 6, 2022 expressing increasing concern about the expanding presence of private equity and corporate investment in health care, including emergency medicine and reaffirming ACEP’s core beliefs and emphasizing the physician-patient relationship as the moral center of medicine that can never be compromised. This statement also acknowledged that objective data is critically needed to measure the impact of private equity and corporate investment in emergency medicine on patient care and outcomes, as well as on emergency physician well-being. The Emergency Medicine Group Ownership Task Force was formed in early 2020 to address portions of Council Resolution 58(19): Role of Private Equity in Emergency Medicine. The report, which was distributed to the Council on September 23, 2022,

provides a history of the efforts and a summary of the knowledge gathered regarding the effects of the group ownership model on emergency medicine and in particular, emergency physicians. Milliman, Inc. was retained to investigate and report on data sources that could provide meaningful data to inform the various research elements sought in the initial proposal, including a high-level market scan of emergency medicine ownership models. However, Milliman was unable to identify public and proprietary data sources that could provide sufficient disaggregated or identifiable data. Task force members also unsuccessfully attempted to collect data via an ACEP member survey. The final report of the task force report acknowledged the need to the development of standardized, EM-focused definitions of ownership models, that consider ownership of the facility versus ownership of the physician practice and delineate private equity's role in ownership. Options for both internal and external approaches are presented in this report.

Other research has demonstrated the difficulties in obtaining this information for similar projects. In 2022, ACEP asked the [Physicians Advocacy Institute](#) to report specifically on emergency medicine in its next round of research with Avalere on trends in physician employment and acquisitions of medical practices. All of the major physician specialties were included in the [report they published on their website](#). However, their results seem to undercount corporate ownership of emergency medicine practice models. For example, compared to a national average of 73.9%, only 66.7% of emergency medicine physicians were employed by hospitals and other corporate entities in 2022. Broken down, they found that more EM physicians were hospital-employed (53.4% vs 52.1% overall) and fewer EM physicians were employed by "other corporate entities" (13.3% vs 21.8% overall). This places EM as one of the specialties with the least amount of corporate employment. Further, they found that the decline in independent EM physicians/physicians practices (from around 45% in 2019 to 33% in 2022) mainly shifted to health system ownership (just over 45% in 2019 to 53% in 2022) rather than to corporate (just under 10% in 2019 to 13% in 2022). The PAI/Avalere findings were also of concern for other specialties, such as Anesthesiology, which was found to be among the specialties with the lowest percentage of corporate employment, at 13.9%. While Avalere's definition of "other corporate entities" did include private equity firms or health insurers, it is unclear how the data used in the research (IQVIA OneKey) counts consultant/independent contract physicians. It is also not reported in the findings the extent to which physician practices categorized as "independent" may actually have corporate ownership or backing.

In December 2022, the Centers for Medicare and Medicaid Services (CMS) publicly released ownership data for all Medicare-certified hospitals. The new information includes detailed information on the ownership of more than 7,000 Hospitals certified to participate in the Medicare program regardless of any change in ownership. Additional information can be found at <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-all-owners>. Although this data does not identify practice ownership, ACEP will continue to monitor and advocate for greater disclosure of this kind of data transparency to ensure that facilities are held accountable and people can make the best-informed decisions on their care.

In February 2023, Ivy Clinicians, a career marketplace co-founded by Leon Adelman, MD, MBA, FACEP, FAAEM, released a report on the [State of the Emergency Medicine Employer Market](#). Based on an 18-month search process, the Ivy Clinicians team attempted to fill the data gap by carefully matching every ED with its emergency medicine (EM) practice counterpart. This report examined the EM employer landscape across various metrics (e.g., rurality, insurance rates, residency sites, clinician shortages) by four employer types: clinician partnerships, private equity-owned organizations, health system-employed structures and government-employed structures. ACEP has subsequently established a limited data-sharing agreement with Ivy Clinicians in an attempt to further improve the ongoing quality of the data and potentially establish its use for research such as that called for in this resolution.

Resolution 47 Family and Medical Leave – *first resolved*

RESOLVED, That ACEP advocate for paid family leave, including but not limited to supporting the American Medical Association's effort to study the effects of Family Medical Leave Act expansion including paid parental leave (AMA Policy H-405.954).

Action: Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives.

Broad paid family leave provisions were included in the "Build Back Better" (BBB) budget reconciliation framework adopted by the House of Representatives in November 2021, the main legislative priority for President Biden and the Democratic majority in Congress. ACEP tracked this (in addition to numerous other provisions) and while supportive of paid family leave, ACEP did not take a formal position on the BBB given its expansive nature and overall relatively indirect impact on emergency medicine, as well as other political considerations. However, the significantly slimmed-down budget reconciliation deal that ultimately passed in August 2022 (and renamed as the "Inflation Reduction Act") did not include paid family leave. ACEP continues working to identify legislative opportunities to advocate for paid family leave.

At its November 2022 Interim Meeting, the AMA House of Delegates (HOD) modified existing policy to encourage implementation of parental, family and medical necessity leave for medical students and physicians. The updated policies call on the AMA to: (1) study the impact on and feasibility of medical schools, residency programs,

specialty boards and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave; and (2) recommend that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.

Resolution 48 Financial Incentives to Reduce ED Boarding (as amended)

RESOLVED, That ACEP study financial and other incentives that might be used to reduce boarding of admitted patients in the emergency department.

Action: ACEP participated in a study of ED boarding with the Emergency Department Benchmarking Alliance (EDBA) and the report was released in October 2022.

Addressing boarding and crowding have been longstanding priorities of the College, and federal legislative and regulatory advocacy efforts continue as well. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue. Addressing boarding and crowding were included as key priorities in communications with Congress during the 117th Congress as legislators in both the House and Senate develop legislative efforts to address the nation's mental health crisis. ACEP Advocacy & Practice Affairs staff continue to discuss potential solutions with legislators in both chambers.

ACEP President Christopher Kang, MD, FACEP, met with senior officials of the Biden Administration in mid-October 2022 to discuss several issues and specifically recommended that the White House host a summit on ED boarding and workforce issues that would bring together key stakeholders from the clinician, hospital, nursing home, emergency medical services (EMS), and patient communities to discuss potential solutions. ACEP sent a letter to the White House on October 28, 2022, calling attention to the boarding problems in the U.S. and formally asked the Administration to convene a meeting of stakeholders to identify immediate and long-term solutions. Many other medical organizations signed on to the letter. ACEP also sent a letter sent to the National Governors Association on November 9, 2022, that included a copy of the White House boarding letter. A template letter was also created for ACEP chapters to share the White House letter with their individual governors. ACEP began a communications campaign in November 2022 to keep members informed of the initiatives underway to address boarding. A [resource page](#) was created on acep.org and a [digital storybook](#) to highlight many of the stories ACEP collected.

The Emergency Medicine Practice Committee developed an ED Boarding Toolkit that will be available on the ACEP Website once it is finalized. The committee also revised the "[Boarding of Admitted and Intensive Care Patients in the Emergency Department](#)" policy statement and it was approved by the Board in February 2023.

The 2022 Council adopted Amended Resolution 38(22) Focus on ED Patient Boarding as a Health Equity Issue. A Boarding Task Force was appointed and the EDBA report was provided to them for review. Their objectives include: 1) create an agenda for a boarding summit along with recommendations for organizations to be represented; and 2) create a list of potential solutions to boarding with an emphasis on what the state/federal government can do to reduce boarding.

ACEP hosted a Boarding Summit on September 27, 2023. Attendees included representatives from the Agency for Healthcare Research and Quality (AHRQ), Health & Human Services' Administration for Strategic Preparedness & Response-Biomedical Advanced Research and Development Authority (ASPR-BARDA), nursing homes/post-acute care, hospitals, psychiatry, nursing, emergency nursing, patients, National Governors' Association, Association for State and Territorial Health Officials, and others. The summit participants identified what they perceived as the causes of boarding, discussed barriers to overcome them, and then reached group consensus on areas to prioritize for addressing. The next steps include writing up a report of the Summit and creating a listserv for continued collaboration with the group and others, as appropriate, for advocating at the state and federal level. Information about the Summit will be publicized along with the results of public opinion polling that is being conducted.

Resolution 49 Forced EMS Diversion – first resolved

RESOLVED, That ACEP work with other stakeholders to discourage states and hospitals from using forced EMS diversion to substitute for system-wide hospital admission load balancing.

Action: Assigned to the EMS Committee. The committee worked with other stakeholders such as the National Association of EMS Physicians (NAEMSP), National Association of State EMS Officials (NASEMSO), National Association of EMTs (NAEMT), International Association of Fire Chiefs (IAFC), and the American Ambulance Association (AAA) to develop strategies to address forced EMS diversion. Historically EMS diversion has best been addressed at the local level through collaboration between the facilities and EMS services once the reasons for the diversion have been identified.

Resolution 50 Complications of Marijuana Use (as amended)

RESOLVED, That ACEP develop practice guidelines on the treatment of complications of marijuana use as seen in emergency department presentations; and be it further

RESOLVED, That ACEP provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses; and be it further

RESOLVED, That ACEP develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department.

Action: Assigned first resolved to the Clinical Policies Committee to develop a clinical policy or practice guidelines. Assigned second and third resolves to the Public Health & Injury Prevention Committee.

The Clinical Policies Committee began reviewing information on the conditions where there is evidence for an association between marijuana use and ED presentations: hyperemesis, psychosis, trauma, and, possibly, dysrhythmias. An initial literature search was performed to gain understanding of the scope of existing literature on the topic and found there was limited published data. The committee was also informed that the Society for Academic Emergency Medicine's "Guidelines for Reasonable and Appropriate Care" (GRACE) program is currently working on a practice guideline for cannabis-induced hyperemesis. The committee shifted its focus to developing a systematic review of the evidence for an association between marijuana use and specific ED presentations, which will take the form of a scientific article accompanied by a best practice document. The literature for the first critical question, regarding cardiovascular outcomes in marijuana users, is being graded by methodologists. The second critical question, regarding psychiatric outcomes in marijuana users, is in the literature review stages. The committee will continue working on the resolution in the 2023-24 committee year.

The Public Health & Injury Prevention Committee developed two handouts that are available on the ACEP website: 1) [patient information on risks and potential effects of marijuana use](#); and 2) [physician information on management of tetrahydrocannabinol presentations in the emergency department](#).

Resolution 52 Standardization of Medical Screening Exams of Arrested Persons Brought to the ED (as amended)

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

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

Action: Assigned to the Ethics Committee to work with the Medical-Legal Committee and the State Legislative/Regulatory Committee to develop a policy statement and Policy Resource & Education Paper (PREP). The committees developed the policy statement "[Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department](#)" and it was approved by the Board in August 2023. A Policy Resource & Education Document (PREP) was also developed as an adjunct to the policy statement. The PREP will be available on the ACEP website as soon as it is finalized.

Resolution 54 Understanding the Effects of Law Enforcement Presence in the Emergency Department (as amended)

RESOLVED, That ACEP support the research, development, and adoption of best practices regarding law enforcement and security personnel presence in the hospital environment, including but not limited to the ED, to create transparency and protect the rights of its vulnerable patient populations; and be it further

RESOLVED, That ACEP collaborate with other interested organizations to create easily accessible transparent toolkits that outline state-specific policies and laws regarding law enforcement presence in the hospital environment, including but not limited to the ED.

Action: Assigned to the Medical-Legal Committee to work with the Diversity, Equity, & Inclusion Committee; Diversity, Inclusion, & Health Equity Section; and the Social Emergency Medicine Section to develop a policy statement and Policy Resource & Education Paper (PREP). Assigned second resolved to the State Legislative/Regulatory Committee.

The State Legislative/Regulatory Committee solicited emergency physician groups for different approaches to law enforcement presence in the ED. The Medical-Legal Committee and the State Legislative/Regulatory Committee will continue working on this resolution in the 2023-24 committee year.

Resolution 55 Patient Experience Scores (as amended)

RESOLVED, That ACEP acknowledge and affirm existing ACEP policy (e.g., the 2016 “Patient Experience of Care Surveys” policy statement); and be it further

RESOLVED, That ACEP define standardized inclusion and exclusion criteria for patient experience survey populations; and be it further

RESOLVED, That ACEP define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias, and appropriate power calculations such that sufficient surveys are collected to yield more statistically valid results; and be it further

RESOLVED, That ACEP aggressively advocate for patient experience survey validity and work with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Action: Assigned first three resolves to the Emergency Medicine Practice Committee. Assigned fourth resolved to Advocacy & Practice Affairs staff for federal advocacy initiatives.

The Emergency Medicine Practice Committee revised the 2016 “Patient Experience of Care Surveys” policy statement and submitted it to the Board in June 2022. The Board referred the revised policy back to the committee for additional revisions. A revised draft was submitted to the Board for consideration at their September 28, 2022, meeting and it was again referred back to the committee for revisions. The Board of Directors approved the revised policy statement “[Patient Experience of Care Surveys](#)” in February 2023.

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 our [response](#) to the Calendar Year (CY) 2023 Physician Fee Schedule proposed rule. Specifically, we 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.

Resolution 56 Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities (as amended)

RESOLVED, That ACEP issue a statement to the membership regarding the lack of validity in race-based science and its detrimental impact on the health of Black, Indigenous, and People of Color patients and communities; and be it further

RESOLVED, That ACEP commit to the education of its membership by denouncing the use of race-based calculators in its clinical policies; and be it further

RESOLVED, That ACEP commit to not support research studies that utilize race-based calculations that are not supported by sound scientific evidence.

Action: Assigned to the Research Committee to work with the Diversity, Equity, & Inclusion Committee to develop a policy statement. Assigned second resolved to the Clinical Policies Committee to ensure race-based calculators are not used in ACEP’s clinical policies.

The Research Committee developed the policy statement “[Appropriate Use of Race in Research](#)” and it was approved by the Board of Directors in June 2023. The Clinical Policies Committee confirmed that it does not use race-based calculators and race-based science to inform clinical policy recommendations.

Resolution 57 Social Determinants of Health Screening in the Emergency Department (as amended)

RESOLVED, That ACEP seek to improve the recognition of, and attention to, social determinants of health (SDH) by supporting research of evidence-based SDH screening and interventions in the ED; and be it further

RESOLVED, That ACEP advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and be it further

RESOLVED, That ACEP push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

Action: Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives.

ACEP has repeatedly addressed the issue of addressing social determinants of health in our responses to various Medicare and Medicaid regulations and request for information, and responses to Congressional inquiries. In these responses, we have educated regulators and legislators about the role emergency physicians play in identifying and

screening for social risk factors, as well as some of the tools being used in the ED to help identify barriers to health such as transportation and access to food and housing.

Resolution 58 Updating and Enhancing ED Buprenorphine Treatment Training and Support

RESOLVED, That ACEP support the development of training sessions focused solely on the implementation of buprenorphine induction and prescribing in the emergency department setting to replace the 8-hour training that had previously been required for X-waiver applications; and be it further

RESOLVED, That ACEP develop an online peer mentoring platform, similar to Providers Clinical Support System, but limited to emergency physicians, that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices while responding to specific practice-based challenges that arise in an asynchronous messaging forum available to all ACEP members.

Action: The first resolved has been addressed. ACEP continues to provide education and provide training sessions focused solely on the implementation of buprenorphine induction and prescribing in the ED, including 8-hour DATA 2000 EM MAT Waiver trainings, 4-hour EM MAT Waiver trainings (as part of the 4x4 wavier trainings), and 2-hour “core/condensed” EM MAT waiver trainings. Additionally, ACEP has also developed the following tools and resources:

- [Opioid Regulations: State by State Guide \(PDF\)](#)
- A series of free webinars on various topics related to [Opioid Use Disorder and Treatment and Management of OUD in the ED](#)
- [Buprenorphine in the ED Point of Care tool](#) that is an algorithm-like tool that walks clinicians through the process of patient evaluation and assessment through to prescription.
- [Buprenorphine Initiation in Emergency Departments: Interactive Case Vignettes](#)
- Hosted and developed an [Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop](#). Topics covered in the workshop covered everything from setting up a ED-Buprenorphine program, Naloxone program, stigma, and pain management in the ED.
- [E-QUAL Network Opioid Initiative](#)

Assigned the second resolved to the Pain Management & Addiction Medicine Section. The section, along with leaders of the Pain & Addiction Care in the ED accreditation program, launched the [EM Opioid Advisory Network](#). This is an open access network that anyone can use to receive clinical guidance, discover tools and resources, and have their questions answered through six national leaders and experts in pain and addiction within the Pain Management & Addiction Medicine Section.

Resolution 59 Use of Medical Interpreters in the Emergency Department (as amended)

RESOLVED, That ACEP promote the use of qualified medical interpreters for emergency department patient interactions with patients with limited English proficiency.

Action: Assigned to the Emergency Medicine Practice Committee to work with the Social Emergency Medicine Section to develop a policy statement and include a definition of “qualified medical interpreter.”

The Emergency Medicine Practice Committee developed the policy statement “[Use of Medical Interpreters in the Emergency Department](#)” and it was approved by the Board in June 2022.

Resolution 60 Accountable Organizations to Resident and Fellow Trainees (as amended)

RESOLVED, That ACEP submit a resolution to the AMA that requests the AMA establish a task force consisting of relevant stakeholders with the following goals:

1. Determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests.
2. Determine how these organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees.
3. Determine methods of advocating for residents and fellows that are timely and effective, without jeopardizing trainees’ current and future employability.
4. Study and report back on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and
5. determine transparent methods to communicate available residency positions to displaced residents.

Action: Assigned to the AMA Section Council on Emergency Medicine.

[A resolution](#) (304) calling for the AMA to work with relevant stakeholders to implement these 5 goals was introduced by the Resident and Fellows Section at the AMA’s 2022 House of Delegates Annual Meeting in June. The

resolution was ultimately referred, following recommendation of the Reference Committee, and input from the Council on Medical Education, due in part to the complexity of the issue. The Council on Medical Education released a report on [The Impact of Private Equity on Medical Training](#), which contained nine recommendations; the recommendations were adopted and the remainder of the report was filed.

Resolution 61 Advocating for a Required Emergency Medicine Experience at All U.S. Medical Schools (as substituted)

RESOLVED, That ACEP advocate that all U.S. medical schools, allopathic and osteopathic, require formal exposure to the specialty of emergency medicine, including but not limited to a formal clerkship or other activities to ensure that graduating medical students understand the role of emergency departments and the practice of emergency medicine.

Action: Assigned to the Academic Affairs Committee. The committee revised the policy statement “Academic Departments of Emergency Medicine in Medical School” with the revised title “[Academic Departments of Emergency Medicine and Required Emergency Medicine Education in Medical Schools](#)” and it was approved by the Board in February 2023.

ACEP’s policy statement “[Guidelines for Undergraduate Education in Emergency Medicine](#)” states that ACEP “believes that all medical students should be taught the basic principles of emergency medicine in order to recognize a patient requiring urgent or emergency care, initiate evaluation and management, and provide basic emergency care.” It also states that, “every medical student should receive clinical exposure to emergency department patients and care” and “should be driven by experts board certified in the field of emergency medicine.” The Academic Affairs Committee updated the policy statement to strengthen it and the [revised policy statement](#) was approved by the Board in June 2023.

Resolution 62 Support of Telehealth Education in Emergency Medicine Residency (as amended)

RESOLVED, That ACEP promote and endorse telehealth training opportunities for emergency medicine residents; and be it further

RESOLVED, That ACEP advocate for inclusion of telehealth in The Model of the Clinical Practice of Emergency Medicine; and be it further

RESOLVED, That ACEP support the development of additional telehealth fellowship programs.

Action: Assigned to the Academic Affairs Committee. ACEP’s recommendations for changes to the EM Model were sent to ABEM in February 2022 and included adding telehealth. The [2022 update to The Model of the Clinical Practice of Emergency Medicine](#) added Telemedicine (20.4.1.5) within the Clinical Informatics area of Systems-based Practice.

This resolution was also addressed by the ACGME Emergency Medicine Requirements Consensus Task Force. The task force developed a list of recommendations for emergency medicine training and workforce needs of the future that were submitted to the ACGME.

The Academic Affairs Committee developed an outline with information on how to support telehealth in residencies and fellowship programs. The manuscript writing phase of the project is still in progress and the committee expects it will be completed in early 2024.

Resolution 63 Physician-Led Team Leader Training (as amended)

RESOLVED, That ACEP engage with the Accreditation Council for Graduate Medical Education, the Council of Residency Directors in Emergency Medicine, the Society of Emergency Medicine Physician Assistants, the American Academy of Emergency Nurse Practitioners, and the American Association of Physician Leaders, and other interested parties to develop a standardized curriculum for teaching physicians to function as team leaders in support of physician-led teams; and be it further

RESOLVED, That ACEP develop continuing medical education to instruct physician-led teams based on the curriculum identified by the stakeholders for physicians who are post residency; and be it further

RESOLVED, That ACEP advocate to the American Board of Emergency Medicine and the American Osteopathic Board of Emergency Medicine that specific competencies in team leadership be incorporated in the next revision of The Model of the Practice of Clinical Emergency Medicine.

Action: Assigned first and third resolves to the Academic Affairs Committee. Assigned second resolved to the Education Committee and Educational Services staff.

ACEP’s recommendations for changes to the EM Model were sent to ABEM in February 2022 and included adding physician-led team leadership/team management. Several updates regarding physician-led team leadership and management are included in the [2022 update to The Model of the Clinical Practice of Emergency Medicine](#)

The Academic Affairs Committee worked with stakeholders and is developing a manuscript. The committee

expects the manuscript will be completed in early 2024. The Education Committee is working to develop and deliver a CME module to instruct physician-led teams based on the curriculum identified by the stakeholders for physicians who are post-residency.

Resolution 64 Rural Emergency Medicine Education and Recruitment (as amended)

RESOLVED, That ACEP support staffing rural hospitals with ED volumes greater than 5,000 patients per year with ABEM/AOBEM board-certified/eligible emergency physicians including cost-based reimbursement that covers the cost of 24/7 ABEM/AOBEM board-certified/eligible physician coverage and support expanded ACEP-led rural provider education, board-certified emergency physician medical direction, and telemedicine access for all rural emergency departments including those who do not yet have full ABEM/AOBEM-certified/eligible physician coverage or those with extremely low volumes; and be it further

RESOLVED, That ACEP support the creation of links between rural hospitals and larger health networks and academic institutions, including medical schools and colleges, to facilitate the creation of rural medicine internships and electives for interested learners at the undergraduate and medical school level; and be it further

RESOLVED, That ACEP support the use of government funding for rural elective rotations for emergency medicine residents at rural critical access hospitals to better train residents for this work and recruit residents to rural practice, where they are most needed; and be it further

RESOLVED, That ACEP support student loan forgiveness for physicians choosing to practice emergency medicine in rural areas.

Action: This resolution is a policy statement. Assigned to the Emergency Medicine Practice Committee to review and determine if additional language is needed for a new policy statement or if the language should be incorporated into the “Definition of Rural Emergency Medicine” policy statement. Include language from Amended Resolution 65(21) Rural Provider Support and a Call for Data (first, third, fourth, and fifth resolves). Also seek input from the ED Accreditation Task Force to ensure consistency with their work. The committee revised the policy statement “Definition of Rural Emergency Medicine” with the revised title “[Rural Emergency Medical Care](#)” and it was approved by the Board in June 2022.

Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives. Assigned to the Education Committee and Educational Services staff to consider for potential education opportunities.

In October 2021, information was included in ACEP’s 911 Update when the Biden Administration announced the student loan forgiveness program. In January 2022, ACEP sent an email to members to remind them of the April 30, 2022, deadline to apply for student loan relief and included information about ACEP’s partnership with [Panacea Financial](#) and [SoFi](#) to provide members-only options on navigating student loan assistance. ACEP has since established a new partnership with Laurel Road for a full suite of premier financial solutions, including student loan consultation and refinancing. The Young Physicians Section also included information in their communications to section members.

ACEP has developed federal legislation to address emergency medicine workforce considerations and encourage emergency physicians to practice in rural and underserved communities by establishing emergency medicine health professional shortage areas (HPSAs) to help expand access to the National Health Service Corps (NHSC) student loan repayment options, as well as providing relocation/job placement assistance and benefits to spouses/partners of emergency physicians based on existing programs available for spouses of members of the U.S. Armed Forces.

Resolution 65 Rural Provider Support and a Call for Data (as amended)

RESOLVED, That ACEP recognize that patients presenting to rural emergency departments are arguably our most vulnerable ED patient population in the U.S. and deserve increased support; and be it further

RESOLVED, That ACEP support the Rural Section in collecting survey data from rural emergency departments to investigate volumes, clinician staffing patterns, and common barriers of care and staffing based and stratified as follows:

| | |
|------------------|---|
| Extreme Frontier | < 0.25 pts/hr (annual volume < 2,190) |
| Frontier | 0.25 pts/hr – 0.5 pts/hr (annual volume 2,191 to 4,380) |
| Small Rural | 0.5 pts/hr – 2 pts/hr (annual volume 4,381 to 17,520) |
| Medium Rural | 2 pts/hr – 4 pts/hr (annual volume 17,521 to 35,040) |
| Large rural | > 4 pts/hr (annual volume > 35,041); and be it further |

RESOLVED, That ACEP recognize that ABEM/AOBEM-certified or eligible physicians are underrepresented in rural emergency departments and that very low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; and be it further

RESOLVED, That ACEP encourage rural emergency departments to retain ABEM/AOBEM-certified physicians to serve as emergency department medical directors so there will be physician-led teams in all U.S. EDs; and be it further

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

Action: Assigned first, third, fourth, and fifth resolves to the Emergency Medicine Practice Committee to review in conjunction with Amended Resolution 64(21) Rural Emergency Medicine Education and Recruitment and determine if additional language is needed for a new policy statement or if the language should be incorporated into the “Definition of Rural Emergency Medicine” policy statement. Also seek input from the ED Accreditation Task Force to ensure consistency with their work. The committee revised the policy statement “Definition of Rural Emergency Medicine” with the revised title “[Rural Emergency Medical Care](#)” and it was approved by the Board in June 2022.

Assigned second resolved to the Rural Emergency Medicine Section to collect the data and provide recommendations to the Board on how to utilize the data. The section developed a survey, identified the locations to be surveyed, and developed a plan to deploy the survey to approximately 2,000 hospitals.

Resolution 70 Creation of Specialized Scope Expansion Advocacy Teams for State Level Advocacy (as amended)

RESOLVED, That ACEP create a toolkit for members to use at the state level to address practice scope expansion efforts that emphasizes the importance of a physician led team for optimal patient safety; and be it further

RESOLVED, That ACEP’s advocacy team create a tracking system for unsupervised practice efforts in each state to ensure that the voice of emergency physicians can be heard for this important patient safety topic; and be it further

RESOLVED, That ACEP’s advocacy team create a “strike team” of advocacy experts in emergency medicine scope expansion issues that can be tasked to help engage states who are actively involved in scope expansion legislation and support the state chapters and physicians at the local level; and be it further

RESOLVED, That ACEP report on efforts to maintain and challenge scope of practice for our Council’s consideration highlighting, at a minimum, activities by ACEP and state chapters in states where scope of practice is being challenged and outcomes of those efforts.

Action: Assigned to Advocacy & Practice Affairs staff for state advocacy initiatives in coordination with the strategic plan.

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 released on ACEP’s [YouTube channel](#) to better explain the vital role of emergency physicians. A toolkit, which includes talking points, a sample op-ed and social media posts, infographics, and video content are available in the [ACEP Media Hub](#).

ACEP staff and the State Legislative/Regulatory Committee created a framework for a dashboard tracking key issues regulated at the state level, including scope of practice. The dashboard will begin to be populated in 2022-23.

ACEP recently joined the National Conference of State Legislatures (NCSL) Foundation to give us a seat at the table to provide the EM perspective on some of the biggest issues we face right now, most notably scope of practice. Our membership gives us unparalleled access to state legislators in NCSL-hosted meetings on health and insurance related issues – in most cases, the chair of insurance and health committees. ACEP will identify key emergency physician advocates and fund their travel to these meetings as appropriate when scope issues are underway for a particular state.

ACEP contracted with VoterVoice, an advocacy platform and digital advocacy tool for communicating to federal and state legislative officials and tracking advocate actions. ACEP chapters were offered options to utilize the tool for state level grassroots advocacy. In the first option, the chapter provides alert text and audience targets to ACEP DC staff to send messaging directly on their behalf and provide reports throughout the campaign. The SD and WI chapters utilized this option in regard to scope battles in their state legislatures in 2022. ACEP also negotiated a discounted rate for chapters to purchase their own state platform that they would manage independently. Six states are participating including FL, IL, MI, NY, TX and VA.

ACEP also partnered with the Congressional Management Foundation (CMF), which offers educational and motivational tools to help individuals and organizations gain an understanding of Congress, the skills to influence public policy, and the value of citizen engagement. Throughout the year, ACEP provides information about CMF-sponsored webinars to ACEP chapters allowing their members to access the training either live or through a recorded version at no cost. Brad Fitch, the head of CMF, has also addressed participants at past Leadership and Advocacy Conferences on best practices.

Resolution 72 Fair Compensation to Emergency Physicians for Collaborative Practice Agreements & Supervision (as amended)

RESOLVED, That ACEP support emergency physicians be fairly compensated to supervise ABEM/AOBEM board certified/eligible physician led teams.

Action: This resolution is a policy statement. Assigned to the Reimbursement Committee to determine if the language should be added to the policy statements “Compensation Arrangements for Emergency Physicians,” “Fair Payment for Emergency Department Services,” and “Emergency Physician Compensation Transparency.” The committee determined that the language in the resolution was sufficient as a stand-alone policy statement, although there are some common themes included in the other referenced policies. The rationale for a separate policy statement is that it speaks to a very specific point that could be obscured if included within the broader content of the existing policies. The Board of Directors approved the policy statement “[Fair Compensation to Emergency Physicians to Supervise ABEM/AOBEM Board Certified/Board Eligible Led Teams](#)” in June 2023.

Resolution 74 Regulation by State Medical Boards of All Who Engage in Practice of Medicine (as amended)

RESOLVED, That ACEP support that anyone, physicians or non-physician practitioners, who engage in the practice of medicine be regulated by the respective state medical board of their respective states; and be it further

RESOLVED, That ACEP work with the AMA and submit a resolution to their house of delegates to create a universal definition of the practice of medicine to include the ordering of diagnostic tests, diagnosing clinical condition/disease, prescribing of medications, and/or ordering of treatments on human beings.

Action: Assigned first resolved to the State Legislative/Regulatory Committee to develop a policy statement. Assigned second resolved to the AMA Section Council on Emergency Medicine.

The State Legislative/Regulatory Committee had initial discussions on how to break the objective into actionable parts. A work group was assigned to research regulation of the practice of medicine in the states to determine how to best support the position of emergency physicians. The committee developed the policy statement, “[State Board of Medicine Regulation of Non-Physician Practitioners Practicing Medicine](#)” and it was approved by the Board in April 2023.

The AMA Section Council on Emergency Medicine discussed the second resolved extensively and was concerned that, contrary to the seeming intent of the resolution, a universal definition of the practice of medicine could leave emergency medicine more vulnerable on scope of practice issues rather than less vulnerable. If defined too narrowly, it leaves an opening for nurse practitioners to further expand their scope of practice and if defined too broadly it could remove needed functions provided by nurse practitioners and potentially nurses as well. An overly broad definition could also introduce new complications wherein anyone offering friendly advice to someone could be construed as providing medical advice and therefore subject them to liability concerns. Another challenge is if a universal definition is offered by emergency medicine to the AMA House of Delegates (HoD), primary care and other specialties in attendance would then propose alterations or alternative definitions more suited to their own members. This could pit emergency medicine against other specialties within the house of medicine with no guarantee that our definition would prevail, and thereby introduce risk that whatever consensus definition ultimately emerged from the HoD could be much more problematic for emergency medicine (especially given its unique nature) than any perceived issues posed by the current lack of a definition. The Board approved recommendations on April 30, 2023, to rescind the motion approved at the October 28, 2021, meeting to adopt the second resolved and to overrule it. The Board also adopted a motion “that ACEP work with the American Medical Association and other stakeholders to support that anyone, physicians or non-physician practitioners, who engage in the practice of medicine be regulated by the respective state medical board of their respective states.” The Steering Committee was informed of the recommendations to the Board at their April 30, 2023, meeting. A message regarding the Board’s decision was posted on the Council engaged on May 30, 2023. The position and vote of each Board member was provided to the Steering Committee for the October 6, 2023, meeting and included in the 2023 Council meeting materials.

Resolution 78 In Memory of Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE

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

Action: A framed resolution was sent to Dr. Haley’s family.

Resolution 79 In Memory of Juan Francisco Fitz, MD, FACEP

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the magnanimous life of Juan Francisco Fitz, MD, FACEP, on the State of Texas and the Texas College of Emergency Physicians; and be it further

RESOLVED That the American College of Emergency Physicians and the Texas College of Emergency Physicians acknowledges the substantial loss to the medical community and bereavement of his many colleagues and friends, but above all extend condolences to his family.

Action: A framed resolution was sent to Dr. Fitz's family.

Resolution 80 In Memory of Jay Edelberg, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remember with honor and gratitude this trailblazing pioneer, Jay Edelberg, MD, FACEP, and his selfless contributions to emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians extends the same gratitude and condolences to his wife, Caral, his family members, colleagues, and friends who are deeply saddened by this loss.

Action: A framed resolution was sent to Dr. Edelberg's family.

Resolution 81 Leon L. Haley, Jr. Award

RESOLVED, That the American College of Emergency Physicians create a national award to honor champions of diversity, inclusion, and health equity and it be named the "Leon L Haley Jr Award" in honor of one of the emergency medicine leaders who promoted diversity, inclusion, health equity and eliminating health disparities throughout his career; and be it further

RESOLVED, That each year at the ACEP Scientific Assembly that there should be a "Leon L Haley, Jr Lecture" that will focus on diversity, equity, and inclusion and on the outstanding qualities exemplified by Leon Haley, including professionalism, humanitarianism, and advocacy for the elimination of healthcare disparities.

Action: Assigned to staff to work with the Diversity, Inclusion, & Equity Section to develop the award description and award criteria for approval by the Board of Directors. Assigned second resolved to the Education Committee and Educational Services staff to develop a plan to incorporate the named lecture for ACEP22 and for the future.

The award description and eligibility criteria was approved by the Board at their September 28, 2022, meeting. The award is now part of ACEP's awards program. Nominations for the award began in 2023.

The Education Committee formalized the named lecture into the annual planning for *Scientific Assembly*. The first lecture was held at ACEP22 in San Francisco and the lecture will be continued for future years.

Resolution 82 Defining the Job Description of an Emergency Physician (as amended)

RESOLVED, That, the American College of Emergency Physicians (ACEP) work with appropriate stakeholders and the insurance industry to develop ACEP policy defining an accurate job description that can apply to all emergency physicians; and be it further

RESOLVED, That ACEP consider developing an accurate job description for emergency physicians, which can be used to support appeals of long term disability claim denials, until an acceptable ACEP policy is created.

Action: Assigned to the Emergency Medicine Practice Committee.

ACEP developed a letter with a description of emergency medicine work and describing the job requirements of an emergency physician. The letter can be used on behalf of a member's disability claim and can serve as the foundation for a future document.

The Emergency Medicine Practice Committee developed the policy statement "[Defining the Job Description of an Emergency Physician](#)" and it was approved by the Board September 28, 2022. The committee also developed the Policy Resource & Education Paper (PREP) "[Physical and Cognitive Skills Required for the Practice of Clinical Emergency Medicine.](#)"

Resolution Referred to the Council Steering Committee

Resolution 15 Member Determined Council Representation

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

1. Council composition to be determined by the allocation of credits or points that each individual emergency physician members in good standing of the College will be allotted equally.

2. Each and every full member in good standing who pays full membership dues will be assigned five (5) points or credits that the individual emergency physician is free to assign in whatever breakdown the member wishes towards his/her state chapter, another state chapter, a particular section, or any combination the member wishes to assign the points/credits.
3. Council representation will be determined by the total number of votes/points that were assigned by all paying emergency physician members, i.e., total number of Council positions available (councillors) will be divided into the total number of points to determine how many available councillors will be assigned to each specific chapter, section, etc.
4. Consider maintaining a minimum number of councillor positions i.e., one (1) could be assigned to each state and each section with a minimum of 100 paying members, with the remaining councillor positions assigned according to the pro-rated number of credits/points that the individual emergency physicians assigned.
5. Consider a hybrid that gives preference as seen fit; and be it further

RESOLVED, That a task force or committee assigned to review alternative methods of determining representation of the members in the Council conclude its investigation, research, and suggestions and report back to the Board with sufficient time for the Board to report the information to the Council at least one month before the resolution submission deadline for the 2022 Council meeting.

Action: The Steering Committee discussed this resolution at their January 24, 2022, meeting and it was assigned to the Bylaws & Council Standing Rules Subcommittee to review and provide a recommendation to the Steering Committee. The subcommittee's recommendations were discussed at the May 1, 2022, Steering Committee meeting.

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

Resolutions Referred to the Board of Directors

Resolution 16 ACEP Group Membership

RESOLVED, That ACEP group membership policy be revised to provide individual members a 20% discount on annual ACEP membership dues for every year that the group maintains 100% membership in ACEP beginning in 2022; and be it further

RESOLVED, That ACEP state chapters be encouraged to provide annual state chapter individual dues discount for members of groups who maintain 100% ACEP membership.

Action: Assigned to membership staff to review and provide a recommendation to the Board of Directors. ACEP staff have begun testing discounting and other group benefits as a means of enticing and supporting ACEP 100% Club membership. This has included working with the Oregon Chapter for dues discounting to match the national offer, as well as drafting a list of new organizational benefits that further entice groups to join the 100% Club based on their needs as an employer. Feedback from groups is being used to further refine offerings, and any recommended changes to dues structure or pricing will include involvement by chapter leadership and will be submitted to the Board of Directors for approval.

Resolution 25 ACEP Report Card

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

RESOLVED, That ACEP publish and widely distribute the results of a state chapter survey in a National Report

Card 2022 and provide assistance and resources for chapter activities to improve access and quality of emergency care in their state.

Action: Assigned to Clinical Affairs staff, with input from state chapter executives, to develop a recommendation to the Board of Directors regarding implementation of this resolution. The resolution background estimated costs for using an outside contractor(s) to perform many of the tasks, without conducting the additional primary and secondary research performed in the first three Report Cards, could exceed \$150,000.

The Board discussed the referred resolution at their June 2022 meeting, including concerns about the scope of the project, associated costs, and the potential value. The Board expressed support for identifying other ways to curate information chapters found most valuable in previous report cards or that could help evaluate and compare health care issues across states. Staff were directed to work to identify ways to provide data through dashboard tools and other resources and provide recommendations to the Board at a future meeting.

Resolution 35 Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals – last three resolveds

RESOLVED, That ACEP support cost-based reimbursement for rural critical access hospitals and rural emergency hospitals at a minimum of 101% of patient care, including emergency care, to enable rural critical access hospitals to provide a safety net for rural patients and cost-based reimbursement should be increased beyond this 101% minimum according to the proportion of Medicare, Medicaid, and uninsured patients seen in the emergency department; and be it further

RESOLVED, That ACEP support changes in Center for Medicare and Medicaid Services regulation that would allow rural off-campus emergency departments and rural emergency hospitals to collect the facility fee as well as the professional fee, as this essential for rural emergency hospital financial viability; and be it further

RESOLVED, That ACEP advocate for insurance plans to aggregate all institutional and professional billing related to an episode of care and send one unified bill to the patient for their portion to shift the burden of collecting from the patient with a high-deductible insurance plan to the insurance company and allow for more equitable payments to both the rural and referral hospitals for initial stabilization in a rural area and definitive care at a tertiary center.

Action: Assigned to Advocacy & Practice Affairs staff to provide a recommendation to the Board of Directors.

ACEP has advocated for increased reimbursement for clinicians, including emergency physicians, that may work in rural emergency hospitals (REHs) once they have been established. The Consolidated Appropriations Act, which created REHs allowed for an additional five percent payment for each service delivered in REHs as well as a monthly payment for REHs. These additional payments would go to the REH facilities themselves under the Medicare Outpatient Prospective Payment System (OPPS), not the physicians or other clinicians who actually provide the services. In order to incentivize physicians and other clinicians to work in rural areas and appropriately staff REHs, ACEP requested in our official [response](#) to the Calendar Year (CY) 2023 OPPS proposed rule that the Centers for Medicare & Medicaid Services (CMS) consider creating an add-on code or modifier under the Medicare Physician Fee Schedule (PFS) that clinicians could append to claims for services delivered in REHs. CMS could consider setting the value of this add-on code or modifier at five percent of the PFS rate for each code that is billed—consistent with the additional OPPS payment that the statute provides. In other words, although the statute provides an additional payment for facilities, ACEP argues that there must also be a commensurate payment for clinicians under the PFS in order for REHs to have the resources and staff necessary to be a viable option for patients who need emergency treatment or other services in rural areas.

The third resolved attempts to address insurer billing practices that both confuse patients and add administrative complexity. ACEP has advocated for Congress to enact legislation that would accomplish the specific request articulated in the resolved. When Congress was debating a ban on balance billing in 2018 and 2019, before the *No Surprises Act* was eventually passed into law, ACEP released a [framework](#) of what we wanted to see in any legislation. One key element was a request that the insurer directly pay any coinsurance, copay, and deductible for emergency care to the clinician or facility. Insurers would then collect back these amounts from the patient. This ensures patients only have a single point of contact for emergency medical billing and payment and will no longer receive and have to reconcile multiple, confusing bills and EOBs that result from the many clinicians and facilities that are often involved in a single emergency episode. Unfortunately, while this request would have addressed the third referred resolved, not only for rural care but for all emergency services, Congress did not incorporate this policy into the final legislation and it would be difficult at this time to pass additional legislation to reopen this issue. ACEP has previously attempted to push Congress to enact legislation that would meet the goals of the third resolved and will continue to monitor legislation and regulations affecting rural emergency care, including those that would address the complex insurance and billing practices that emergency physicians and their patients continue to face.

The Board of Directors discussed this referred resolution at their September 28, 2022, meeting and affirmed that the intent of the resolution is being addressed by ACEP continuing to monitor legislation and regulations affecting rural emergency care and advocate on behalf of emergency physicians and patients.

Resolution 37 Physician Pay Ratio

RESOLVED, That ACEP support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians based on what is collected on the billings for the services provided by that individual emergency physician, before collection costs; and be it further

RESOLVED, That ACEP support that when a nominal compensation amount is stated to compensate the emergency physician, the amount must meet or exceed an established Minimum Emergency Physician Pay Ratio; and be it further

RESOLVED, That ACEP support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians a reasonable, prorated percentage of any other revenue that the contract management group or employer receives as a direct or indirect result of the individual, or group of individual, emergency physicians, providing his/her/their services with a suggested starting point: 0.80-0.85 (80-85%).

Action: As was noted in the resolution background, ACEP’s Antitrust Policy states “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.” Further, “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.”

Assigned to ACEP’s General Counsel to provide a legal opinion on the feasibility and advisability of implementing this resolution and seek an opinion from outside legal counsel if needed. The Board will consider further action pending this opinion. The Medical-Legal Committee was assigned an objective for the 2023-24 committee year to develop an information paper on the legal ramifications of collective bargaining and unionization for emergency physicians.

As a means to further general education and awareness on the topic of collective bargaining, a panel entitled “Physician Collective Action: Does Standing on the Picket Line Cross a Moral Line” was presented during the 2022 Leadership & Advocacy Conference.

Resolution 43 Autonomous “Shared Governance” Due Process

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

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

Definitions

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

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

Action: Assigned to the Medical-Legal Committee and to provide a recommendation to the Board of Directors on the advisability of implementing this resolution. ACEP's General Counsel to assist in providing a legal opinion on the advisability of implementing this resolution and seek an opinion from outside legal counsel if needed. The committee will continue working on this resolution in the 2023-24 committee year.

Resolution 47 Family and Medical Leave – *third resolved*

RESOLVED, That ACEP develop a policy statement in support of paid family leave outside of the language in ACEP's "Family and Medical Leave" policy statement revised in 2019.

Action: Assigned to the Emergency Medicine Practice Committee to work with the Well-Being Committee to review ACEP's "Family and Medical Leave" policy statement and provide a recommendation to the Board of Directors regarding the advisability of expanding the policy statement in support of paid family leave and any potential revisions as requested in the referred third resolved.

The Emergency Medicine Practice Committee, with input from the Well-Being Committee, revised the policy statement "[Family and Medical Leave](#)" and it was approved by the Board in August 2022.

The Well-Being Committee developed the information paper "Recommendations for the Best Practices Supporting Physician Pregnancy, Adoption, Surrogacy, Parental Leave, and Lactation in the Emergency Department" and it has been submitted for publication consideration. It will be available on the ACEP website after publication.

Resolution 49 Forced EMS Diversion – *second resolved*

RESOLVED, That ACEP collect data on the clinical impact of EMS diversion policies.

Action: Assigned to the EMS Committee to develop a recommendation and cost estimates for the Board of Directors regarding the advisability of implementing the second resolved.

The committee worked with other stakeholders such as the National Association of EMS Physicians (NAEMSP), National Association of State EMS Officials (NASEMSO), National Association of EMTs (NAEMT), International Association of Fire Chiefs (IAFC), and the American Ambulance Association (AAA) to collect information and develop strategies to address forced EMS diversion. A list of resources to include examples of EMS systems that have developed effective plans to address diversion are being added to the ACEP website in the EMS Resources section and will be shared with the EMS Section members through the section engaged. ACEP staff are also available to assist with providing information and resources to address the specific causes of the forced EMS diversion. Historically EMS diversion is most effectively addressed at the local or regional level through collaboration between the facilities and EMS services once the reasons for the diversion have been identified. The medical directors and administration of the local hospitals and EMS services typically meet and agree on a plan to address the specific needs of the local system. Coordination between all involved parties and an agreement to follow a planned solution is essential to the success of the system. The Board of Directors affirmed in June 2023 that the actions taken by the EMS Committee meet the intent of the resolution.

Resolution 51 Medical Bill of Rights for Detained and Incarcerated Persons While Receiving Emergency Medical Care

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

Detained, arrested, and incarcerated persons have the right to:

1. Medical neutrality – equal evaluation and treatment for emergency medical conditions regardless of their status as a detained or incarcerated person.
2. Speak with their provider privately.
3. Removal of physical restraints for the purpose of a physical exam at the request of the treating physician.
4. Medical care at a facility that has a protocol for and supports quality analysis of medical care.
5. Privacy and protection from inquiry regarding charges, conviction, or duration of sentence unless expressly pertinent to delivery of care.
6. Informed consent – to be adequately informed of diagnoses, treatment options, risks and alternatives, and follow-up plans.
7. Refuse care and diagnostic testing, including nutrition, laboratory studies, medications, and procedures, with the exception of psychoactive medications if the patient is deemed a potential harm to self or others if psychoactive medications are withheld OR with the exception of previously set forth state policies or contracts determining otherwise.
8. Administration of interventions and requests for consultations in a timely manner consistent with local standards of care.

9. Make their healthcare decisions independently, if deemed competent, and to appoint an appropriate surrogate medical decision-maker in the event they become incompetent. Wardens, sheriffs, guards, police officers, prison administrators, and other law enforcement officials are not eligible medical decision-makers.
10. Visitation by their medical decision-maker according to state laws regardless of the policies of law enforcement or carceral institutions.; and be it further

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

Action: Assigned to the Ethics Committee to collaborate with the Medical-Legal Committee to review and provide a recommendation to the Board of Directors on the advisability of implementing the resolution.

The Ethics Committee discussed the resolution and agreed it is a significant moral issue. It was noted that the committee has written and revised the “[Law Enforcement Information Gathering in the Emergency Department](#)” policy statement and committee members have authored several published articles on law enforcement in the ED. It was also noted that many vulnerable groups receive care in the ED, including patients with autism, other behavioral health conditions, involuntarily committed patients, and undocumented immigrants, but ACEP has not adopted a bill of rights for any of these groups. The committee believes that a general bill of rights for ED patients can include rights that are significant for vulnerable patient groups, including detained and incarcerated persons. If medical rights of prisoner patients require additional recognition, ACEP could follow up with a bill of rights specific to that population. The Medical-Legal Committee confirmed their support for this approach. The Board approved assigning an objective to the Ethics Committee for the 2022-23 committee year to develop a medical bill of rights for all ED patients that includes rights for vulnerable patient groups and detained or incarcerated persons. A draft policy statement was submitted to the Board for consideration in August 2023. The Board referred the policy back to the committee for revisions.

Resolution 66 ACEP Promotion of Emergency Physician Led Teams (as substituted in lieu of Resolutions 66, 67, and 76)

RESOLVED, That ACEP publish and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an ABEM/AOBEM board certified emergency physician; and be it further

RESOLVED, That ACEP support the standard that board certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

Action: Assigned to the Emergency Medicine Practice Committee to review and develop a recommendation to the Board of Directors on the advisability of implementing the resolution as a new policy statement or if the language should be included in any existing policy statements.

The Board revised the policy statement “[Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department](#)” on March 9, 2022, to address offsite supervision. The policy statement supports the standard that emergency physicians are to be involved in every patient encounter presenting to an emergency department.

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.

Resolution 73 Offsite Supervision of Nurse Practitioners and Physician Assistants

RESOLVED, That the ACEP policy statement, [Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department](#),” be revised to remove “offsite” supervision, including via telephone, telehealth, or video, as a type of indirect supervision of physician assistants and nurse practitioners in the emergency department; and be it further

RESOLVED, That ACEP oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Action: The Board of Directors discussed the referred resolution at their January 27-28, 2022, meeting and assigned a Board workgroup to revise the policy statement. The Board adopted the revised policy statement “[Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department](#)” on March 9, 2022.

Memorandum

To: 2023 Council

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

Date: October 1, 2023

Subj: Action on 2020 Resolutions

The 2020 Council considered 58 resolutions: 44 were adopted, 7 were not adopted, and 7 were referred to the Board of Directors.

Note: The first resolved of Resolution 27 was referred to the Board and the three remaining resolveds were adopted. The first two resolveds of Resolution 29 were adopted and the remaining three resolveds were referred to the Board.

The attached report summarizes the actions taken on the 2020 resolutions adopted by the The [updated actions](#) are also available on the ACEP website. Scroll to the end of the document to see amended or substituted language and to see the implementation action.

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Action on 2020 Council Resolutions

Resolution 1 Commendation for Stephen H. Anderson, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends and thanks Stephen H. Anderson, MD, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Anderson.

Resolution 2 Commendation for James J. Augustine, MD, FACEP

RESOLVED, That the American College of Emergency Physicians extends heartfelt appreciation and gratitude and commends James J. Augustine, MD, FACEP, for his dedication as an emergency physician and his outstanding service and leadership to the College and the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Augustine.

Resolution 3 Commendation for Jon Mark Hirshon, MD, MPH, PhD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Jon Mark Hirshon, MD, MPH, PhD, FACEP, for his devotion as an emergency physician, educator, and leader in emergency medicine.

Action: A framed resolution was sent to Dr. Hirshon.

Resolution 4 Commendation for Janyce M. Sanford, MD, MBA, FACEP

RESOLVED, That the American College of Emergency Physicians commends Janyce M. Sanford, MD, MBA, FACEP, for her service as Chair and Chief of Service for the Department of Emergency Medicine at the University of Alabama at Birmingham.

Action: A framed resolution was sent to Dr. Sanford.

Resolution 5 Commendation for Dean Wilkerson, JD, MBA, CAE

RESOLVED, That the American College of Emergency Physicians commends Dean Wilkerson, JD, MBA, CAE, for his outstanding contributions to ACEP and the specialty of emergency medicine.

Action: A framed resolution was sent to Mr. Wilkerson.

Resolution 6 In Memory of Walter J. Bradley, III, MD, MBA, FACEP

RESOLVED, That the American College of Emergency Physicians (ACEP) cherishes the memory of Walter J. Bradley, III, MD, MBA, FACEP, whose philosophy and approach to patient care was "Whatever the hour you may come, you will find light, hope, and human kindness," and be it further

RESOLVED, That national ACEP and the Illinois Chapter extends to his wife Meme, son Ryan, and the extended Bradley and Wood families gratitude for his tremendous service to emergency medicine and EMS.

Action: A framed resolution was sent to the family of Dr. Bradley.

Resolution 7 In Memory of Lorna Breen, MD, FACEP

RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Lorna Breen MD, FACEP, our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the patients and physicians of New York and the United States.

Action: A framed resolution was sent to the family of Dr. Breen.

Resolution 8 In Memory of Col (ret) Christopher Scharenbrock, MD, CPE, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Colonel (ret) Christopher G Scharenbrock, MD, CPE, FACEP, as one of the leaders in emergency medicine and military medicine; and be it further

RESOLVED; That the American College of Emergency Physicians extends to his wife Mary, his daughters Emily and Anna, his extended family, colleagues, and friends our condolences and gratitude for his tremendous service to the specialty of emergency medicine, military medicine, and to the countless patients and physicians across the world whom he selflessly served.

Action: A framed resolution was sent to the family of Dr. Scharenbrock.

Resolution 9 ACEP Committee Quorum Requirement – Bylaws Housekeeping Amendment

RESOLVED, That the ACEP Bylaws Article XI – Committees, Section 1 – General Committees, be amended to read:

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

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

Action: The Bylaws were updated.

Resolution 10 Commendation and Memorial Resolutions – Council Standing Rules Amendment

RESOLVED, That the Council Standing Rules, “Reference Committees” section, paragraph one, be amended to read:

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

RESOLVED, That the Council Standing Rules, “Resolutions” section, be amended to read:

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

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

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

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

- **Regular Non-Bylaws Resolutions**

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

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

- **Bylaws Resolutions**

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

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

- **Late Resolutions**

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

- **Emergency Resolutions**

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

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

Action: The Council Standing Rules were updated.

Resolution 12 Council Resolution Sponsors and Cosponsors – Council Standing Rules Amendment (as amended)

RESOLVED, That the Council Standing Rules, “Resolutions” section, be amended to read:

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

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

Action: The Council Standing Rules were updated.

Resolution 13 Counting Fellowship Training Time Toward FACEP – Bylaws Amendment

RESOLVED, That the ACEP Bylaws, Article V – ACEP Fellows, Section 1 - Eligibility, be amended to read:

ARTICLE V — ACEP FELLOWS Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

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

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

Action: The Bylaws were updated. The fellow application and processes were updated.

Resolution 14 Ethics Procedures – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 3 – Agreement, and Section 4 – Disciplinary Action, be amended to read:

Section 3 — Agreement

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

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

Section 4 — Disciplinary Action

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

Action: The Bylaws were updated.

Resolution 15 Procedures for Addressing Charges of Ethical Violations and Other Misconduct – College Manual Amendment

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

Procedures for Addressing Charges of Ethical Violations and Other Misconduct

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

A. Definitions

1. ACEP means the American College of Emergency Physicians.
2. Code of Ethics means the Code of Ethics for Emergency Physicians.
3. Procedures means the Procedures for Addressing Charges of Ethical Violations and Other Misconduct.
4. Ethics Complaint Review Panel consists of three (3) members of the Ethics Committee and two (2) members of the Medical-Legal Committee – 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.

~~A.~~ B. Complaint Received

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

1. Must be in writing and signed by the complainant;
2. Must specify in reasonable detail an alleged violation by an ACEP member of an ACEP policy as it existed at the time of the alleged violation, including ACEP Bylaws, ~~current~~ ACEP ~~“Principles Code of Ethics, for Emergency Physicians,”~~ other ~~current~~ ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within ~~twelve (12)~~ ten (10) years prior to the submission of the complaint, is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired;
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating documentation must accompany the complaint. Complainant is responsible for ensuring that the documentation does not provide information that can be used to identify a particular patient, including but not limited to, the patient’s name, address, social security number, patient identification number, or any identifying information related to members of the patient’s family;
5. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director, ~~the Ethics Committee, the Bylaws Committee, the Board of Directors,~~ any additional ACEP review body listed in these Procedures, and ~~to~~ the respondent should the complaint be forwarded to the respondent; and
6. Must be submitted to the ACEP Executive Director.

~~B.~~ 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 ~~1. Sends~~ a written acknowledgement to the complainant confirming ~~the~~ complainant’s intent to file a complaint. Includes a copy of ACEP’s Procedures providing and identifying the elements-guidelines and timetables that must-will be addressed-followed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the Procedures.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the ~~“Procedures for Addressing Charges of Ethical Violations and Other Misconduct” (“Procedures”)~~ Procedures.

3. Notifies the ACEP President and the ~~e~~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 ~~e~~Chair of the Ethics ~~and/or~~ **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 for Emergency Physicians* or ~~of~~ ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or
 - b. Determines, in consultation with the **ACEP President and the Chair of the** Ethics Committee ~~chair, 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 for Emergency Physicians*, and if so, forwards the complaint and the response together, **as soon as after** both are received, to each member of the Ethics ~~Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose~~ **Complaint Review Panel**, or
 - c. Determines, in consultation with the **ACEP President and the Chair of the** Bylaws Committee ~~chair, or other committee designee~~, that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, **as soon as after** both are received, to each member of the Bylaws Committee, or at the discretion of the ~~e~~Chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or
 - d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, the complaint will not be considered. The ~~Board of Directors~~ **Ethics Complaint Review Panel or the Bylaws Committee** will review the President's action, ~~at the next regularly scheduled Board meeting~~. The President's action can be overturned by a majority vote of the ~~Board, or~~ **applicable ACEP review body**.
 - e. ~~Determines that the alleged violation is not the subject of a pending ACEP Standard of Care Review. If the alleged violation is the subject of a pending Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.~~
5. Within ten (10) business days after the determinations specified in Section ~~BC.4.b.~~ or Section ~~BC.4.c.~~ of these *Procedures*, forwards the complaint to the respondent by ~~certified U.S. mail~~ **USPS Certified Mail** with a copy of these *Procedures* and requests a written response within thirty (30) days of receipt of the documents. The communication will indicate that ACEP is providing notice of the complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the ~~Board~~ **applicable ACEP review body** decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant will be included in this communication. Such notice must also include a summary of the respondent's rights in the hearing, and a list of the names of the members of the ~~ACEP Ethics Committee or the ACEP Bylaws Committee, as appropriate~~ **applicable ACEP review body, including, and** the Board of Directors. The respondent will have the right to raise any issues of potential conflict or reason that any individuals should recuse themselves from the review. Such recusal shall be at the discretion of the ACEP President.
6. When a written response to a complaint is received, the Executive Director will forward that response and any further related documentation to the complainant and the Ethics ~~Committee, Complaint Review Panel~~ **or** the Bylaws Committee, ~~or the subcommittee~~ appointed to review the complaint, as appropriate.

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

1. Reviews the written record of any complaint that alleges a violation of ~~current~~ the ACEP "**Principles Code of Ethics for Emergency Physicians**" or other ~~current~~ ACEP ethics policies **as they existed at the time of the alleged violation and the accompanying response**.
2. Discusses the complaint and response by telephone conference call~~s~~.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
 - a. ~~Current~~ **Applicable version of the** ACEP "**Principles Code of Ethics for Emergency Physicians**" or other ~~current~~ ACEP ethics policies apply.

- b. Alleged behavior constitutes a violation of ~~current-~~ the applicable version of the ACEP “Principles Code of Ethics for Emergency Physicians” or other ~~current-~~ ACEP ethics policies.
- c. Alleged conduct warrants censure, suspension, or expulsion.
- ~~5. Proceeds to develop its recommendation based solely on the written record.~~
- ~~6. Develops a report regarding the complaint and recommendation for action. Minority reports may also be presented.~~
- ~~7.5. The Ethics Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Ethics Committee shall recommend that the Board of Directors Decides to:~~
 - a. Dismiss the complaint; or
 - b. ~~Take-~~ Ethics Complaint Review Panel renders a decision to impose disciplinary action, ~~the specifics of which shall be included in the committee's report.~~ based on the written record.
- ~~8. At the discretion of the chair of the Ethics Committee, these functions may be carried out by a subcommittee of five or more members of the Ethics Committee. The Ethics Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.~~
- 6. If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review Panel’s determination and the option of:
 - a. A hearing; or
 - b. The imposition of the Ethics Complaint Review Panel decision based solely on the written record.
- 7. If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will implement its decision to impose disciplinary action based on the written record.

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

- 1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws as it existed at the time of the alleged violation and the accompanying response.
- 2. Discusses the complaint and response by telephone conference call.
- 3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
- 4. Considers whether:
 - a. ~~Current-~~ Applicable version of the ACEP Bylaws apply.
 - b. Alleged behavior constitutes a violation of ~~current-~~ the applicable version of the ACEP Bylaws.
 - c. Alleged conduct warrants censure, suspension, or expulsion.
- ~~5. Proceeds to develop its recommendation based solely on the written record.~~
- ~~6. Develops a report regarding the complaint and recommendation for action. A minority reports may also be presented.~~
- ~~7.5. The Bylaws Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors Decides to:~~
 - a. Dismiss the complaint; or
 - b. ~~Take-~~ Bylaws Committee renders a decision to impose disciplinary action, ~~the specifics of which shall be included in the committee’s report~~ based solely on the written record.
- ~~8. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a subcommittee of five or more members of the Bylaws Committee. The Bylaws Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.~~
- 6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee’s determination and the option of:
 - a. A hearing; or
 - b. The imposition of the Bylaws Committee’s decision based solely on the written record.

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

~~E. Board of Directors~~

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

~~F. Ad Hoc Committee~~

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

G. F. Right of Respondent to Request a Hearing

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

H. G. Hearing Procedures

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

~~the hearing is conducted by an Ad Hoc Committee pursuant to Section F., the decision of such Ad Hoc Committee will be final and will be implemented by the Board.~~

- ~~10-9.~~ The decision of the Board ~~or Ad Hoc Committee~~ **Hearing Panel** will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the ~~Board's or Ad Hoc Committee~~ **Board Hearing Panel's** decision will be sent by ~~certified U.S. mail~~ **USPS Certified Mail** to the respondent and complainant within sixty (60) days of the decision. This written notice will include the ~~Board's or Ad Hoc Committee's~~ **Board Hearing Panel's** decision and a statement of the basis for that decision.

H. Notice to the Board of Directors

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

I. Possible Disciplinary Action: ~~Censure, Suspension, or Expulsion~~ and Disclosure to ACEP Members

1. Nature of Disciplinary Action

a. Censure

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

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

- ~~2.~~ **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 ~~Board of Directors~~ **ACEP President**. At the end of the twelve-~~(12)~~ month period of suspension, the suspended member ~~shall be offered~~ **may request** reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues). **The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. ACEP is also required to report the suspension from membership and a description of the conduct that led to the suspension to the Board of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.**

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

J.—Disclosure

1.—Nature of Disciplinary Action

- a.—~~Private censure: the content of a private letter of censure shall not be disclosed, but the fact that such a letter has been issued~~ **announced in an appropriate ACEP publication. The published announcement shall be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed; also state which ACEP policy or Bylaws provision was violated by**
- b.—~~Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.~~
- c.—~~Suspension: the dates of suspension, including whether or not the member was reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to~~

suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which **and shall inform ACEP members that they** may result in a report of such **request further information about the disciplinary** action. ~~to the National Practitioner Data Bank.~~

~~d. Expulsion: the date of expulsion, along with a statement of the basis for the expulsion, shall be disclosed. If the five-year period has elapsed, the disclosure shall indicate whether the former member petitioned for reinstatement and, if so, the Board's decision on such petition.~~ ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

2. Scope and Manner of Disclosure

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

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

~~K~~ **J. Ground Rules**

1. All proceedings are confidential until a final decision on the complaint is rendered by the ~~Board of Directors or an Ad Hoc Committee pursuant to Section F.~~ **applicable ACEP review body**, at which time the decision will be available upon request by ACEP members, to the extent specified in Section ~~J~~ **I.** Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics ~~Committee~~ **Complaint Review Panel**, the Bylaws Committee, ~~or the Board of Directors, their appointed subcommittees, as appropriate, or an Ad Hoc Committee~~ **Hearing Panel**, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the ~~committee's, Board's, subcommittee's, or Ad Hoc Committee's overall time to complete its task. However, such requests and the responses thereto shall not extend the time to deliver a recommendation or a decision to the Board beyond ninety (90) days from the date the complaint is forwarded to the appropriate committee, subcommittee, or Ad Hoc Committee.~~ **ACEP review body's overall time to complete its task.**
4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
5. If a participant in this process (such as a member of the Ethics ~~Committee~~ **Complaint Review Panel**, the Bylaws Committee, or ~~the Board of Directors~~ **Hearing Panel**) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic competition with the respondent, that person shall recuse himself or herself from the process except as a complaining party or respondent. ~~Any committee member who recuses himself or herself shall report this recusal promptly to the committee chair, and any Board member who recuses himself or herself shall report this recusal promptly to the chair of the Board.~~ **at which time the ACEP President will appoint a replacement.**
6. Once the ~~Board~~ **Ethics Complaint Review Panel or the Bylaws Committee** has made a decision ~~or implemented a decision of an Ad Hoc Committee pursuant to Section F.~~ on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
7. The ~~Board's~~ **Ethics Complaint Review Panel or the Bylaws Committee's** decision ~~or the decision of an Ad Hoc Committee pursuant to Section F.~~ to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.
8. If a respondent fails to respond to a complaint, to **a** notice of the right to request a hearing, or to a request for information, the ~~Board or an Ad Hoc~~ **Ethics Complaint Review Panel, the Bylaws** Committee, ~~pursuant to Section F.~~ **or the Board Hearing Panel** may make a decision on the complaint solely on the basis of the information it has received.
- ~~9. If a complaint alleges a violation that is the subject of a pending ACEP Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.~~

~~10.9.~~ 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.

Action: The College Manual was updated.

Resolution 16 Special Board of Directors Meetings – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article IX – Board of Directors, Section 3 – Meetings be amended to read:

Section 3 — Meetings

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

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

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

Special meetings of the Board of Directors may be called by the president or the chair of the Board with not less than ~~10~~ **48 hours** ~~nor more than 50 days~~ notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting

Action: The Bylaws were updated.

Resolution 17 Unanimous Consent Agenda – Council Standing Rules Amendment

RESOLVED, That the Council Standing Rules, “Unanimous Consent Agenda” section, be amended to read as follows with the proviso that the changes will become effective after the 2020 Council meeting:

Unanimous Consent Agenda

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

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

All resolutions assigned to a Reference Committee, except for Bylaws resolutions, ~~and resolutions that require substantive amendments~~ shall **not** be placed on a Unanimous Consent Agenda.

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

Action: The Council Standing Rules were updated.

Resolution 18 ACEP Membership and Leadership (as amended)

RESOLVED, That ACEP will study and create a plan for improving racial/ethnic, gender, and other forms of diversity of its members, committee members, councillors, Council Officers, and Board of Directors; and be it further

RESOLVED, That ACEP collect and publish demographic data about its members, Council, and leaders and encourage community and academic emergency medicine groups alike to publish demographic data about its members and, likewise, to create a plan for improving racial/ethnic, gender, and other forms of diversity among its members; and be it further

RESOLVED, That ACEP create an annual diversity report to be presented to Council for the next 5 years.

Action: ACEP's diversity, equity, and inclusion efforts are headed by the Diversity, Equity, and Inclusion Committee, the Diversity, Equity, Inclusion Section, the Board of Directors, staff liaisons, and supported by others across the organization to ensure that diversity, equity, and inclusion is in the strategic plan and the internal and external work of the College and to develop a plan with the ultimate goal of developing and disseminating measurable benchmarks.

ACEP is committed to increasing the diversity of members in all leadership positions in the Council, the national Board of Directors, committees, sections, and chapters. As directed by Resolution 14(18), ACEP regularly reminds its chapters and sections about the value and importance of appointing and mentor councillors and alternate councillors that represent the diversity of their membership. It is equally important for residents, young physicians, and others who represent a minority of members of the College, to become active in their chapters and sections, seek appointment or election as a councillor or alternate councillor within their chapter or section, and to apply for and be selected to serve on national ACEP committees.

A series of reports about the diversity of ACEP's membership is provided in the Council meeting materials as directed by Amended Resolution 12(19) ACEP Composition Annual Report. The report includes demographics of councillors and alternate councillors by chapter, ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment. The data is limited to the extent that members provide this information in their membership profile. Fewer than two-thirds of ACEP members have provided race and ethnicity data on their membership record, with more complete records skewed to members who joined more recently. We will make this data public when we are confident about its accuracy and completeness.

ACEP supported the Society for Academic Emergency Medicine's May 2022 Consensus Conference: [Diversity, Equity and Inclusion: Developing a Research Agenda for Addressing Racism in Emergency Medicine](#). The stated purpose of this meeting is the development of a consensus-driven research agenda, research collaboration network, and dissemination plan for evidence-based practices related to the care of health disparity populations in emergency care settings. The themes of the conference have been informed by national experts both within and outside our specialty and include: Education and Training; Leadership; Research, and Social Determinants of Health. The specific objectives are to: 1) Identify best practices, clarify knowledge gaps and prioritize research questions; 2) Bring together key stakeholders with varied backgrounds to develop collaborative research networks; and 3) Disseminate findings of the consensus conference through peer-reviewed publications, national meetings, policy briefs, and other venues." As a follow-up to the meeting, an All Emergency Medicine Organizations Task Force on Diversity, Equity and Inclusion (DEI) was established by SAEM, with representatives from AACEM, AAEM, AAEM/RSA, ABEM, ACEP, ACOEP, CORD, EMRA, and RAMS. The task force assisted in the development the [All EM DEI Vision Statement](#) that was created and approved by the Board of Directors from each organization.

ACEP's Diversity, Equity, & Inclusion Committee was appointed in July 2022 and has been assigned objectives to address health equity and advocacy, data collection and monitoring, organizational accountability, and education as well as a specific objective to address this resolution. One early accomplishment of the committee was to develop a standard set of demographic questions and categories that are now being collected across multiple channels at ACEP and saved into ACEP member records. The responses to the demographic questions are confidential and include a "choose not to answer" response option so that these data fields can be made mandatory. This data will only be used for reporting in aggregate form and will facilitate the kind of reporting called for in this resolution.

Resolution 19 Framework to Assess the Work of the College Through the Lens of Health Equity (as amended)

RESOLVED, That ACEP 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 be it further

RESOLVED, That ACEP provide to members a biennial assessment of the work of the College as it pertains to health equity.

Action: ACEP's efforts in support of health equity are headed by the Diversity, Equity, and Inclusion Committee, the Diversity, Equity, Inclusion Section, Board of Directors, staff liaisons, and supported by others across the organization. An objective of the committee will be to develop a plan to ensure that diversity, equity, and inclusion is in the strategic plan and the internal and external work of the College as well as develop guiding principles that can be used when creating any new products, education, resources, etc.

ACEP is committed to playing a defining role in addressing health care equity in emergency medicine and in promoting and facilitating diversity and inclusion and cultural sensitivity within emergency medicine. Fourteen of ACEP's

30 committees were assigned objectives in the 2020-21 committee year related to health care disparities/health equity. At the direction of the ACEP President, those committee chairs convened to identify lessons learned from the COVID-19 pandemic regarding health disparities and possible solutions to improve health equity for future public health crises. A report of this work is being developed and is expected to be disseminated in 2022.

ACEP's Legislative & Regulatory Priorities for the First and Second Sessions of the 117th Congress and the First Session of the 118th Congress have included "promote legislative options and solutions to identify and eliminate health disparities, address structural racism, and improve health equity in the health care system. In October 2020, ACEP responded to a request for information (RFI) from the House of Representatives Committee on Ways and Means Chairman Richard Neal regarding racial health inequities and specific questions about the misuse of race and ethnicity in clinical decision support (CDS) tools and algorithms. ACEP's response included specific efforts and initiatives the College has undertaken to reduce disparities and improve outcomes for communities of color, including efforts to reduce unconscious or implicit bias in the delivery of emergency care. It also detailed disparities resulting from or exacerbated by COVID-19 that were identified in the ACEP COVID-19 Field Guide. Additionally, the letter addressed questions about the use of race and ethnicity in CDS tools and clinical algorithms and how this was an ongoing topic of discussion and study not just within emergency medicine, but also the broader field of medicine.

In March 2021, ACEP submitted a response to the Senate Health, Education, Labor, and Pensions (HELP) Committee hearing on COVID-19-related health disparities, detailing issues identified in the emergency department and strategies for prevention, screening, and mitigation.

In July 2021, ACEP held a congressional panel discussion during the 2021 Leadership and Advocacy Conference (LAC), entitled "Breaking Down Barriers: Improving Health Equity Through the Emergency Department." The panel featured congressional staff that ACEP has worked with on health equity issues to provide insight on how emergency physicians can engage with legislators on these topics.

ACEP supported the Society for Academic Emergency Medicine's May 2022 Consensus Conference: [Diversity, Equity and Inclusion: Developing a Research Agenda for Addressing Racism in Emergency Medicine](#). The stated purpose of this meeting is the development of a consensus-driven research agenda, research collaboration network, and dissemination plan for evidence-based practices related to the care of health disparity populations in emergency care settings. The themes of the conference have been informed by national experts both within and outside our specialty and include: Education and Training; Leadership; Research, and Social Determinants of Health. The specific objectives are to: 1) Identify best practices, clarify knowledge gaps and prioritize research questions; 2) Bring together key stakeholders with varied backgrounds to develop collaborative research networks; and 3) Disseminate findings of the consensus conference through peer-reviewed publications, national meetings, policy briefs, and other venues." As a follow-up to the meeting, an All Emergency Medicine Organizations Task Force on Diversity, Equity and Inclusion (DEI) was established by SAEM, with representatives from AACEM, AAEM, AAEM/RSA, ABEM, ACEP, ACOEP, CORD, EMRA, and RAMS. The Task Force assisted in the development the [All EM DEI Vision Statement](#) that was created and approved by the Board of Directors from each organization.

ACEP's Diversity, Equity, & Inclusion Committee was appointed in July 2022 and has been assigned objectives to address health equity and advocacy, data collection and monitoring, organizational accountability, and education as well as a specific objective to address this resolution.

Resolution 20 ACEP Award for Excellence in Innovations in the ED Care of Patients with Behavioral Health and Substance Use Disorder (as amended)

RESOLVED, That ACEP will honor emergency physicians with this annual award who have led the way in improving the care of patients with behavioral health and substance use disorder.

Action: The award eligibility and criteria was developed and approved by the Board of Directors in October 2021. A formal call for award nominations was included in the 2022 awards cycle. A recommendation for the first award recipient was approved by the Board at their April 2022 meeting.

Resolution 21 Medical Society Consortium on Climate & Health

RESOLVED, That ACEP become an official member of the Medical Society Consortium on Climate & Health; and be it further

RESOLVED, That ACEP support one ACEP member representative by paying registration and travel expenses to attend the Medical Society Consortium on Climate & Health annual meeting starting in 2021.

Action: The Consortium was notified of ACEP's decision to join the organization as a Member Society. The liaison representative was approved by the president and participated in the May 2021 annual meeting that was held virtually. ACEP's liaison representative also serves on the Consortium's Steering Committee. Funds for the liaison representative to attend future annual meetings are included in the annual budget.

Resolution 22 State Media Training for Emergency Physicians

RESOLVED, That ACEP develop a dedicated media training course for emergency physicians to respond to requests from state or local media outlets via ACEP constituent chapters and sections with an emphasis on specific talking points pertinent to the key issues affecting those physicians at that level; and be it further

RESOLVED, That ACEP develop a media training course specifically focused on effective, unbiased, fact-based social media delivery; and be it further

RESOLVED, That ACEP partner with state chapters and sections to effectively market a media training course for chapter and section leaders and encourage that chapter and section officers are offered the opportunity to enroll in such training in conjunction with ACEP *Scientific Assembly* or other ACEP meetings.

Action: ACEP developed the Communication Master Course “[PR for the ER](#),” an enduring online set of training videos designed to provide members with the fundamentals of effective communications. This course supplements other resources offered on the [ACEP Spokespersons’ Network webpage](#). ACEP continues to promote and offer the course to chapters and additional licenses were secured to ensure that all chapters can participate in the virtual training.

ACEP will launch a new national scope of practice campaign in correlation with National Doctors Day on March 30. In addition to the results of a national opinion poll on scope of practice issues, ACEP will release 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.

Resolution 24 911 Awareness and Policy (as amended)

RESOLVED, That ACEP promote awareness that healthcare professionals are increasingly accessing 911 on behalf of patients who cannot call 911 themselves, will not call 911 themselves, or have inadequate communication when speaking to 911 dispatchers themselves; and be it further

RESOLVED, That ACEP promote awareness that medical directors of Public Safety Access Points and EMS may need to build policies to take into strong consideration the patients’ medical information and patients’ medical needs provided by the treating doctor who activates the 911 emergency on behalf of a patient; and be it further

RESOLVED, That ACEP work with relevant stakeholders to facilitate the process of emergency medical dispatcher processing of calls originated by medical professionals – especially by those utilizing telehealth technologies.

Action: The EMS Committee identified resources in collaboration with other EMS organizations to address 9-1-1 call centers who receive calls from someone other than the patient. The resources were shared on the EMS Section engagedED site and on the section’s web page. ACEP’s policy statement “[Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch, and Public Emergency Aid Training](#)” addresses EMS-related public safety answering points.

Resolution 25 Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement & Optimal Patient Coverage

RESOLVED, That ACEP create a task force and commission an independent study on the extraordinary financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and withholding appropriate reimbursement against emergency physicians; and be it further

RESOLVED, That ACEP engage an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care; and be it further

RESOLVED, That ACEP advocate for higher standards and additional scrutiny of health insurer spending, including the Medical Loss Ratio (MLR) standards, to ensure more resources are dedicated to the patient health services and not diverted for other business pursuits without clear benefit to their patient population; and be it further

RESOLVED, That ACEP work with other similarly affected professional organizations, consumer advocacy groups, and the American Medical Association (AMA) to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

Action: A task force was appointed to develop an RFP for commission of a study. The Board of Directors approved the RFP in June 2021. Only one response to the RFP was received and it was reviewed by the Board at their October 28, 2021, meeting. The Board discussed their concerns that only one response was received and the optics of awarding a contract based on the singular response. The Board agreed to seek input from the Emergency Medicine Policy Institute regarding ways to address the resolution. The Emergency Medicine Policy Institute (EMPI) continues to explore ways to study the questions contained in this resolution.

Discussions began in February 2022 regarding possible collaboration related to the specialty specific impact of the *No Surprises Act* driving reimbursement determined by payers using an All Payers Claim Database (APCD). A proposal was developed to review retrospective national claims and analyze median commercial rates for emergency medicine, radiology, and anesthesiology to see if the qualified payment amounts (QPA) match what is expected for fair payment rates.

ACEP will continue advocacy efforts to address the adverse impact of health care insurers on emergency medicine reimbursement and its effect on patients.

Resolution 26 Addressing Systemic Racism as a Public Health Crisis (as amended)

RESOLVED, That ACEP reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism as it pertains to emergency care; and be it further

RESOLVED, That ACEP continue to explore models of health care that would make equitable health care accessible to all; and be it further

RESOLVED, That ACEP continue to use its voice as an organization and support its members who seek to 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.

Action: ACEP is committed to playing a defining role in addressing health care equity in emergency medicine and in promoting and facilitating diversity and inclusion and cultural sensitivity within emergency medicine. Fourteen of ACEP's 30 committees were assigned objectives in the 2020-21 committee year related to health care disparities/health equity. ACEP's Legislative & Regulatory Priorities for the First and Second Sessions of the 117th Congress included "promote legislative options and solutions to identify and eliminate health disparities, address structural racism, and improve health equity in the health care system."

The Public Health & Injury Prevention Committee was assigned an objective to "compile and disseminate information on health care disparities and strategies to address the disparities related to systemic racism and social determinants of health." The committee was also assigned to work with the Diversity, Equity, & Inclusion Section to obtain their input on ways to address the resolution. A subcommittee developed an article titled "Addressing Bias, Racism, and Disparities in the Emergency Department" and it was submitted to *ACEP Now*. The committee also developed an article titled "Impact of Perceived Race on Public Health" that was also submitted to *ACEP Now*.

ACEP Advocacy & Practice Affairs staff have established and maintained several lines of communication with congressional leaders on efforts to address health disparities, systemic racism, and social determinants of health. This includes direct conversations with House Ways & Means Committee Chairman Richard Neal's staff regarding the committee's efforts to address racial equity and specific efforts related to emergency medicine and ACEP priorities, as well as meetings with the three leaders of the Ways & Means Committee's Racial Equity Initiative to share ACEP's advocacy priorities and efforts. ACEP also submitted a response to the Senate Health, Education, Labor, and Pensions (HELP) Committee hearing on COVID-19-related health disparities on March 25, 2021, detailing issues identified in the emergency department and strategies for prevention, screening, and mitigation. Additionally, ACEP held a congressional panel discussion during LAC21, "Breaking Down Barriers: Improving Health Equity Through the Emergency Department," featuring congressional staff that ACEP has worked with on health equity issues to provide insight on how emergency physicians can engage with legislators on these topics. In 2022, ACEP also highlighted the issue of equity gaps and longstanding disparities in health care in a letter to the House Ways & Means Committee, asking the Committee to examine the COVID-19's disproportionate impact on racial and ethnic minorities, especially among children, that has been exacerbated by systemic inequalities. And in response to the Senate Health, Education, Labor, and Pensions (HELP) Committee's "PREVENT Pandemics" draft legislation issued, ACEP noted support for the Committee's efforts to develop and support robust tracking of granular demographic data related to COVID-19 to better understand the impact on racial and ethnic minority groups and other historically underserved populations, and encouraged the committee to ensure that medical professional organizations such as ACEP would be eligible for the grants created under this bill.

ACEP has repeatedly addressed the importance of addressing social determinants of health in our responses to various Medicare and Medicaid regulations and request for information. In these responses, ACEP educated regulators about the role emergency physicians play in identifying and screening for social risk factors, as well as some of the tools being used in the ED to help identify barriers to health that continue to impact disenfranchised communities and perpetuate health-related disparities.

Resolution 27 Attributing the Unqualified Term "Resident" to Physicians (as amended) – last 3 resolveds

RESOLVED, That ACEP recognize the valuable contribution of NPs and PAs within a physician-led team in the emergency department and that any development of NP/PA post-graduate training programs must be done with approval of the emergency department leadership; and be it further

RESOLVED, That ACEP work with relevant stakeholders to clarify non-physician post-graduate title terminology, and advocate for alternative terminology replacing the terms "resident" and "residency" and "fellow" and "fellowship" in conjunction with, but not limited to, nurse practitioners (NP) and physician assistants (PA) as their training is not equivalent to the training undertaken by physicians in an ACGME accredited emergency medicine residency and fellowship programs; and be it further

RESOLVED, That ACEP create a "Definition of Emergency Medicine Residency" policy statement.

Action: The first resolved was addressed by the previously convened multi-organization Emergency PA/NP Utilization Task Force. A report from the task force was completed in June 2020. ACEP’s policy statement “[Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department](#)” also addresses this issue.

A [resolution](#) was submitted for the AMA’s Interim Meeting in November 2020 by the Resident and Fellows Section. ACEP’s resident representatives in the Resident and Fellow Section (RFS) were among the authors of the resolution. However, because of the AMA’s strict rules for that meeting that only allowed consideration of resolutions of an urgent and high priority nature, the resolution was not approved by the committee set up to screen every resolution for submission to the House of Delegates. The resolution was resubmitted by the RFS for the June 2021 AMA Annual Meeting and was adopted in part. Specifically, the first 5 resolves of AMA Resolution 305. [Non-Physician Post-Graduate Medical Training](#), introduced by Resident and Fellow Section, were adopted and the final two resolves were referred.

The Academic Affairs Committee developed the policy statement “[Definition of Emergency Medicine Residency](#)” and it was approved by the Board of Directors in June 2021.

Resolution 29 Billing and Collections Transparency in Emergency Medicine (as amended) – first two resolves

RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Contractual Relationships” through deletion and substitution as follows: “The emergency physician is entitled to detailed itemized reports on what is billed and collected for his or her service on a semi-annual basis regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law. The emergency physician shall not be asked to waive access to this information.”; and be it further

RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Rights and Responsibilities” through deletion and substitution as follows: “5. Emergency physicians are entitled to detailed itemized reports of billings and collections in their name on a semi-annual basis and have the right to audit such billings at any time, without retribution. The emergency physician shall not be asked to waive access to this information.”

Action: The Emergency Medicine Practice Committee revised the policy statements “[Emergency Physician Contractual Relationships](#)” and “[Emergency Physician Rights and Responsibilities](#)” and they were approved by the Board of Directors in April 2021. The revised policy statements include the revisions directed in the resolution.

Resolution 30 Protection and Transparency (as amended)

RESOLVED, That ACEP establish policy that encourages all employers, persons or entities who contract for emergency physician services to provide information on a semi-annual basis to non-federal physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or Contract Management Group (CMG) as a result of the physician providing his or her services without any requirement of the physician requesting it.

Action: : The Emergency Medicine Practice Committee revised the policy statements “[Emergency Physician Contractual Relationships](#)” and “[Emergency Physician Rights and Responsibilities](#)” and they were approved by the Board of Directors in April 2021. The revised policy statements reflect the intent of the resolution.

Resolution 31 Insurer Accountability/Policy Weakness Disclosure (as amended)

RESOLVED, That ACEP establish policy advocating for legislation requiring health insurers to provide written disclosures to potential customers explaining the policy and potential shortfalls where customers would be financially responsible, before they could receive any benefit and at the time of sale of any healthcare policy; and be it further

RESOLVED, That ACEP support legislation imposing penalties on insurers who do not provide written disclosures explaining the policy and potential shortfalls where customers would be financially responsible to policyholders as required, i.e., before they purchase the policy that include requiring the insurer to cover 100% of all charges without deductible, co-pay, exclusions, etc.

Action: The resolution was assigned to the Federal Government Affairs Committee. Insurer transparency is a key component of ACEP’s advocacy on congressional efforts to address out-of-network billing issues. Communications with stakeholders urged inclusion of these provisions and they were secured into law under the *No Surprises Act* that ensured patients’ financial responsibility will be no more than their in-network deductible and cost sharing whether in- or out-of-network, as well as requiring that policyholders’ insurance cards include information on their deductibles and out-of-pocket maximums to provide a better understanding of the extent/limits of their coverage. Patients must also be supplied with meaningful and simple explanations regarding their coverage for emergency care guaranteed under federal law.

Unfortunately, the Biden Administration is significantly behind in implementing the regulations for several major insurer transparency provisions from the *No Surprises Act*. These include:

- Plan obligations related to delivery of patient advanced EOBs
- Plan obligations related to accuracy of network directories.
- Plan obligations related to plan/insurance identification cards.

ACEP continues to advocate to the Administration to strongly urge them to implement these important

requirements. ACEP also supported legislation, the “Improving Seniors’ Timely Access to Care Act” (H.R. 3173) that passed the House of Representatives on September 14, 2022. This bill improves and streamlines the burdensome “prior authorization” process that some Medicare Advantage plans use to inappropriately delay or deny care. It also requires plans to annually publish specified prior authorization information, including percentage of requests approved and average response time, and to provide each beneficiary with access to the criteria used by the plan for making such determinations (unless it would disclose proprietary information), as well as establishing other beneficiary protection standards.

Resolution 34 Public/School Bleeding Control Kit Access and Training

RESOLVED, That ACEP support access to bleeding control kits in all schools and public venues nationwide akin to the automated external defibrillators (AED) access programs; and be it further

RESOLVED, That ACEP support the expansion of bleeding control training in schools and communities to support educated use of these kits in the event of an emergency until help arrives.

Action: The resolution was assigned to the EMS & Disaster Preparedness staff to continue efforts to expand the Until Help Arrives training program in schools and public venues. The Until Help Arrives program was on hold during the COVID-19 pandemic because of the in-person nature of the training. The program is promoted by the Disaster Medicine Section on their [website](#) as well as the EMS-Prehospital Care Section [website](#).

Starting in late spring 2022, ACEP began collaborating with the American Red Cross to update and expand the course to include treatment of opioid overdose and Naloxone use. The American Red Cross is taking the lead on updating the course (with ACEP providing medical content review), administration, and distribution of the course through online availability only.

Resolution 35 Supporting the Development of a Seamless Healthcare Delivery System to Include Prehospital Care

RESOLVED, That ACEP take a leadership role to ensure the inclusion of prehospital care (e.g., emergency medical services) as a seamless component of health care delivery rather than merely a transport mechanism; and be it further

RESOLVED, That ACEP advocate for bidirectional data integration between hospitals and EMS; and be it further

RESOLVED, That ACEP advocate for appropriate payment of EMS services to include all clinical services separate from transport; and be it further

RESOLVED, That ACEP advocate for the development of a payment structure for EMS medical direction and oversight including physician field response; and be it further

RESOLVED, That ACEP advocate for additional support to the National Highway Traffic Safety Administration Office of EMS to allow for further federal leadership of EMS systems development and evolution and expansion of the National EMS Information System; and be it further

RESOLVED, That ACEP collaborate with other stakeholder organizations to promote legislation that will allow for the integration of reimbursed prehospital care into a seamless patient-centered system of healthcare delivery.

Action: The resolution was assigned to the Advocacy & Practice Affairs staff for federal advocacy initiatives and to Chapter & State Relations staff for state advocacy initiatives.

ACEP’s Legislative & Regulatory Priorities for the First and Second Sessions of the 117th Congress and the First Session of the 118th Congress have included “support legislative efforts to improve pre-hospital services and oversight, especially medical direction of EMS and community paramedicine” and “maintain/establish federal funding levels for the National EMS Information System (NEMIS).” This continues to be a priority for the First Session of the 118th Congress.

ACEP has been working in conjunction with the National Association of EMS Physicians (NAEMSP) to develop legislation that would improve quality and accountability in EMS, as well as provide reimbursement for both off-line and on-line EMS medical direction. The “Assuring Quality and Accountability of EMS Care” legislation has been drafted and ACEP is working to identify congressional sponsors to introduce the legislation. ACEP sought support from other organizations representing EMS interests, such as the fire chiefs, firefighters, EMTs, and ambulance transport during the drafting phase, however, these groups expressed significant opposition to the proposal, which will make advancing the legislation through Congress more difficult.

ACEP tracks and report to chapters legislation related to EMS service and staff have been involved in meetings to promote the development of the new mental health crisis 988 lines. ACEP is also working with other stakeholder organizations as significant legislation is proposed in many states.

ACEP has worked with the Centers for Medicare & Medicaid Services (CMS) around the implementation of the [Emergency Triage, Treat, and Transport \(ET3\) payment model](#). As background, the ET3 model is a voluntary payment model that allows Medicare to pay ambulance providers for taking beneficiaries to alternative destinations beyond the emergency department (such as urgent care centers and primary care clinics). It also would reimburse for treatments provided in place by a qualified health care practitioner (physician, NP, or PA) either in-person on the scene of the 911 emergency response or via telehealth. In June 2019, ACEP met with CMS to discuss the model in detail. ACEP expressed strongly that the ET3 payment model must include appropriate patient safeguards, specifically oversight of all triage,

treatment, transport, and destination decisions by involved EMS medical director physicians. ACEP outlined some concerns about the model to CMS and expressed its commitment to work with CMS going forward to ensure that ambulance providers participating in the model have sufficient patient safety safeguards included in their protocols.

ACEP also included comments in response to the Senate Health, Education, Labor, and Pensions (HELP) Committee's draft of the "PREVENT Pandemics Act," noting the need for a broader and more coordinated national trauma system, the "National Trauma and Emergency Preparedness System" (NTEPS) model built upon a framework of Regional Medical Operations Coordination Centers (RMOCCs) (a framework supported by ACEP in concert with the American College of Surgeons). Among the numerous functions of this framework are efforts to integrate all levels of health care leadership from regional health systems and hospitals into emergency operations centers and operational plans; provide real-time situational awareness of capabilities and capacity including data collection, analysis, and dissemination (i.e., hospital and EMS capacity data), and other functions that ensure EMS is incorporated into this integrated model.

ACEP will continue advocacy efforts to ensure the inclusion of EMS is vital component of health care delivery.

Resolution 38 Universal Access to Telehealth Care

RESOLVED, That ACEP, in collaboration with other medical organizations, advocate for universal access to telehealth care through expanded broadband infrastructure and wireless connectivity to all rural and underserved areas of the United States as well as supporting innovative strategies to improve individual access to broadband and cellular technology.

Action: ACEP has and continues to advocate for expanded telehealth access, including increased broadband infrastructure for rural and underserved communities. Previously, ACEP's comments on this specific issue were directly quoted in the House Ways & Means Committee's Rural and Underserved Communities Task Force [report](#) issued in July 2020, and ACEP continues to advocate on this point. In the First Session of the 117th Congress, ACEP again helped draft and endorsed the "Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021," which in addition to several emergency-medicine specific provisions, included provisions aimed at expanding telehealth use in rural and underserved communities. The Infrastructure Investment and Jobs Act (P.L. 117-58) passed in November 2021 provided \$65 billion to increase broadband deployment and provide internet subsidies for low-income families. ACEP is also working on bipartisan emergency medicine-specific telehealth legislation and supports legislation that would extend the Medicare waivers of the geographic and originating site restrictions for a full two years once the COVID-19 public health emergency (PHE) ends. ACEP joined 374 other organizations in [a letter](#) to Senate leadership calling for such an extension. ACEP continues to work with numerous other physician specialties to encourage Congress to make these telehealth expansions permanent and fully integrate telehealth into the U.S. health care system.

Resolution 41 Personal Protection Equipment (as amended)

RESOLVED, That ACEP work with relevant stakeholder organizations to establish appropriate minimum standards and regulations applicable to hospitals for the readily accessible storage of appropriate levels of personal protections equipment for all workers at the facility, and to strengthen penalties for violation for such regulations; and be it further

RESOLVED, That ACEP work with relevant stakeholders to establish or strengthen whistleblower protections who in good faith report deficiencies in the quantity or quality of personal protective equipment (PPE) made available to them for the purposes of caring for patients; and be it further

RESOLVED, That ACEP establish a new policy supporting emergency physicians and other emergency workers providing their own personal protection equipment without any penalty of any kind if adequate and sufficient personal protection equipment to be used as intended by the manufacturer of the personal protection equipment is not provided.

Action: ACEP has worked with federal lawmakers and regulators throughout the COVID-19 pandemic to ensure prioritization of the production of medications and PPE and more effectively distributed to needed sites of care, with an emphasis on domestic production, and to secure \$10 billion in federal appropriations to carry out activities under the Defense Production Act, which was used for the manufacturing and procurement of PPE, drugs, diagnostic products, medical devices, and biological products. ACEP also advocated for increased transparency of the supply chain for these products to better identify and proactively address current and future potential shortages. ACEP worked with the Congress and the Biden Administration to review the country's response to the pandemic, promote additional policy changes to prevent PPE shortfalls in the future, and develop legislative proposals to better prepare the country for another man-made or natural disaster. Additionally, ACEP worked with federal lawmakers to advance legislation that would provide due process protections for all emergency physicians, regardless of their practice arrangement.

The Supply Chain Task Force developed a report with recommendations that addressed PPE supply.

In February 2021, ACEP participated in a meeting of health care industry leaders hosted by OSHA on how to best strengthen COVID-19 workplace protections. During the meeting, ACEP again strongly advocated for emergency physicians' rights to be supplied effective PPE by their hospital, to wear their own PPE if they prefer, and to have access to peer support and mental health treatment without fear of professional reprisal.

The Emergency Medicine Practice Committee worked with the Medical-Legal Committee to review the current policy statements and determine if revisions were needed or whether a new policy statement should be developed to specifically address whistleblower protection. After discussion with ACEP's General Counsel, proposed revisions to the current policy statement "Safer Working Conditions for Emergency Department Staff" were developed to address the third resolved of the resolution. The Board discussed the revised policy statement their October 22, 2021, meeting, and referred it back to the committee for further revisions to address whistleblower protections for emergency physicians who raise concerns regarding patient safety/clinical issues, the safe environment of the emergency department, and the responsibility of the hospital to provide/allow appropriate PPE. The committee submitted an updated revised policy statement to the Board of Directors for consideration at their October 6, 2023, meeting.

ACEP has also taken numerous actions to advocate for emergency physicians' right to wear their own PPE or be able to report safety concerns without fear of reprisal. In March 2020, ACEP started collecting stories of emergency physicians being restricted by their hospital from wearing PPE or even being punished for doing so (whether the PPE was supplied by the hospital or personally obtained). ACEP relayed these examples directly to The Joint Commission (TJC) and the Occupational Safety and Health Administration (OSHA). ACEP staff met with TJC the same month to convey our concerns about this issue. Right after our meeting, TJC issued a statement supporting physicians' right to bring their own standard face masks or respirators to wear at work when their healthcare organizations cannot routinely provide access to PPE.

In April 2022, ACEP submitted a [letter](#) responding to OSHA's Emergency Temporary Standard (ETS), "Occupational Exposure to COVID-19." OSHA is in the process of developing a final safety standard for COVID-19 and sought comments on specific topics and questions related to the ETS to help inform that process. ACEP's comments included allowing health care workers to wear the PPE they believe is needed to feel safe, including their own PPE.

Resolution 42 Addressing Ethical Challenges of the COVID-19 Pandemic for Emergency Physicians (as amended)

RESOLVED, That ACEP develop policy statements to address:

- 1) the implications of inadequate personal protective equipment for emergency physicians;
- 2) the care of patients under crisis treatment standards; and
- 3) the proportionality of responses by hospitals and practice organizations toward emergency physicians' compensation or benefits during times of pandemic illness or other similar events.

Action: Sixteen of ACEP's 30 committees were assigned objectives for the 2021-22 committee year to address COVID-19/future pandemics. The Ethics Committee developed the policy statement "[National Pandemic Readiness: Ethical Issues](#)" and it was approved by the Board of Directors in April 2021.

The Disaster Preparedness & Response Committee developed four policy statements in response to the resolution and three were approved by the Board of Directors at their October 22, 2021, meeting: "[Emergency Physician Involvement, Utilization, and Compensation During a Pandemic](#)," "[Role of Emergency Physicians in Disaster Preparedness and Response \(Impact of COVID Pandemic\)](#)," "[The Care of Patients Under Crisis Standards of Care](#)." The committee developed a draft policy statement "Protecting Emergency Physicians and Health Care providers from Inadequate Personal Protective Equipment" that was referred back to the committee regarding the utilization of personal protective equipment (PPE) and consider language that would allow emergency physicians to bring their own PPE if the baseline supplies did not meet their perceived risk standards. The draft policy statement will be resubmitted to the Board of Directors for review at their September 28, 2022, meeting.

The Disaster Preparedness & Response Committee developed the information paper "The Challenges of Providing Health Care in Rural Areas with a Focus on the Challenges Created by the COVID-19 Pandemic." The committee also worked with the Emergency Medicine Practice Committee to assess personal protective equipment based on five exposure potentials and information was posted on the ACEP website.

The Medical-Legal Committee reviewed liability issues for emergency physicians who speak out about or refuse to work due to insufficient PPE. The committee developed language for a "smart phrase" for emergency physicians to insert on charts indicating that care is being provided during a federal disaster declaration.

ACEP created multiple resources on the ACEP website regarding [COVID-19](#), including a [Field Guide](#) that has been widely used by members.

Resolution 43 Creating a Culture of Anti-Discrimination in our Emergency Departments and Healthcare Institutions (as amended)

RESOLVED, That ACEP promote transparency in institutional data to better identify disparities and biases in medical care; and be it further

RESOLVED, That ACEP continue to encourage training to combat discrimination for all clinicians; and be it further

RESOLVED, That ACEP continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees,

staff physicians, administration, and other stakeholders.

Action: The resolution was assigned to the Diversity, Inclusion, & Health Equity Section to work in collaboration with committees that have assigned objectives on this issue and provide recommendations to the Board to address this resolution.

ACEP is committed to playing a defining role in addressing health care equity in emergency medicine and in promoting and facilitating diversity and inclusion and cultural sensitivity within emergency medicine. Fourteen of ACEP's 30 committees were assigned objectives in the 2020-21 committee year related to health care disparities/health equity. ACEP's Legislative & Regulatory Priorities for the First and Second Sessions of the 117th Congress and the First Session of the 118th Congress have included "promote legislative options and solutions to identify and eliminate health disparities, address structural racism, and improve health equity in the health care system."

The Emergency Medicine Practice Committee revised the policy statements [Cultural Awareness and Emergency Care](#)" and "[Non-Discrimination and Harassment](#)" and they were approved by the Board in April 2021.

In July 2021, ACEP was selected to join the Council of Medical Specialty Societies and ACGME as part of [ACGME EquityMatters™](#). ACGME Equity Matters is a new initiative that introduces a framework for continuous learning and process improvement in the areas of diversity, equity, inclusion (DEI), and anti-racism practices. The initiative aims to drive change within graduate medical education (GME) by increasing physician workforce diversity and building safe and inclusive learning environments while promoting health equity by addressing racial disparities in health care and overall population health. ACEP representatives to this program include Mark Rosenberg DO MBA FACEP, ACEP President 2020-2021, Jenice Baker MD FACEP, New Jersey Chapter President 2021-2022, and ACEP Executive Director, Sue Sedory. The purpose of this initiative is to achieve health equity through increasing physician workforce diversity, and by creating clinical learning environments that are safe, inclusive, and equitable." ACEP's participation in the program continued through December 2022 and will culminate in a capstone project. ACEP will coordinate efforts from this initiative with those of the Diversity, Inclusion, & Health Equity Section and selected ACEP committees to address specific challenges for the College.

ACEP's Diversity, Equity, & Inclusion Committee was appointed in July 2022 and has been assigned objectives to address health equity and advocacy, data collection and monitoring, organizational accountability, and education. The committee will work with the Diversity, Inclusion, & Health Equity Section to develop recommendations to address this resolution.

ACEP is a participating member of the All Emergency Medicine Organizations Task Force on Diversity, Equity and Inclusion (DEI), established by SAEM, with representatives from AACEM, AAEM, AAEM/RSA, ABEM, ACEP, ACOEP, CORD, EMRA, and RAMS. The Task Force assisted in the development the [All EM DEI Vision Statement](#) that was created and approved by the Board of Directors from each organization.

Resolution 47 Honoring Employment Contracts for Graduating Emergency Medicine Residents (as amended)

RESOLVED, That ACEP partner with the Emergency Medicine Residents' Association to encourage all employers to honor their employment contracts with graduating emergency medicine resident and fellow physicians.

Action: The Emergency Medicine Practice Committee revised the policy statement "[Emergency Physician Contractual Relationships](#)" and it was approved by the Board of Directors in April 2021. The revised policy statement added a sentence to the bullet concerning the honoring of contractual agreements stating that this also applies to honoring contracts prior to the initiation of employment or in cases of deferred/delayed employment, such as that of a graduating resident.

Resolution 49 Strangulation Policy Statement and Educational Resources (as substituted in lieu of Resolution 28 and Resolution 49)

RESOLVED, That the American College of Emergency Physicians (ACEP) acknowledges the hazard associated with air-choke holds, strangulation and carotid restraint; and be it further

RESOLVED, That ACEP educate its members and relevant stakeholders on the hazards and the recognition and appropriate management of patients who present to the emergency department with injuries associated with air-choke holds, strangulation, and carotid restraint maneuvers in various settings.

Action: The resolution was assigned to the Public Health & Injury Prevention Committee. The committee led a workgroup of members of from ACEPs Forensic Medicine Section, Tactical Emergency Medicine Section, the Pediatric Emergency Medicine Committee, and the EMS Committee. The workgroup developed a policy statement and an information paper. The Board of Directors approved the policy statement "[Strangulation and Neck Compression](#)" and reviewed the information paper "[Considerations for the Management of Strangulation in the Emergency Department](#)" in October 2021. The information paper was published by *JACEP Open* in April 2022 and is also available on the ACEP website.

Resolution 50 Support for Expedited Partner Therapy (as amended)

RESOLVED, That ACEP develop a ~~clinical~~ policy supporting the use of expedited partner therapy; and be it further

RESOLVED, That ACEP develop model legislation that removes legal obstacles to expedited partner therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care professionals that choose to prescribe expedited partner therapy; and be it further

RESOLVED, That ACEP work with state and local health departments and key stakeholders to develop expedited partner therapy protocols.

Action: The Clinical Policies Committee reviewed the current literature and, based on the limited amount of existing quantitative data and the number of existing guidelines on this topic, the committee recommended to the Board that a clinical policy not be developed at this time and existing educational materials on the topic be further disseminated. The Board approved the committee's recommendation in June 2021. The Board adopted a motion to amend the resolution by deletion of the word "clinical" from the first resolved and assigned an objective to the Public Health & Injury Prevention Committee for the 2021-22 committee year to develop a policy statement. The Board's action to amend the resolution was accepted by the Steering Committee at their October 22, 2021, meeting. The Public Health & Injury Prevention Committee developed the policy statement "[Expedited Partner Therapy for Selected Sexually Transmitted Diseases](#)" and it was approved by the Board in April 2022. The committee also developed an [accompanying Policy Resource & Education Paper \(PREP\)](#) as an adjunct to the policy statement.

The resolution was also assigned to the State Legislative/ Regulatory Committee to assess the need for and develop, as appropriate, model state legislation and other resources for chapters to work with state and local health departments. Currently, 45 states allow expedited partner therapy and it is prohibited only in South Carolina. The committee developed model state legislation that was approved by the Board of Directors in June 2023 and it was distributed to chapters.

Resolution 51 Telehealth Disaster Pilot and Educational Resources

RESOLVED, That ACEP create new policy that promotes federal, state, and private funding for pilot projects and studies to help provide care, once a disaster is officially declared by a state or federal agency, entity or official, to disaster victims and rescue workers using telehealth and other technology as tools and to study the effectiveness of using telehealth as a vehicle for the evaluation and treatment of disaster victims and patients; and be it further

RESOLVED, That ACEP create new policy that encourages federal, state, and private funding to develop and implement telehealth and other technology educational programs and training of first responders and disaster workers to become more familiar with such tools to improve access, evaluation of, and the care delivered to victims of natural and man-made disasters.

Action: The resolution was assigned to the ED Telehealth Task Force. Members of the Disaster Preparedness & Response Committee participated in discussions with the task force. The task force objectives were divided into five key subject areas: 1) Care Models; 2) Quality; 3) Legislative, Regulatory, Policies; 4) Reimbursement; and 5) Education. The task force's final report was submitted to the Board of Directors in October 2021. The Board filed the report and assigned subgroups of the Board to review each of the recommendations contained in the report and provide their analysis to the Board. The subgroup reports were reviewed by the Board at their January 2022 meeting. The Board approved supporting the majority of the recommendations, revised two of the recommendations, and referred the Reimbursement recommendations to the Reimbursement Committee and the Coding & Nomenclature Advisory Committee to provide further analysis and submit their recommendations to the Board on appropriate advocacy action regarding telehealth reimbursement. The Board reviewed the reimbursement recommendations in June 2022 and approved supporting 11 of the 14 reimbursement strategies.

The Telehealth Task Force also developed the draft policy statement "Disaster Telehealth." The Board referred the policy statement to the Disaster Preparedness & Response Committee to review and provide a recommendation to the Board.

Resolution 53 In Memory of Lindsey J. Myers, MD

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician Lindsey Jo Myers, MD and extends condolences and gratitude to her family and friends for her service to the specialty of emergency medicine and to patient care.

Action: A framed resolution was sent to the family of Dr. Myers.

Resolution 54 In Memory of Herbert Arnold ("Arn") Muller, MD, FACEP

RESOLVED, That the American College of Emergency Physicians cherishes the memory and expresses its appreciation for the professional accomplishments and personal influence of “Arn,” a consummate gentleman and emergency medicine pioneer, and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Anne, daughters Janice and Sarah, and sons Carl “Gus,” Peter, and Paul, and the extended Muller family gratitude for his tremendous service to public health and to the specialty of emergency medicine as one of its founding fathers.

Action: A framed resolution was sent to the family of Dr. Muller.

Resolution 55 In Memory of J. Ward Donovan, MD, FACEP, FACMT

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of J. Ward Donovan, MD, FACEP, FACMT, who dedicated himself to his patients, to his profession, and to his family, and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Joan, daughter Erin, son-in-law, Greg, and grandchildren, Seamus and Aoife, and to the extended Donovan family gratitude for his tremendous service to the specialty of emergency medicine and to his leadership, vision, and commitment in the development of emergency medicine and medical toxicology.

Action: A framed resolution was sent to the family of Dr. Donovan.

Resolution 56 In Memory of Craig Manifold, DO, FACEP, FAAEM, FAEMS

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the magnanimous life of Craig Manifold, DO, FACEP, FAAEM, FAEMS, on the State of Texas, the Texas College of Emergency Physicians, and the Government Services Chapter of ACEP; and be it further

RESOLVED, That the aforementioned groups acknowledge the substantial loss to the medical community and bereavement of his many colleagues and friends, but above all extend condolences to his beloved wife of 31 years, Denise L. Moore, and their precious children Hanna Moore Manifold Cappadonna, her husband, Barrett; Della Caroline Manifold-Stolle, and her husband, Steven; and his son, Caleb Andrew Manifold.

Action: A framed resolution was sent to the family of Dr. Manifold.

Resolution 57 In Memory of Douglas W. Lowery-North, MD, MSPH, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Douglas W. Lowery-North, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Douglas W. Lowery-North, MD FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of California, Georgia, Oregon, and the United States.

Action: A framed resolution was sent to the family of Dr. Lowery-North.

Resolution 58 In Memory of Debra Sanders. Hawaii Chapter Executive

RESOLVED, That the American College of Emergency Physicians and the Hawaii Chapter recognizes Debra Sanders for her Aloha and her outstanding contributions to the chapter.

Action: A framed resolution was sent to the family of Ms. Sanders.

Resolutions Referred to the Board of Directors

Resolution 27 Attributing the Unqualified Term “Resident” to Physicians (as amended) – first resolved

RESOLVED, That ACEP reaffirm the gold standard for emergency medicine training is, and must remain, the completion of an ACGME accredited emergency medicine residency training program and board certification by ABEM or ABOEM; and be it further

Action: ACEP’s policy statement “[Emergency Medicine Training, Competency, and Professional Practice Principles](#)”

specifies that it is the “role and responsibility of ABEM and AOBEM to set and approve the training standards” for emergency physicians. ACEP’s policy statement “[The Role of the Legacy Emergency Physician in the 21st Century](#)” emphasizes that “physicians who begin the practice of emergency medicine in the 21st century must have completed an accredited emergency medicine residency training program and be eligible for certification by ABEM or AOBEM.” ACEP’s policy statement “[Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department](#)” states “the gold standard for care in an ED is that performed or supervised by a board-certified/board eligible emergency physician.”

The Academic Affairs Committee developed the policy statement “[Definition of Emergency Medicine Residency](#)” and it was approved by the Board of Directors in June 2021.

Resolution 29 Billing and Collections Transparency in Emergency Medicine (as amended) – last three resolveds

RESOLVED, That ACEP adopt as policy that: “No member of ACEP will, directly or indirectly, deny another emergency physician the ability to receive detailed itemized billing and remittance information for medical services they provide.”; and be it further

RESOLVED, That ACEP petition the appropriate state or federal legislative and regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, will directly provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis; and be it further

RESOLVED, That ACEP adopt this policy: “Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with ACEP will as of January 1, 2021, provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed information on what has been billed and collected in the physician’s name. This information must be provided without the need for the physician to request it. Physicians cannot be asked to waive access to this information. The entities affected include but is not limited to revenue cycle management companies, physician groups, hospitals, and staffing companies.”

Action: In January 2021, the Board of Directors assigned the following to address the three referred resolveds and the overall intent of this resolution.

Regarding the first referred resolved, the Board directed the Emergency Medicine Practice Committee to review and provide a recommendation regarding further action on the referred resolved statements from this resolution.

Regarding the second referred resolved statement, the Board directed ACEP Advocacy & Practice Affairs staff to investigate possible legislative or collaborative approaches to address billing and collections transparency.

Regarding the third referred resolved, the Board also directed ACEP’s General Counsel to develop a legal position regarding the extent to which ACEP or other entities have the legal authority to enforce these policies, particularly as it pertains to taking punitive action against its members and/or customers.

Recognizing the importance and complexity of this issue for all ACEP members, Board leaders were actively involved throughout the year, talking to members, offering their time and resources to better understand and guide ACEP’s actions to fully address the intent of this referred resolution.

Related to the first referred resolved statement, the Emergency Medicine Practice Committee recommended and the Board approved numerous updates to two ACEP policies, “[Emergency Physician Rights and Responsibilities](#)” and “[Emergency Physician Contractual Relationships](#)” to include numerous changes specific to the approved resolved in resolution 29(20). Subsequently, an objective was assigned to the Medical-Legal Committee to provide a primer and explanation of unionization and collective bargaining to determine if there are additional options for emergency physicians to require groups to have detailed itemized billing and remittance information for medical services they provide.

Regarding the second referred resolved statement, ACEP’s Advocacy & Practice Affairs staff contacted both Majority and Minority congressional staff to discuss potential legislative or other approaches to address billing and collections transparency. Broadly, while there was some interest from congressional staff in the overarching concept of transparency, the most common concerns raised were questions about the role of the federal government in this matter and a reluctance about stepping into contract issues between two private entities. Several congressional staff members noted that federal pushes for increased transparency are typically motivated by the direct patient/consumer impact.

Additionally, Board members met with the original authors of the resolution to discuss the intent of the second resolved and to brainstorm options. There were questions about what federal mechanisms could be used for implementation and enforcement, with conditions of participation (COPs), labor law, and FTC. Several staff noted that this option could be further explored, but we should anticipate there will likely be substantial pushback from the hospital community.

Separate from these Congressional discussions, ACEP Advocacy & Practice Affairs staff and General Counsel investigated whether the False Claims Act (31 U.S.C. §§ 3729–3733), or FCA, could provide a lever for physicians to secure reporting of what has been billed and collected in their name. While the FCA provides mechanisms for penalty (including a private right of action for whistleblowers) if incorrect or fraudulent billing is suspected in Medicare, Medicaid, and other federal programs, there is no specific legal requirement around billing transparency under the law. The False Claims Act only applies when a person “knowingly presents, or causes to be presented, a false or fraudulent claim for

payment or approval” or “knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent”. Under the law, “knowingly” means that “a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information;” and “require no proof of specific intent to defraud.”

Subsequently, ACEP engaged outside counsel to advise on whether securing regular reporting of billing in a physician’s name could inadvertently subject that physician to potential liability under the False Claims Act, since provision of this information could now leave them considered to be “knowing.” ACEP developed a [primer](#) on the False Claims Act to help empower emergency physicians to better understand their rights under federal law and empowers them to gain access to Medicare billings made in their name. The primer is organized by employment type/payment arrangement.

Regarding the third referred resolved statement, ACEP’s General Counsel engaged Powers, Pyles, Sutter & Veille, P.C., a legal firm with specialized expertise in healthcare and representation of nonprofit organizations, as outside counsel to review the resolution and provide a third-party outside legal opinion on the anti-trust risk to ACEP to implement the referred resolution as written. It should be noted that this assignment occurred with a similar assignment for responding to Referred Amended Resolution 44(20). At its June 2021 meeting, outside counsel presented the Board of Directors with available case law and previous legal opinions shared on this matter. It was the recommendation of outside counsel that the findings of all four available legal opinions were consistent and clearly demonstrated that there was substantial risk to implementing the resolution as written. However, suggestions were made by general and outside counsel that meet the intent of the resolution. Specifically, ACEP could seek to obtain non-competitive information from all emergency physician-employing entities, including exhibitors, advertisers, and sponsors of ACEP meetings and products, with the intent to increase transparency and encourage all employers adhere to key ACEP policy statements related to employer best practices.

Following the Board presentation, the Board and staff developed an employer profile survey meant to serve as an accountability mechanism to increase pressure on all employer groups and set a higher bar of expectations for any entities employing emergency physicians, including exhibitors, advertisers, and sponsors of ACEP meetings and products, asking them to provide information about their organizations. The survey asked employers to provide details on group governance structure, billing practices, ownership model, size, funding, and more. It also included an attestation that the entities affirm their adherence to ACEP policy statements as they pertain to the emergency physicians in their group, including “Emergency Physician Rights and Responsibilities” and “Emergency Physician Contractual Relationships,” which specifically mention due process and transparency in billing. Several iterations of the draft questionnaire were discussed with ACEP members, including the original authors of the resolution.

The employer survey was distributed in September 2021, in advance of ACEP21. Each employer participating in ACEP’s annual conference was asked to complete the survey and made aware that their answers would be available to all ACEP members in an ongoing fashion. [An existing searchable employer database](#) was enhanced to accommodate the survey data and it remains available on the ACEP website, protected behind the member log in. For the initial launch, employer profiles were promoted at ACEP21 using QR codes in the onsite program for employer exhibitors, on meter boards, and on tabletop signs for each booth and Job Fair table. These codes allowed members to quickly access information about all employer groups. The information, or lack thereof, provided members the information on potential employers and their practices and transparency. If no data exists, an opportunity existing to request the employer provide it. Additionally, promotion of the survey responses was included in the ACEP21 mobile app and promotion also occurred via *EM Today*, *Weekend Review*, social media, [ACEP.org](#) and a From the College note in *ACEP Now*.

Following ACEP21, ACEP leaders met with several large staffing groups to ask that they complete the employer profile survey. The staff conducted outreach to employers throughout the year in pursuit of employer information that could be provided to members. Several email campaigns were conducted, and phone outreach took place during the spring of 2022 requesting employer groups provide the information and embrace ACEP policies regarding best practices. In August 2022, ACEP distributed the survey to employers attending ACEP22.

ACEP’s commitment to transparency and employer accountability will continue as this pilot program gains traction. ACEP will continue to push for greater transparency among employers and work to ensure members have the necessary tools to make informed decisions about their employment options.

As affirmed in ACEP’s strategic plan, the Board and leadership are dedicated to ensuring that ACEP fights for the rights of all emergency physicians across all landscapes and levels, supported by ACEP policy and advocacy efforts and as intended by this referred resolution.

Resolution 36 Telehealth (as substituted)

RESOLVED, That ACEP support legislation to ~~make the CMS waivers that were allowed during the COVID-19 declared emergency related to telehealth permanent, i.e.,~~ allow 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; and be it further,

RESOLVED, That ACEP support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer's network, or outside of insurer's network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; and be it further

~~RESOLVED, That ACEP support legislation requiring all payers to pay parity to physician and non-physician health providers for telehealth services as would be paid for in-person services for appropriate or equivalent care; and be it further~~

~~RESOLVED, That ACEP support penalties to insurers for intentional actions, rules or policy that limit, restrict, delay, deny or prevent access to necessary acute unscheduled care or services from the physician or non-physician provider of the patient's choice in an appropriate time period as determined by physicians in that region, or national determined standard or in the payment to the practitioner for the care or services provided.~~

RESOLVED, That ACEP advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; and be it further

RESOLVED, That ACEP, in collaboration with other medical organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and be it further

RESOLVED, That ACEP oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

Action: The resolution was assigned to the ED Telehealth Task Force. The task force was not instructed to focus solely on the referred resolves and instead developed numerous objectives divided into five key subject areas: 1) Care Models; 2) Quality; 3) Legislative, Regulatory, Policies; 4) Reimbursement; and 5) Education. The task force's final report was submitted to the Board of Directors in October 2021. The Board filed the report and assigned subgroups of the Board to review each of the recommendations contained in the report and provide their analysis to the Board. The subgroup reports were reviewed by the Board at their January 2022 meeting. The Board approved supporting the majority of the recommendations, revised two of the recommendations, and referred the Reimbursement recommendations to the Reimbursement Committee and the Coding & Nomenclature Advisory Committee to provide further analysis and submit their recommendations to the Board on appropriate advocacy action regarding telehealth reimbursement. The Board reviewed the reimbursement recommendations in June 2022 and approved supporting 11 of the 14 reimbursement strategies. The Board believes that the task force work satisfies the intent of this referred resolution.

Resolution 44 Due Process in Emergency Medicine (as amended)

RESOLVED, That ACEP adopt this policy; "No member of ACEP will, directly or indirectly, deny another emergency physician the right to due process regarding their medical staff privileges and ability to see patients in an emergency department. No member of ACEP will hold a management position with any entity that denies an emergency physician of this right.;" and be it further

RESOLVED, That ACEP modify the existing policy statement "Emergency Physician Rights and Responsibilities" through deletion and substitution as follows: "6. Emergency physicians ~~should be accorded~~ **are entitled to** due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges. Emergency physicians' medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law. 7. Emergency physicians who practice pursuant to an exclusive contract arrangement should not be required to waive their individual medical staff due process rights as a condition of practice opportunity or privileges.;" and be it further

RESOLVED, That ACEP adopt this policy: "Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with the ACEP will as of January 1, 2021 shall remove all restrictions on due process for emergency physicians. Physicians cannot be asked to waive this right as it can be detrimental to the quality and safety of patient care. The entities affected include but is not limited to physician groups, hospitals, and staffing companies."

Action: In January 2021, the Board directed the Emergency Medicine Practice Committee and the Medical-Legal Committee, with support from ACEP's General Counsel, to review and provide a recommendation regarding further action on the resolution. A suggestion was made to consider developing best practices and/or policy resources for contracts and employment rights, including due process. Further, the Board directed ACEP General Counsel to develop a legal opinion on the extent to which ACEP can enforce member, corporate support, or exhibit policies based on such employment rights criteria; it should be noted that this assignment occurred together with a similar assignment for responding to referred resolves in resolution 29(20).

Recognizing the importance and complexity of this issue for all ACEP members, Board leaders were actively involved throughout the year, talking to members, offering their time and resources to better understand and guide ACEP's actions to fully address the intent of this referred resolution. Members of the Board spoke with numerous individuals who had been fired, taken off the schedule, transferred to other sites, or otherwise impacted by terms of their contracts. It became clear that this was happening across all employment models and not just large corporate groups. It also became evident that even with due process protections with their employer, physicians were losing their hospital privileges and being taken off the schedule if the hospital CEO wanted them removed.

Specific to the second referred resolved statement, the policy statement "[Emergency Physician Rights and Responsibilities](#)" that was revised by the Emergency Medicine Practice Committee and approved by the Board of Directors in April 2021, included the revision as directed, replacing "should be accorded due process" with "are entitled to due process." The policy statement has an accompanying [Policy Resource and Education Paper \(PREP\)](#), which states in part: "The core issue behind language in emergency medicine contracts having to do with termination of the physician's ability to practice is that of due process. Due process refers to the right to have a fair hearing, including input from the affected physician, prior to any decision being made about termination of the ability to practice (specifically the loss of hospital medical staff privileges). The concept of due process is felt to support the independence of a physician in advocating for patients without undue influence from extrinsic forces and preserves the sanctity of the physician-patient relationship. These forces may include non-medical concerns, such as financial, marketing, or political interests."

ACEP leadership and staff developed contracting and [employment resources](#) on the ACEP website to assist members and [develop an accountability mechanism for increasing transparency](#) among members and entities that employ emergency physicians regarding adherence to ACEP policy statements. There are dozens of pages of resources on the ACEP website dedicated to the topics of Employment Contracts and other practice and legal issues, as well as a growing set of resources from ACEP's [Democratic Group Practice section](#). In an effort to better support all members as they face unprecedented challenges in hiring, ACEP staff embarked on a process to update, curate and develop educational and other assets into a complete set of resources designed to educate and empower physicians, at any point in their career, to more knowledgeably [evaluate contract terms](#) and pushback on unfair business practices, regardless of employment model or practice type. To supplement this, the Medical-Legal Committee developed a new contract resource, a checklist of "[Key Considerations in an Emergency Medicine Employment Contract](#)." The checklist is available on the EMRA website and the ACEP website in the [Medical-Legal Resources](#). Additionally, for just \$15 per year, all ACEP members currently have access to legal and financial support assistance through an affinity program with Mines & Associates, our wellness and counseling partner. This service includes a 30-minute in-person consultation for each individual legal matter, a 30-minute telephone consultation per financial matter, and 25% discount on select legal and financial services all with Mines & Associates network of legal and financial professionals. Under the category of Business Legal Services, this includes advice, consultation and representation regarding contracts, incorporation, partnerships, and other commercial activities.

For several years, ACEP has informed, helped draft, and advocated for legislation to support due process for emergency physicians. In fact, due process protections were one of ACEP's three key issues at the 2022 Leadership & Advocacy Conference (LAC) in Washington, DC, with advocates going to Capitol Hill to promote the concept and urge reintroduction of the revised "ER Hero and Patient Safety Act," legislation previously introduced in the 116th Congress by Representative (now Senator) Roger Marshall, MD (R-KS) and Raul Ruiz, MD (D-CA). Due process protections remain a key federal legislative priority for the College, and ACEP continues working with legislators in both the House and Senate to secure bipartisan sponsors prior to introduction of the bill for the current 117th Congress. Additionally, ACEP has urged the Senate Health, Education, Labor, and Pensions (HELP) Committee to include Sen. Marshall's due process legislation in the committee's mental health package, given the relationship of due process rights to emergency physician job satisfaction and stress and burnout, and continues working to identify any opportunities to include this provision in a larger legislative package.

As part of the recent workforce initiative, ACEP leadership has started meeting with the leadership of large employer groups to have open conversations about the state of the workforce and share feedback from our members. ACEP is sharing data on member perceptions of career satisfaction, which includes concerns about billing transparency, and encouraging groups to discuss these concerns with their physicians.

ACEP's General Counsel engaged Powers, Pyles, Sutter & Veville, P.C., a legal firm with specialized expertise in healthcare and representation of nonprofit organizations, as outside counsel to review the resolution and provide a third-party outside legal opinion on the anti-trust risk to ACEP to carry out the resolution as written. At its June 2021 meeting, outside counsel presented the Board of Directors with available case law and previous legal opinions shared on this matter. It was the recommendation of outside counsel that the findings of all 4 available legal opinions were consistent and clearly demonstrated that there was substantial risk to carrying out the resolution as written. However, suggestions were made by general and outside counsel that meet the intent of the resolution. Specifically, ACEP could seek to obtain non-competitive information from all emergency physician-employing entities, including exhibitors, advertisers, and sponsors of ACEP meetings and products, with the intent to increase transparency and encourage all employers adhere to key ACEP policy statements related to employer best practices.

Following the Board presentation, the Board and staff developed an employer profile survey meant to serve as an

accountability mechanism to increase pressure on all employer groups and set a higher bar of expectations for any entities employing emergency physicians, including exhibitors, advertisers, and sponsors of ACEP meetings and products, asking them to provide information about their organizations. The survey asked employers to provide details on group governance structure, billing practices, ownership model, size, funding, and more. It also included an attestation that the entities affirm their adherence to ACEP policy statements as they pertain to the emergency physicians in their group, including “Emergency Physician Rights and Responsibilities” and “Emergency Physician Contractual Relationships,” which specifically mention due process and transparency in billing. Several iterations of the draft questionnaire were discussed with ACEP members, including the original authors of the resolution.

The employer survey was distributed in September 2021, in advance of ACEP21. Each employer participating in ACEP’s annual conference was asked to complete the survey and made aware that their answers would be available to all ACEP members in an ongoing fashion. [An existing searchable employer database](#) was enhanced to accommodate the survey data and it remains available on the ACEP website, protected behind the member log in. For the initial launch, employer profiles were promoted at ACEP21 using QR codes in the onsite program for employer exhibitors, on meter boards, and on tabletop signs for each booth and Job Fair table. These codes allowed members to quickly access information about all employer groups. The information, or lack thereof, provided members the information on potential employers and their practices and transparency. If no data exists, an opportunity existing to request the employer provide it. Additionally, promotion of the survey responses was included in the ACEP21 mobile app and promotion also occurred via *EM Today*, *Weekend Review*, social media, [ACEP.org](#) and a From the College note in *ACEP Now*.

Following ACEP21, ACEP leaders met with several large staffing groups to ask that they complete the employer profile survey. The staff conducted outreach to employers throughout the year in pursuit of employer information that could be provided to members. Several email campaigns were conducted, and phone outreach took place during the spring of 2022 requesting employer groups provide the information and embrace ACEP policies regarding best practices. In August 2022, ACEP distributed the survey to employers attending ACEP22.

In June 2022, ACEP presented to the AMA resolution 219, Due Process and Independent Contractors. This resolution resolved that our American Medical Association develop a model state legislative template and principles for federal legislation in order to protect physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or in the government, which includes independent and third-party contractors providing patient services at said facilities. Thanks to strong advocacy by the AMA Section Council on Emergency Medicine and ACEP’s leadership, this directive to take action was approved by the AMA House of Delegates ([D-405.975](#)) and ensures that the entire House of Medicine and the AMA's significant resources will now be fighting to ensure due process protections for us at both the federal and state level.

As affirmed in ACEP’s strategic plan, the Board and leadership are dedicated to ensuring that ACEP fights for the rights of all emergency physicians across all landscapes and levels, supported by ACEP policy and advocacy efforts and in satisfying the intent of this referred resolution.

Resolution 45 Emergency Licensing and Protection in Disasters (as amended)

RESOLVED, That ACEP create new or reaffirm policy that supports that all states and U.S. territories waive standard licensing requirements including fees for emergency physicians to provide their services, whether in person or not, in any state or territory once a disaster has been declared by a state or federal entity, agency or official ~~and afterwards until services related to the disaster are no longer needed~~ **limited to the duration of the declaration of the state of emergency, including any extensions, within the state where the patient is located**, so long as emergency physician holds a license in good standing in any U.S. state or territory, does not charge for his/her services and practices within his/her area of knowledge and expertise **with limited exceptions such as gross negligence, misconduct and providing care while intoxicated**; and be it further

RESOLVED, That ACEP create new policy that supports legislation protecting any/all emergency physicians who provide their services, in person or otherwise, at no charge during disasters ~~and their aftermath~~, and granting these emergency physicians immunity and holding them harmless for any services **(with limited exceptions such as gross negligence, misconduct and providing care while intoxicated)**, that they provide to patients during disasters and aftermath so long as the emergency physician(s) practices within his/their area of knowledge or expertise.

Action: The resolution was assigned to the Disaster Preparedness & Response Committee to review and provide a recommendation to the Board regarding further action on the resolution. The committee recommended taking no further action on the resolution for the following reasons:

1. Concern that the resolution lacks integration with existing laws and the intent of the volunteer registries and the Medical Reserve Corps (MRC) that have processes in place for credentialing of providers and sometimes legal protection. The committee is supportive of a policy that recognizes the two federal /state programs and supports expansion of easy licensing and legal protections. ACEP should also consider including other medical specialties that are needed in disaster response.

2. The resolution does not meet the needs of ACEP members and society and it is lacking coordination with current methods to provide the support, verification, etc. While the general statement does not reinvent the wheel, it does a disservice to other specialties and to systems currently in place to make it easier for volunteers to respond safely with appropriate credentials, verification, etc.
3. Not every emergency physician is suited or trained to respond to a disaster and additional training and mentoring are needed beyond residency courses.
4. ACEP should encourage members to volunteer and pre-register at the state level instead of creating a new bureaucracy.

Additionally, ACEP has multiple policy statements that address the intent of the resolution:

- ACEP’s policy statement “[Support for National Disaster Medical System and Other Response Teams](#)” supports the National Disaster Medical System (NDMS) and encourages further development and funding of the program. ACEP also supports members who participate in the Disaster Medical Assistance Teams (DMAT), Urban Search and Rescue (USAR teams), or other federal or state-sponsored medical teams.
- ACEP’s policy statement “[Disaster Medical Response](#)” supports a national credentialing mechanism and up-to-date database of available physicians and medical volunteers who could be deployed as needed in the face of a national emergency. A policy and program must be in place to provide these responders with workers’ compensation and medical liability protection when deploying to a disaster at the request of the federal or state government.
- ACEP’s policy statement “[Good Samaritan Protection](#)” supports good samaritan protection legislation designed to reduce liability exposure. ACEP also supports the extension of existing good samaritan legislation to provide protection from liability for emergency physicians who respond to emergencies outside the emergency department, including but not limited to in-hospital and out-of-hospital emergencies, mass casualty incidents, and other disasters.
- ACEP’s policy statement “[Health Care System Surge Capacity Recognition, Preparedness, and Response](#)” includes the following excerpt: Legislation should be enacted where necessary to mitigate provider liability issues during crisis situations.
- ACEP’s policy statement “[Hospital Disaster Physician Privileging](#)” includes language that The Joint Commission (TJC) has put forth standards (TJC Standard EM.02.02.13) to address Hospital Disaster Physician Privileging. During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners (LIP).
- ACEP’s policy statement “[Unsolicited Medical Personnel Volunteering at Disaster Scenes](#)” is a joint statement with the National Association of EMS Physicians that encourages “members to become affiliated with pre-established disaster response organizations. This includes becoming pre-registered as disaster response personnel through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), which is present in every state and provides for license verification, personnel notification, and rostering of response teams.”

The Board discussed the committee’s recommendation at their October 22, 2021, meeting and directed the committee to consider additional work that can be done to address the resolution, such as considering whether the “Disaster Medical Response” policy statement and/or the “Good Samaritan Protection” policy statement should be revised to include the expanded liability protection (gross negligence) suggested in the resolution; adding a link to the Disaster Medicine Section website directing members to where they can volunteer or pre-register to serve in case of a disaster; and adding information to the ACEP website regarding the interstate medical licensure compact (<https://www.imlcc.org/>) to increase awareness of this option for licensing in additional states. The committee developed a primer for disaster deployments describing subjects such as liability in disaster response and Good Samaritan protection as applied from state to state. Volunteer information and links from existing ACEP web resources and additional resources for both national and international opportunities were identified and are available on the ACEP website.

Resolution 48 Residency Program Expansion

RESOLVED, That ACEP engage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to construct objective criteria for new residency accreditation that takes into account emergency medicine workforce needs, competitive advantages and disadvantages, geographical distribution of workforce, and expected shortages and/or excess of emergency physicians to adequately steward needs for newly accredited emergency medicine residency programs.

Action: In 2021, ACEP convened a multi-organization ACGME Emergency Medicine Requirements Workgroup was appointed to develop recommendations regarding the optimal training and skills needed to prepare medical students entering the field of emergency medicine for future practice in the field. Workgroup members represented the original organizations that agreed to participate in the Emergency Physician Workforce Study: ACEP, CORD, EMRA, SAEM,

AACEM, AAEM ACOEP, and RAMS. Representatives from each organization began holding meetings in June 2021 to discuss proposed program requirement changes for the RRC-EM for the ACGME to consider in 2022 and align with of the scheduled review and major revision of the EM program requirements according to ACGME timeline. The task force discussed procedural competency numbers, scholarly activity requirements, facility requirements (trauma designations, patient volumes, scaling size of residency programs), faculty requirements (fellowship training, single site affiliation, geographic proximity to residency program), and rotational requirements or electives (rural EM, telehealth, neurocritical care) to anticipate changing educational needs for the future. Individuals reviewed the available formal and gray literature on selected topics both within and beyond emergency medicine, as appropriate as selected by the group. The task force recommendations were compiled and submitted to the ACGME to consider when reviewing and developing the standards for emergency medicine. The consensus recommendations were also submitted to *Annals of Emergency Medicine* and *Academic Emergency Medicine* for publication consideration.

Resolution 52 The Corporate Practice of Medicine (as amended)

RESOLVED, That ACEP will prepare a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine and fee splitting in each state and the results of this review will be compiled into a resource and announced to members as an available electronic download; and be it further

RESOLVED, That ACEP adopt as policy: “~~The~~ ACEP, in concert with its relevant component state chapter, in those states where there are existing prohibitions on the corporate practice of medicine, will provide assistance to physician owned groups who are threatened with contract loss to a corporate entity or to hospital employed physicians whose site will be taken over by a corporate entity by providing, upon request, a written review of the legality of the corporation obtaining the contract for emergency services.”; and be it further

RESOLVED, That ACEP, in those states that are found to have existing prohibitions on the corporate practice of medicine, along with the relevant state chapter, will petition the appropriate authorities in that state to examine the corporate practice of emergency medicine if such is believed to occur within that state and ACEP will reach out to the state professional societies ~~of anesthesia and radiology~~ as appropriate in this effort and solicit the support of the state medical society; and be it further

RESOLVED, That ACEP will work with the American Medical Association to convene a meeting with representatives of physician professional associations representing specialties and other stakeholders affected by ~~private equity and other lay influence involvement to examine joint efforts to combat~~ the corporate ~~control~~ practice of medicine ~~by lay entities, to ensure the autonomy of physician owned groups or hospital employed physicians contracting with corporately-owned management service organizations.~~

Action: The Board and staff began extensive discussions on this referred resolution starting in April 2021. Discussions also included several ACEP state chapter leaders, as aspects of the suggested work would involve them. At the September 22, 2021, meeting, the Board of Directors approved several recommendations and actions to address the intent of this referred resolution.

Regarding the first referred resolved, it is consistently recognized by the AMA and legal professionals that the adoption and enforcement of corporate practice of medicine doctrine is not just a matter of statutory law, but as well a complex and living web of case law and attorney general or agency opinions. An internet search yields several different types of state-level comprehensive reviews, albeit, each limited in some way and nearly all cautioning about the complexities of this issue residing in of notoriously porous statutes and in a constant state of change. However, the American Health Law Association develops and sells a report, AHLA Corporate Practice of Medicine: A Fifty State Survey. It is designed to be a road map for determining which model a state follows and what sources to consult. The publication includes information on corporate practice restrictions and related issues such as fee splitting and the unlicensed practice of medicine. The cost of the current edition (664 pages softbound) of this document is \$269 for non AHLA members.

Additionally, ACEP currently works with our chapters to summarize or curate resources via our Legislative Information Clearinghouse. This is currently being used to monitor such issues as crowding, liability reform, reimbursement issues, and many more. Matters of CPOM are not one of the issues currently tracked as a state legislative issue. Hence, the Board has directed the State Legislative/Regulatory Committee, with support from the Medical-Legal Committee and interested state chapters, to compile and make available to members a hyperlinked reference webpage on selected existing legal and regulatory resources related to the corporate practice of medicine and fee splitting in states. As part of this assignment, ACEP will purchase and make available a digital copy of the American Health Law Association (AHLA) Corporate Practice of Medicine: A Fifty State Survey, although the committees and chapters are not bound to exclusively use this resource. This webpage would reside within the State Legislative area of the ACEP website and be available to members only.

Regarding the second resolved, the Board recommended that ACEP Membership and Practice Affairs staff continue curating and expanding the promotion of educational and third-party assets for members needing contract and legal support related to various practice matters; this includes promotion of the affinity program with Mines & Associates that provides

ACEP members with access to legal and financial support assistance at a modest fee. This recommendation is consistent with suggestions made via testimony that, rather than by ACEP policy, this legal assistance could be offered in light of furthering member benefits. There are dozens of pages of resources on the ACEP website dedicated to the topic of Employment Contracts and other practice and legal issues, as well as a growing set of resources from ACEP's Democratic Group Practice Section. In an effort to better support all members as they face unprecedented challenges in hiring, ACEP Membership and Practice Affairs staff have embarked on a process to update, curate, and develop educational and other assets into a complete set of resources designed to educate and empower physicians, at any point in their career, to have more knowledge to evaluate contract terms and pushback on unfair business practices, regardless of employment model or practice type. Additionally, for the nominal fee of \$15 per year, all ACEP members currently have access to legal and financial support assistance through an affinity program with Mines & Associates, our wellness and counseling partner. This service includes unlimited 30-minute in-person consultation for each individual legal matter, unlimited telephonic 30-minute consultation per financial matter, and 25% discount on select legal and financial services all with MINES network legal and financial professionals. Under the category of Business Legal Services, this includes advice, consultation and representation for contracts, incorporation, partnerships, and other commercial activities.

Regarding the third referred resolved, the Board directed ACEP Chapter Relations staff to convene an interested working group of state chapter executives, chapter presidents, and councillors to conduct an informal needs assessment regarding the need to petition appropriate state authorities regarding matters of the corporate practice of medicine statutes in their state. This approach is in keeping with internal operating policy, "ACEP Involvement in State Legislative Activities," adopted by the Board in May 2018, which stipulates that "on issues of strategy, national should defer to the chapter, given the chapter's better understanding of local political dynamics." This approach also ensures that ACEP and its state chapter executives work together to better understand and cross-promote ACEP's offerings regarding direct legal support to members via our affinity program with Mines & Associates, as well as to understand ACEP's procedures for determining whether to pursue other legal remedies, e.g., filing lawsuits, amicus briefs. Pending the results of the needs assessment, ACEP could work with its chapters to sponsor a webinar or curate resources or toolkits that would guide chapters on a process for addressing CPOM either through direct advocacy or through their members.

Regarding the fourth referred resolved, in July 2021, ACEP's executive director discussed ACEP's concerns with the AMA's CEO regarding matters related to the corporate practice of medicine and interest in potentially collaborating with the AMA on an educational or needs assessment meeting. There was mutual interest in exploring this further, possibly through a virtual summit that could convene professional and state medical societies, as well research organizations. Like ACEP has experienced, many of these research efforts are limited by a lack of transparency around ownership models and/or the ability to link ownership data to claims-based or other government data base research, as well as published literature to study the CPOM landscape. At this time, ACEP and AMA staff continue working to develop this collaborative summit.

The Board also acknowledged that current ACEP policy supports a position of neutrality when it comes to contractual arrangements; specifically, the "Emergency Physician Contractual Relationships" policy statement states: "quality medical care is provided by emergency physicians organized under a wide variety of group configurations and with varying methods of compensation. ACEP does not endorse any single type of contractual arrangement between emergency physicians and the contracting vendor."

ACEP began a campaign in March 2022 to collect stories that would help inform the Federal Trade Commission's (FTC) efforts to update its health care merger guidelines by expanding its evaluations on the impact of mergers and acquisitions to assess labor conditions rather than just competition. [Stories were submitted](#) through the ACEP website and other communications promoting the campaign were launched. The stories were reviewed to identify common themes and statistics and were used to create [ACEP's response to a recent FTC/DOJ request for information](#). ACEP President Dr. Gillian Schmitz and ACEP Executive Director, Sue Sedory, [provided public comments in a listening session hosted by the FTC and DOJ](#) on April 14, 2022, on the effects of mergers and acquisitions in the healthcare industry. In their comments, Dr. Schmitz and Ms. Sedory shared results from ACEP's story collection that showed numerous anti-competitive labor-related effects associated with mergers and acquisitions in emergency medicine including: reduced wages and/or non-cash benefits; infringement of due process rights; interference with physician autonomy to make independent medical decisions benefiting patients; inability to find a job or undue imposed restrictions on ability to switch jobs; and a shift to use of a less-skilled health care workforce jeopardizing patient care.

ACEP filed an amicus brief in the AAEMPG v. Envision case on March 25, 2022, upholding the sanctity of a physician's duty to patients and the importance of allowing them to practice medicine without undue pressure from outside forces. Through this filing, ACEP is applying its might on behalf of our nearly 40,000 members in legal efforts to assert the physician's right to autonomy in medical decision-making. EMRA also filed a Declaration of Interest in support of the ACEP position.

The Board of Directors approved the [ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine](#) on April 6, 2022, reaffirming ACEP's core beliefs and emphasizing the physician-patient relationship as the moral center of medicine that can never be compromised.

In June 2022, ACEP presented to the AMA resolution 219, Due Process and Independent Contractors. This resolution resolved that our American Medical Association develop a model state legislative template and principles for federal legislation in order to protect physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or in the government, which includes independent and third-party contractors providing patient services at said facilities. Thanks to strong advocacy by the AMA Section Council on Emergency Medicine and ACEP's leadership, this directive to take action was approved by the AMA House of Delegates ([D-405.975](#)) and ensures that the entire House of Medicine and the AMA's significant resources will now be fighting to ensure due process protections for us at both the federal and state level.

The Emergency Medicine Group Ownership Task Force developed a report to address the effects on individual physicians and ACEP advocacy efforts of the actions of private equity groups, insurance company ownership, hospital ownership, corporate non-physician ownership and management of emergency physician groups. The report was provided to the Council on September 23, 2022.

Additionally, ACEP asked the [Physicians Advocacy Institute](#) to report specifically on emergency medicine in its next round of research with Avalere on trends in physician employment and acquisitions of medical practices. All of the major physician specialties were included in the [report they published on their website](#). However, their results seem to undercount corporate ownership of emergency medicine practice models. For example:

- Compared to a national average of 73.9%, only 66.7% of emergency medicine physicians were employed by hospitals and other corporate entities in 2022.
 - Broken down, they found that more EM physicians were hospital-employed (53.4% vs 52.1% overall) and fewer EM physicians were employed by “other corporate entities” (13.3% vs 21.8% overall). This places EM as one of the specialties with the least amount of corporate employment.
- Further, the decline in independent EM physicians/physicians practices (from around 45% in 2019 to 33% in 2022) mainly shifted to health system ownership (just over 45% in 2019 to 53% in 2022) rather than to corporate (just under 10% in 2019 to 13% in 2022).
- Their findings were also of concern for other specialties, such as Anesthesiology, which was found to be among the specialties with the lowest percentage of corporate employment, at 13.9%.

While Avalere's definition of “other corporate entities” did include private equity firms or health insurers, it is unclear how the data used in the research (IQVIA OneKey) counts consultant/independent contract physicians. It is also not reported in the findings the extent to which physician practices categorized as “independent” may actually have corporate ownership or backing. ACEP is still trying to work with PAI and Avelere to look at the OneKey data, but this further confirms the findings of the Emergency Medicine Group Ownership Task Force that data or datasets available to clearly define ownership structures currently operating in emergency medicine is lacking. It also supports the task force recommendation for ACEP to both develop standardized definitions of ownership models, particularly as they pertain differently to ownership of facilities employing physicians and the ownership of physician practices. Further, this also supports the second recommendation from the task force that “current available databases often do not understand the nuances of ownership type.”

The 2022 Council adopted Amended Resolution 56(22) Policy Statement on the Corporate Practice of Medicine directing ACEP to develop a policy statement opposing the corporate practice of medicine. The Board of Directors adopted the policy statement “[Corporate Practice of Medicine](#)” in June 2023.

ACEP continues to be actively engaged in directly supporting its members and advocating on behalf of emergency medicine regarding the corporatization of medicine. [Resources](#) to protect physician autonomy are available on the ACEP website.



ADVANCING EMERGENCY CARE 

President-Elect Candidates



Scientific Assembly

PHILADELPHIA, PA **23**

2023 President-Elect Candidates



Jeffrey M. Goodloe, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



Alison J. Haddock, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



Ryan A. Stanton, MD, FACEP

- Written Questions
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2023 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Jeffrey M. Goodloe, MD, FACEP

Question #1: How would you address concerns that ACEP may be unduly influenced by corporate practice interests?

I'll address such concerns directly, relating my cumulative experience during nearly four years of service to date on the ACEP Board of Directors. I genuinely believe that for ACEP to ethically represent *all* of its members, ACEP must be vigilant to avoid being "unduly influenced" by *any* interests other than those that seek to serve *all* of its members with integrity, accountability, and transparency.

Given today's challenging health care environments, I believe what current and potential ACEP members understandably fear is loss of abilities to optimally care for patients, to create growth-minded workplaces, to have entrepreneurial freedoms in forming democratic group practices, to have opportunities to promote in any practice structure, and to provide for their loved ones. Now, what does that pragmatically mean? Such fear may foster cynicism that elected ACEP leaders will sell the aspirations and very souls of emergency physicians for personal windfall through ACEP advocacy and policy that serves self above others, or alternatively, silence when advocacy and policy should speak loudly. Let's speak candidly about this. How often do I encounter "serving self before others" actions by ACEP Board of Directors members? Truly, I haven't seen one appreciable instance yet. If such motive more secretly exists, it certainly hasn't won a contested vote or set a course of ACEP advocacy. Instead, what I've found is a diverse group of leader members, changing yearly in composition, and continuously unified in protecting and advancing the future for emergency physicians, patients, and our beloved specialty.

I welcome both ACEP's most ardent supporters and harshest critics to attend ACEP Board of Directors meetings. Concerns, fears, suspicions, and outright distrust is fostered, unintentionally or otherwise when unknowns are created. Seeing and hearing firsthand your Board of Directors debate and decide advocacy and policy is a powerful way to dissolve prior unknowns and to prevent future ones forming.

ACEP communications now highlight the College's annual budget reflects less than one percent of revenue comes from contract management groups, and by extension, related corporate practice interests. Better quantified, the meaningful measure of ACEP avoiding undue influence by corporate practice interests is found in the College's day to day advocacy priorities and policy making deliberations. I fully support ACEP's statement on private equity and corporate investment in emergency medicine (<https://www.acep.org/administration/physician-autonomy/acep-statement-on-private-equity-and-corporate-investment-in-emergency-medicine>), voting for the statement's passage in April 2022. I am equally committed to continuing representing *all* ACEP members in my elected duties on your Board of Directors and as an enthusiastic candidate to be your next President-Elect.

Question #2: What are your ideas for creating and/or providing tangible and indispensable benefits to ACEP members?

For years now, I have found in successfully recruiting members, and in retaining happy members, in ACEP equates to emergency physicians finding tangible value in ACEP. What does that tangibility 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), 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 of 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.

Beyond these examples of widely shared goals, each of us as emergency physicians find 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.

The key in any and all of this 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 actually 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 immediate 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 smartphone apps to significant wins in reimbursement, liability protection, and work opportunities.

Question #3: What new thoughts do you have in balancing board certified emergency physician workforce distribution gaps and safe scope of practice for non-physicians?

Advances often come through focusing on executing fundamental actions particularly well. Coach John Wooden was famous for focusing on the fundamentals, sometimes called “little things.” When those same fundamentals done right achieve great success, they aren’t little at all. How does that apply to the role of the board certified emergency physician? Fundamentally, I believe every patient coming to an emergency department is best served by care delivered by board certified emergency physicians. Period.

So, to that end, I don’t believe there is a “balance” when it comes to board certified emergency physician anything and scope of practice for non-physicians anything. If that sounds distinctly definitive, then point purposefully made.

Does this lack of balance I promote equate to no role(s) for non-physicians in an emergency department? Considering I’ve worked with numerous physician assistants and nurse practitioners in emergency departments over my 25 years post-residency, you may correctly surmise I have found successful inclusion, which by my definition “successful” includes safety for all involved, of physician assistants and/or nurse practitioners on a **physician-led** team in an emergency department. Did I bold type “physician-led” in that last sentence? Good. Another point purposefully made.

As your national ACEP liaison to the American Academy of Emergency Nurse Practitioners (AAENP), I have the incredible honor, privilege, and responsibility to be your “voice” during AAENP Board of Director meetings. I assure you that I speak for you clearly, respectfully, responsibly, and always in a manner that promotes, first and foremost, the principle that board certified emergency physicians must be the leaders of care in any emergency department.

Today’s reality is many rural emergency departments are staffed solely by physician assistants and/or nurse practitioners. On functionally useless in real time to patient care on-call rosters, these same physician assistants and/or nurse practitioners may be “backed up” by physicians. Often these “back ups” are located 20-30 minutes from being physically present when called to assist patient care at the bedside. Factoring such, an order to transfer the patient immediately by ground or air EMS is the only actual support per se these non-physicians receive. I believe that’s an untenable risk to everyone involved, particularly the patient expecting safe, clinically accurate emergency care.

Our Indiana ACEP colleagues have helped us all as emergency physicians in championing the passage of state legislation mandating a physician leading a hospital’s emergency department to be physically present in that hospital. While that law today does not specify that physician must be a board certified emergency physician, we can readily understand that to be the next step of progress in a future legislative bill that builds upon today’s advance in care. This is an important opportunity for board certified emergency physicians to secure those positions today, impressing upon hospital administrations the essential benefits to the patients, the medical staff, and the hospital itself uniquely enabled by board certified emergency physicians.

In select situations, technology may provide opportunities in the interim until similar laws can be promulgated nationwide. Colleagues at the University of Mississippi Medical Center have developed a robust telehealth network with over 25 critical access hospitals in that state. Physician assistants and/or nurse practitioners receive real-time telehealth consults from residency faculty, board certified emergency physicians in Jackson. The volume over time has allowed for full-time faculty shifts focused on telehealth consults. Today, not in spirit, but in true impact, care is increasingly emergency physician led in these networked emergency departments. We must always work against a balance. The weighting must strongly be on patient safety and on expanding the opportunities for board certified emergency physicians. ACEP advocacy, both nationally and increasingly through state chapter support, is more important than ever in achieving these goals.



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

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: 2860 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 35 % Research 5 % Teaching 10 % Administration 50* %

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.

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: Secretary-Treasurer & Member, Board of Directors

Term of Service: 2019-present (Member); 2021-2022 (Secretary-Treasurer)

Organization: Emergency Medicine Foundation

Address: 4950 W. Royal Ln
Irving, TX 75063

Type of Organization: 501(c)3 Nonprofit Organization for Funding Emergency Medicine Research

Leadership Position: Chair & Member, Board of Trustees

Term of Service: 2018-present (Member); 2021 (Treasurer); 2022 (Chair); 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-present (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 [Conflict of Interest](#) policy statement.

NO

YES

10. I have read and agree to abide by the ACEP [Leadership and Volunteers Conduct](#) policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

NO

YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Jeffrey M. Goodloe, MD, FACEP

Date

June 9, 2023



August 1, 2023

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 the 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 signal agreement by electing him ACEP Secretary-Treasurer last year. Results-focused, team-building, clear-speaking leadership is a decades-long "Jeff Goodloe hallmark" starting prior to his EMRA presidency in the late 1990s. He has been a 15-year plus active councillor, serving on 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 of these legislative leaders at his local emergency department, including arranging their 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 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 and multiple appointments to other committees and task forces, either as a member or as board liaison.

Board of Directors

President

James R. Kennedy, 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
Derek Martinez, MD (resident)

Kurtis Mayz, MD, JD, MBA, FACEP

Craig Sanford, MD, FACEP

Jeffrey M. Goodloe, MD, FACEP

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. We continue to see a multi-generational surge of energy in notable part due to Jeff's tireless encouragement of chapter members' engagement in both OCEP and ACEP. Further, Jeff led OCEP in electing our first resident member to full Councillor status with concurrent election to our board of directors. We are excited to increasingly promote the next generation of emergency medicine leaders in Oklahoma.

Dr. Goodloe is a consummate collaborator and leader, encouraging involvement of any OCEP member willing to serve, especially those focusing on the mentorship of younger members.

We are certain that Dr. Goodloe would verify the above, though reluctantly, given his modest, shining 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 becoming the first Oklahoma-based President-Elect in ACEP history.

Kindest professional regards,

James R. Kennedy, MD, MPH, FACEP
President, Oklahoma College of Emergency Physicians

Board of Directors

President

James R. Kennedy, MD, MPH, FACEP

Vice-President

Cecelia Guthrie, MD, FACEP

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Craig Sanford, MD, FACEP

Jeffrey M. Goodloe, MD, FACEP

Executive Director

Gabe Graham, CPA gabraham11@gmail.com

Jeffrey M. Goodloe, MD, FACEP

Councillors,

I am humbled and motivated by your support while serving you on the ACEP Board of Directors. I so enjoy the privilege of supporting and leading within ACEP – THE home of emergency medicine’s future built upon an unparalleled present and past.

In recent years, we experienced unexpected appreciation. Who can forget seeing, if not directly hearing, the public’s nightly clanging of pots and pans out windows, off porches, and on balconies to “voice” thankfulness that we put our own health on the line in valiantly treating a novel and serious virus? I didn’t expect noisy cooking utensils or any other instrument of praise, though I believe we earned it – not because we are better humans, rather because of what we did and continue to do: carry hope’s torch for anyone, anytime, nearly anyplace that needs emergency physician care.

Perhaps you still hear metallic sounds nightly. I do, but it’s not pots and pans. I hear motor vehicle collisions, firearm discharges in the chaos of uncontrolled emotions, and industrial accidents. And still we stand at the ready, willing to treat any and all. Widespread praise though has given way to assumptions of our presence.

As I’ve worked on incredible ACEP teams – committees, task forces, sections, and with fellow Board of Directors members – there is a common thread to our challenges. We are fighting the simple yet powerful fact that we and our specialty have now existed in abundance – at least in urban and suburban areas – and for enough decades that the once unthinkable are now automatic benefits of American life.

Some vocalize we are witnessing the death of our specialty, we are left to gasp cyanotically while choked by private equity, and our once limitless career prospects have departed as surely as Elvis has left the building. I support freedom of speech, but...I ardently assert those prognostications are wrong.

Emergency physicians embrace many roles in a typical career, but we do not embrace the role of victim. That is not our blood type. That is not within our driving values. And that is not what we and our patients need us to do. We must rise at this point in time – this point in OUR time – for ourselves, for our families, for those who will follow us in service, and for our patients.

As I travel across our country, listening at state chapter gatherings and meeting with myriads of emergency physicians, I see understandable angst though I am certain I am seeing something far stronger – determination that we will prevail – in valuing ourselves, in effectively enlisting a public now passively taking us for granted, and certainly in facing those actively committed to devaluing us through automatic denials of fair reimbursement, through replacing us with paper-milled, independently adrift nurse practitioners, and through legislating and regulating all manner of handcuffs upon us against our abilities to do what we nobly do best for anyone needing our compassion and skills.

It is fitting that we meet in Philadelphia, a city equated with visionaries valuing freedom – to pursue, to serve, to achieve. We must recognize that within us – our dedication to one another, this specialty, and our patients – is far stronger than opposition to our shared values. We must find better ways forward to clearly, effectively, relentlessly build the best days of emergency medicine. Our best days are not described in our history; they are ahead.

Jeffrey M. Goodloe, MD, FACEP

JEFFREY M. GOODLOE, MD, FACEP

For Election as ACEP President-Elect

Accountable

service

Consensus

builder

Enthusiastic

commitment

Proven

leadership



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:



1145 S. Utica Ave, Suite 600 | Tulsa, OK 74104 | 918-704-3164 (Cell)

jeffrey-goodloe@ouhsc.edu | jeffreygoodloe911@gmail.com

CURRICULUM VITAE

Jeffrey Michael Goodloe, MD, NRP, FACEP, FAEMS, LSSBB

Address: Department of Emergency Medicine
The University of Oklahoma School of Community Medicine
1145 South Utica Avenue, 6th Floor
Tulsa, Oklahoma 74104

Telephone: (918) 579-2364 (Department Office)
(918) 704-3164 (Cell)

Fax: (918) 579-2369 (Department Fax)

E-mail: jeffrey-goodloe@ouhsc.edu (EMS/EM/University)
jeffreygoodloe911@gmail.com (ACEP/Special Projects)

II. EDUCATION

| <u>School/College</u> | <u>Field of Study</u> | <u>Degree Earned</u> | <u>Year</u> |
|---|-----------------------|----------------------|-------------|
| 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:

| | | | |
|--|------------------------------|------------|---------|
| 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 |

CURRICULUM VITAE

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

CURRICULUM VITAE

- 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

CURRICULUM VITAE

- 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

CURRICULUM VITAE

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

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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

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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

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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

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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.

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- 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 (NEMESIS) 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

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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*

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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, Adalgais 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, Adalgais 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

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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.

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- 2019 Lyng JW, White CC 4th, Peterson TQ, Lako-Adamson H, **Goodloe JM**, Dailey MW, Clemency BM, Brown LH. Non-Auto-Injector Epinephrine Administration by Basic Life Support Providers: A Literature Review and Consensus Process. *Prehosp Emerg Care*. 2019 Nov-Dec;23(6):855-861.

Evidence-Based Guidelines for EMS Administration of Naloxone. Williams K, Lang ES, Panchal AR, Gasper JJ, Taillac P, Gouda J, Lyng JW, **Goodloe JM**, Hedges M. *Prehosp Emerg Care*. 2019 Nov-Dec;23(6):749-763.

Duval S, Pepe PE, Aufderheide TP, **Goodloe JM**, Debaty G, Labarère J, Sugiyama A, Yannopoulos D. Optimal Combination of Compression Rate and Depth During Cardiopulmonary Resuscitation for Functionally Favorable Survival. *JAMA Cardiol*. 2019; 4(9):900-908.

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- 2017 **Goodloe JM**, Idris AH. Metrics Save Lives: Value and Hurdles Faced. *Curr Opin Crit Care.* 2017 Jun;23(3):204-208.
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- Lurie K, Frascone RJ, **Goodloe JM**. Resuscitation GEMS. Resuscitation Outcomes Consortium (ROC) Studies Dig Deep into the Science of CPR. *Journal of Emergency Medical Services.* 2017 Jan; 42(1): 28-32.
- 2016 Fischer PE, Bulger EM, Perina DG, Delbridge TR, Gestring ML, Fallat ME, Shatz DV, Doucet J, Levy M, Stuke L, Zietlow SP, **Goodloe JM**, VanderKolk WE, Fox AD, Sanddal ND. Guidance Document for the Prehospital Use of Tranexamic Acid in Injured Patients. *Prehosp Emerg Care.* 2016 Sep-Oct;20(5):557-9.
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- Goodloe JM** and Gerecht R. TXA in the USA. Tranexamic Acid's Potentially Bright Future Relies on Collaborative Data. *Journal of Emergency Medical Services,* 2015 Apr; 40(4):30-5.
- 2014 **Goodloe JM**. Stay on Time. A Conversation about the Importance of Count and Cadence of Chest Compressions. *Journal of Emergency Medical Services,* 39(11) Nov Suppl:36-40.
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- 2013 **Goodloe JM,** Purser J. Praxis for Anaphylaxis: Critical Updates in Assessment and Management of Anaphylactic Shock. Journal of Emergency Medical Services, 38(10) Oct 52-56.
- Goodloe JM,** Purser J. ABCs of Epinephrine Autoinjectors. Journal of Emergency Medical Services, 38(10) Oct 54.
- Goodloe JM,** Howerton DS, McAnallen D, Reed H. How Can Tranexamic Acid Help in EMS? TXA Offers New Hope for an Old Challenge in Traumatic Hemorrhagic Shock EMS World, 42(5): 15-6.
- Goodloe JM,** Howerton DS, McAnallen D, Reed H. TXA: A Difference-Maker for Trauma Patients? Role of Tranexamic Acid in EMS & Preoperative Trauma Management. Journal of Emergency Medical Services, 38(4) Apr 60-65.
- Goodloe JM,** Howerton DS, Appleby T. Putting Standards on the Map: Oklahoma Leaders Create Comprehensive Set of Evidence-Based Protocols. Journal of Emergency Medical Services, 38(2) Feb 36-38.
- 2012 **Goodloe JM.** Review of Bobrow et al. Research Manuscript on Layperson Compression-Only CPR. 2013 Lifelong Learning and Self-Assessment Study Guide. EB Medicine.
- Whelan LJ, Justice WA, **Goodloe JM,** Dixon JD, Thomas SH. Trauma Ultrasound in Civilian Tactical Medicine. Emergency Medicine International, 2012; 2012:781570. Epub Nov 15.
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- 2014 The Mobile Integrated Healthcare Practice Collaborative including **Goodloe JM**. “Program Evaluation” Principles for Establishing a Integrated Healthcare Practice. Medtronic Philanthropy. Accessible at mihpresources.com
- 2009 **Goodloe JM**. The STEMI Care Race: Gunder Haag and Roger Bannister must surely be proud of EMS. *Eye of the Eagle Column*. jems.com.July30.

2. Chapters in Textbooks

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- 2017 **Goodloe JM**. "Bronchitis, Pneumonia, and SARS" Tintinalli's Emergency Medicine Manual: 8th Edition. Cline DC, Ma OJ, Cydulka RK, Meckler GD, Handler DA, Thomas ST (Eds) McGraw Hill. New York, USA.
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- (IN PRESS) Goodloe **JM**, Lippmann M, Fowler R. "Evidence Based EMS Medicine" Paramedic Textbook. Navarro K and Hsieh A (Eds) FA Davis, Philadelphia, USA.
- 2015 Seth NB and **Goodloe JM**. "EMS Finance" Cooney's EMS Medicine. Cooney DR (Ed) McGraw Hill. New York, USA.
- Hogue TD and **Goodloe JM**. "Measuring Performance" Cooney's EMS Medicine. Cooney DR (Ed) McGraw Hill. New York, USA.
- Braithwaite SA and **Goodloe JM**. "Blunt Trauma Considerations" Emergency Medical Services: Clinical Practice and Systems Oversight. Brice J, Cone D, Delbridge T, Myers B (Eds) Wiley. Hoboken, New Jersey, USA.
- Hinchey PR and **Goodloe JM**. "Finance" Emergency Medical Services: Clinical Practice and Systems Oversight. Brice J, Cone D, Delbridge T, Myers B (Eds) Wiley. Hoboken, New Jersey, USA.
- 2013 Thomas SH and **Goodloe JM**. "Foreign Bodies" Rosen's Emergency Medicine - Concepts and Clinical Practice: 8th Edition. Marx J, Hockberger R, Walls R (Eds) Mosby.
- Goodloe JM**. "Pneumonia, Bronchitis, and Upper Respiratory Tract Infection" Tintinalli's Emergency Medicine: Just the Facts, Third Edition. Cline DC, Ma OJ (Eds) McGraw Hill. New York, USA.
- 2012 **Goodloe JM**. "Avoid Hyperventilation in the Intubated Patient" and "Don't Underestimate Continuous Waveform Capnography in the Intubated Patient" Avoiding Common Errors in Prehospital Medicine. Lawner B, Slovis C, Fowler R, Pepe P, Mattu A, Marcucci L(Eds).
- Goodloe JM**. "Bronchitis, Pneumonia, and SARS" Tintinalli's Emergency Medicine Manual: 7th Edition. Cline DC, Ma OJ, Cydulka RK, Meckler GD, Handler DA, Thomas ST (Eds) McGraw Hill. New York, USA.
- Goodloe JM** and Biddinger PD. "Prehospital care and emergency medical services" An Introduction to Clinical Emergency Medicine: 2nd Edition. Mahadevan SV and Garmel GM (Eds) Cambridge University Press, Cambridge, UK.
- Other:**
- a. Abstracts or Posters**
- 2022 Fleegler M, Albright D, Wadman M, Findley S, Sampson C, Sanson T, Goodloe J, Wilkinson B, Rimple D. Rural Emergency

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Medicine: The State of Rural Rotations in Residency Training Programs. Poster Presentation at ACEP Research Forum at ACEP 23, San Francisco, CA, September/October 2022. Published in Ann of EM, 80 (4), Supplement.
DOI: <https://doi.org/10.1016/j.annemergmed.2022.08.406>

2020 Medrano NW, Villareal CL, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Statewide System-Based Geographic Approach to Trauma Care Access. Abstract Poster Presentation at American Association for the Surgery of Trauma (Virtual Annual Conference). September.

Medrano NW, Villareal CL, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Statewide System-Based Geographic Approach to Trauma Care Access. Abstract Online Poster Presentation at Esri User Conference (Virtual Annual Conference). July.

Villareal CL, Medrano NW, Remenapp CM, Wang Z, MacKenzie EJ, Nolte KB, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Evaluating Inter-rater Reliability When Determining Pre-Hospital Injury Survivability. Abstract Poster Presentation at U.S. Military Health System Research Symposium (Virtual Annual Conference).

Villareal CL, Medrano NW, Remenapp CM, Wang Z, MacKenzie EJ, Nolte KB, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Evaluating Inter-rater Reliability When Determining Pre-Hospital Injury Survivability. Abstract Poster Presentation at Military City USA Trauma Collaborative Research Conference (Virtual Annual Conference).

Villareal CL, Medrano NW, Remenapp CM, Wang Z, MacKenzie EJ, Nolte KB, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Examining Differences in Injury Survivability Determinations Between Medical Examiners and Trauma Surgeons Evaluating Pre-Hospital Trauma Deaths. Abstract Podium Presentation at National Association of Medical Examiners Conference (Virtual Annual Conference).

Eastridge BJ, Nolte KB, MacKenzie EJ, Stewart FM, Villareal CL, Medrano NW, Price MA, Davis GG, Maxson RT, Mazuchowski EL, MIMIC Study Group (**Goodloe JM**). Preliminary Analysis of the Multi-Institutional Multidisciplinary Injury Mortality Investigation in the Civilian Pre-Hospital Environment (MIMIC). Abstract Podium Presentation at Western Trauma Association Meeting.

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- 2017 **Goodloe JM** (presenter), Vinson LD (EM resident), Cox, ML, Burns BD. Paramedic compliance with a novel defibrillation strategy in a large, urban EMS system in the United States. Poster presentation. Canadian Association of Emergency Physicians Annual Meeting, Whistler, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2017; 19 Suppl 1, S98.
- Goodloe JM** (presenter), Vinson LD (EM resident), Cox, ML, Burns BD. Morbid obesity association with return of spontaneous circulation from sudden cardiac arrest treated in a large, urban EMS system in the United States. Poster presentation. Canadian Association of Emergency Physicians Annual Meeting, Whistler, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2017; 19 Suppl 1, S97-98.
- 2016 Duval S, Pepe PE, **Goodloe JM**, Sugiyama A, Yannopoulos D. The CPR “Sweeter Spot”: A Target Combination of Optimal Chest Compression Rate and Depth to Achieve Survival with Favorable Neurological Function After Out of Hospital Cardiac Arrest. [abstract] Circulation 2016;134 Suppl 1: A19230.
- 2015 **Goodloe JM** (presenter), Arthur AO, Arthur EN (high school student), Reed H. Prevalence and Survival Impact of Bystander Cardiopulmonary Resuscitation in Sudden Cardiac Arrest Victims Treated by a Large, Urban EMS System in North America. Oral Presentation. Canadian Association of Emergency Physicians Annual Meeting, Edmonton, Alberta. Abstract in Canadian Journal of Emergency Medicine 2015; 17 Suppl 2, S22-3.
- Goodloe JM** (presenter), Arthur AO, Arthur EN (high school student), Reed H. Demographics of Twenty-One Years of Sudden Cardiac Arrest Victims Treated by a Large, Urban EMS System in North America. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Edmonton, Alberta. Abstract in Canadian Journal of Emergency Medicine 2015; 17 Suppl 2, S64-5.
- Goodloe JM** (presenter), Arthur AO, Arthur EN (high school student), Braithwaite SA, Reed H. The Prevalence and Impact of Ventricular Fibrillation as the Initial Cardiac Arrest Dysrhythmia Twenty Years in a Large, Urban EMS System. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Edmonton, Alberta. Abstract in Canadian Journal of Emergency Medicine 2015; 17 Suppl 2, S64. Poster Presentation. National Association of EMS Physicians Annual Meeting, New Orleans, Louisiana. Abstract in Prehospital Emergency Care 19(1), 156.

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Mahoney B, Yannopoulos D, Aufderheide T, Abella B, Duval S, Frascone R, **Goodloe J**, Nadkarni V, Halperin H, O'Connor R, Idris A, Pepe P, Becker L. The Effect of CPR Quality: A Confounder of CPR Clinical Trials and Important National Healthcare Issue. Poster Presentation. National Association of EMS Physicians Annual Meeting, New Orleans, Louisiana. Abstract in *Prehospital Emergency Care* 19(1), 156.

2014 **Goodloe JM** (presenter), Martinez M (EM resident/presenter), Arthur AO, Parker S (undergraduate student), Thomas SH. Tourniquet Utilization Patterns & Impacts on Hemostasis in a Large, Urban EMS System. Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in *Prehospital Emergency Care* 18(1), 161-162. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in *Canadian Journal of Emergency Medicine* 2014; 16 Suppl 1, S52. Poster Presentation. International Conf for Emergency Medicine, Hong Kong, China.

Goodloe JM (presenter), Arthur AO, Holder P (EM resident), Murry W (medical student), Witmer JW, Higgins L (undergraduate student), Thomas SH. Airway Management Practices in Adult Non-Traumatic Cardiac Arrest in a Large, Urban EMS System. Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in *Prehospital Emergency Care* 18(1), 136-137. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in *Canadian Journal of Emergency Medicine* 2014; 16 Suppl 1, S88. Poster Presentation. International Conf for Emergency Medicine, Hong Kong, China.

Goodloe JM (presenter), Arthur AO, Holder P (EM resident), Murry W (medical student), Witmer JW, Higgins L (undergraduate student), Thomas SH. Endotracheal Intubation in Adult Non-Traumatic Cardiac Arrest in a Large, Urban EMS System. Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in *Prehospital Emergency Care* 18(1), 136-137. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in *Canadian Journal of Emergency Medicine* 2014; 16 Suppl 1, S88. Poster Presentation. International Conference for Emergency Medicine, Hong Kong, China.

Goodloe JM (presenter), Arthur AO, Letson C (undergraduate student), Witmer JW, Thomas SH. Adenosine Utilization and Effect on Supraventricular Tachycardia in a Large, Urban EMS System. Poster Presentation. National Association of EMS

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Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 18(1), 128. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S87-88. Poster Presentation. International Conf for Emergency Medicine, Hong Kong, China.

Goodloe JM (presenter), Arthur AO, Cory B (EM resident), McNitt W (medical student), Thomas SH. Presentation of Acute Allergic Reactions in a Large, Urban EMS System. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S88-89. Poster Presentation. International Conference for Emergency Medicine, Hong Kong, China.

Goodloe JM (presenter), Arthur AO, Genzel R, Burns BD (presenter), Thomas SH. Mass Gathering Medical Care in a Motorsports Event-Based Collaborative Training Program. Innovations in EMS Fellowship Education Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 18(2). Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S35.

Goodloe JM (presenter), Arthur AO, Justice W, Massie K, Burns BD (presenter), Thomas SH. Tactical EMS Care in a Military Medicine, Law Enforcement, and Emergency Medicine Collaborative Training Program. Innovations in EMS Fellowship Education Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 18(2). Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S66-67.

2013 Beck EH (presenter), White L, **Goodloe J**, Myers B, Moy H, Tan D, Bourne S, Beeson J, Craig A, Racht E, Mellor J. Mobile Integrated Healthcare Practice: Improving Population Health Through Innovative Alignment of Existing Mobile Health Infrastructure. Poster Presentation. American Public Health Association Annual Meeting, Boston, Massachusetts.

Goodloe JM (presenter), Arthur AO, Rhoades T (medical student), Holder P (EM resident), Winham JW, Thomas SH. EMT-Basic Acquisition and Transmission of 12-lead ECG Using a Novel Device (ReadyLink™). Poster Presentation, Canadian Association

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of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S44.

Kallsen T (medical student), Arthur AO, Thomas SH, **Goodloe JM** (presenter). EMS Stretcher “Misadventures” in a Large, Urban EMS System: A Longitudinal Analysis of Contributing Factors and Resultant Injuries. Poster Presentation, Canadian Association of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S59-60.

Crane RD (EM resident), Arthur AO, Dunn K (medical student), Thomas ST, **Goodloe JM** (presenter). Emergency Medical Services Initiation of Therapeutic Hypothermia in Post-Return of Spontaneous Circulation from Cardiac Arrest: Chillingly Low Rates and Contributing Factors. Oral Presentation, Canadian Association of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S18-19.

Goodloe JM (presenter), Lehrfeld D (EMS fellow), Schrank K. A Nationwide Survey of Emergency Medical Services Standards of Care for Cardiac Arrest – Variability Amongst America’s Largest Urban Systems. Oral Presentation, Canadian Association of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S19.

Williams E (EM resident), Reginald TJ, Likens J, Arthur AO, Notley D (medical student), Thomas ST, **Goodloe JM** (presenter). Parenteral Dextrose Utilization in a Large, Urban EMS System. Poster Presentation, Canadian Association of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S59.

Goodloe JM, Arthur AO (presenter), Rhoades T (medical student), Holder P (EM resident), Winham JW, Thomas SH. EMT-Basic Acquisition and Transmission of 12-lead ECG Using a Novel Device (ReadyLink™). Poster Presentation, Society for Academic Emergency Medicine Annual Meeting, Atlanta, Georgia. Abstract in Academic Emergency Medicine, 20(5), Suppl 1, S272.

Goodloe JM (presenter), Arthur AO, Rhoades T (medical student), Holder P (EM resident), Winham JW, Thomas SH. EMT-Basic Acquisition and Transmission of 12-lead ECG Using a Novel

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Device (ReadyLink™). Poster Presentation, American College of Cardiology Annual Meeting, San Francisco, California. Abstract in Journal of American College of Cardiology (JACC), March 12, 61(10_S), Supplement A.

Kallsen T (medical student/presenter), Arthur AO, Thomas SH, **Goodloe JM**. EMS Stretcher “Misadventures” in a Large, Urban EMS System: A Longitudinal Analysis of Contributing Factors and Resultant Injuries. Poster Presentation, National Association of EMS Physicians Annual Meeting, Bonita Springs, Florida. Abstract in Prehospital Emergency Care 17(1), 109-110.

Dixon JD, Arthur AO, Williams E (EM resident), **Goodloe JM** (presenter), Thomas SH. Ambulance Patients are More (or Less) Likely to be Insured. Poster Presentation, National Association of EMS Physicians Annual Meeting, Bonita Springs, Florida. Abstract in Prehospital Emergency Care 17(1), 132.

2012 Crane RD (EM resident), Arthur AO, Dunn K (medical student), Thomas ST, **Goodloe JM** (presenter). Emergency Medical Services Initiation of Therapeutic Hypothermia in Post-Return of Spontaneous Circulation from Cardiac Arrest: Chillingly Low Rates and Contributing Factors. Poster Presentation, Texas Department of State Health Services 2012 EMS Conference, Austin, Texas.

Williams E (EM resident), Reginald TJ, Likens J, Arthur AO, Notley D (medical student), Thomas ST, **Goodloe JM** (presenter). Parenteral Dextrose Utilization in a Large, Urban EMS System. Poster Presentation, Texas Department of State Health Services 2012 EMS Conference, Austin, Texas.

Goodloe JM, Lehrfeld D (EMS fellow/presenter), Schrank K, Pepe PE. A Nationwide Survey of Emergency Medical Services Standards of Care for Cardiac Arrest – Variability Amongst America’s Largest Urban Systems. Poster Presentation, Society for Academic Emergency Medicine Annual Meeting, Chicago, Illinois. Abstract in Academic Emergency Medicine, 19(4), Suppl 1, S260.

Goodloe JM (presenter), Lehrfeld D (EMS fellow), Schrank K. A Nationwide Survey of Emergency Medical Services Standards of Care for Cardiac Arrest – Variability Amongst America’s Largest Urban Systems. Poster Presentation, American College of Cardiology Annual Meeting, Chicago, Illinois. Abstract in Journal of the American College of Cardiology (JACC), March 27, 59(13), Supplement A, A87.

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Goodloe JM (presenter), Hartline J (medical student), Crane RD (EM resident), Johnson KV (medical student), Reddick EA (EM resident), Synovitz CK. A Statewide Survey of Emergency Department Standards of Care for Acute Coronary Syndromes - Variability and Opportunity for Advancement. Poster Presentation, American College of Cardiology Annual Meeting, Chicago, Illinois. Abstract in Journal of the American College of Cardiology (JACC), March 27, 59(13), Supplement A, A113

Hatfield J (EM resident), Arthur AO, Reddick E (EM resident/presenter), Shear M (medical student), Stilwell A (student), **Goodloe JM**, Thomas ST. Availability of On-Site Helipads Among Acute Care Facilities in Oklahoma. Poster Presentation, National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 16(1), 160.

Arthur AO, Thomas ST, **Goodloe JM**, Reginald TJ, Thiems G (medical student), Redmon T (medical student), Holder P (medical student/presenter). Patients Refusing Prehospital Transport are Increasingly Likely to be Geriatric. Poster Presentation, National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 16(1), 164.

Reginald TJ, Crane RD (EM resident), Arthur AO, Dunn K (medical student), Thomas ST, **Goodloe JM** (presenter). Emergency Medical Services Initiation of Therapeutic Hypothermia in Post-Return of Spontaneous Circulation from Cardiac Arrest: Chillingly Low Rates and Contributing Factors. Poster Presentation, National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 16(1), 182.

Williams E (EM resident/presenter), Reginald TJ, Likens J, Arthur AO, Notley D (medical student), Thomas ST, **Goodloe JM**. Parenteral Dextrose Utilization in a Large, Urban EMS System. Poster Presentation, National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 16(1), 187.

- 2011 **Goodloe 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, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

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Goodloe JM (presenter), Crowder CJ (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, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas. Second Place Poster Award.

Goodloe JM (presenter), Swope MS (EM resident), Arthur AO, Thomas SH. Use of an Ambulance Siren Low Frequency Enhancer, Howler™ in a Large, Urban Emergency Medical Services (EMS) System - Do Collision Rates Decrease? Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

Goodloe JM, Winham JO, Reginald TJ (presenter), 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, University of Oklahoma - Tulsa Annual Research Forum.

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, University of Oklahoma - Tulsa Annual Research Forum.

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, University of Oklahoma - Tulsa Annual Research Forum.

Goodloe JM, Hartline J (medical student), Crane RD (presenter/EM resident), Johnson KV (medical student), Reddick EA (EM resident), Synovitz CK. A Statewide Survey of Emergency Department Standards of Care for Acute Coronary Syndromes - Variability and Opportunity for Advancement. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

Brown EJ (presenter/EM resident), Synovitz CK, Gilpen J,

Goodloe JM, Burns BD, Justice W, Halcome C. Residents Gain Confidence in Trauma Skills During Special Operations Medical

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Specialist Course. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

Brown B (presenter/EM resident), Reginald TJ, Williams E (medical student), **Goodloe JM**. Missed STEMI by ECG Software Analysis. Case Report Poster Presentation. University of Oklahoma - Tulsa Annual Research Forum.

Goodloe 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

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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)

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- 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, Schepke K, Banerjee P. The Eagles Panel. EMS Today –

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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 Know 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)

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

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 Tornadoes. 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)

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

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: EtCO₂ 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). Journées 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.

CURRICULUM VITAE

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.

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

- 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

CURRICULUM VITAE

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

CURRICULUM VITAE

- 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

CURRICULUM VITAE

- 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

CURRICULUM VITAE

- 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

CURRICULUM VITAE

- 2013 **TRANEXAMIC ACID**
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Hemostasis options in traumatic hemorrhage
What is tranexamic acid (TXA)? Historical uses of TXA
Review of CRASH-2 and MATTERs research studies of TXA
Protocol changes and review & Operational handling of TXA
Interview with Dr. William Havron, OU Trauma Services
- PRAXIS FOR ANAPHYLAXIS**
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Defining anaphylaxis
Cardiovascular collapse form of anaphylaxis
World Allergy Organization treatment guidelines
Epinephrine treatment of anaphylaxis
Review of recent publications/abstracts regarding anaphylaxis
Protocol changes and review
- EMS CAPNOGRAPHY**
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Basic of the capnography waveform
Uses of capnography in EMS
Advanced concepts of capnography and research review
Protocol review
- 2012 **CPR TEAM DYNAMICS**
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Resuscitation team roles and dynamics
Continuity of chest compressions
Timing of defibrillation
Passive oxygenation in limited rescuer situations
Supportive care strategies
Practical lab and video production
- 2011 **CPR CHEST COMPRESSION TECHNIQUES**
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Compression rate with metronome use
Compression techniques
Practical lab
- 2007 **SIMPLE, COOL CHANGES IN PARAMEDIC AIRWAY CARE**
Plano Fire Department Paramedic CE
Intubation techniques

CURRICULUM VITAE

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

CURRICULUM VITAE

AHA guidelines for bradycardias & tachycardias
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

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

BURNS & LIGHTNING INJURIES

Plano Fire Department Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management
Lightning injuries & EMS lightning injury care

EXPLOSIVE EVENT INJURIES

Plano Fire Department Paramedic CE
Risks identification & complicating factors
Injury prediction based upon type of explosive and patients
Crush syndrome and its field treatment
Primary, secondary, and tertiary explosion injury paradigm

NERVE AGENTS, ORGANOPHOSPHATES, & CYANIDE

Plano Fire Department Paramedic CE
Pathophysiology and field treatments

CAPNOGRAPHY UPDATES IN EMS

Plano Fire Department Paramedic CE
Review of use in intubation confirmation
Use in non-intubated patients
 COPD, Asthma, Undifferentiated dyspnea
Review of new capnograph within LP12 monitor

MEGACODE MANAGEMENT

Plano Fire Department Paramedic CE
Tachy/Bradycardia 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

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

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

CURRICULUM VITAE

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)

CURRICULUM VITAE

- 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

CURRICULUM VITAE

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)

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- 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

CURRICULUM VITAE

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

CURRICULUM VITAE

- 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

CURRICULUM VITAE

- 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

CURRICULUM VITAE

- 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

2023 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Alison J. Haddock, MD, FACEP

Question #1: How would you address concerns that ACEP may be unduly influenced by corporate practice interests?

ACEP must do everything we can to have a singular focus on the individual emergency physician. While we strive to include all kinds of EM practices, **emergency physicians are our reason for being**. The individual EP who is weathering the recurrent boarding crises, the COVID cases with insufficient PE, the shift work sleep disorder is our center; that individual must feel **empowered and supported by ACEP** for our organization to remain vibrant. If any EM practice is failing to provide a high-quality working environment for emergency physicians, ACEP must be unafraid to shine a light on this situation. Our employer profile database is starting to highlight the size, staffing model and group governance of any group that chooses to advertise or sponsor with ACEP. We are also asking employers to attest that their group adheres to critical ACEP policies which ensure that EPs are compensated fairly and transparently. ACEP must continue to **adopt policies that prioritize the needs of the practicing emergency physician over corporate interests** – like our paid parental leave policy – and continue to develop ways to identify which groups and locations are following those policies. Over the past several years, I have served as Board Liaison for the ED Accreditation Task Force and helped spearhead our forthcoming ED Accreditation Program. Through accreditation, ACEP can set the standard for what a high-quality emergency department looks like and make sure that the physicians working in that department are prioritized, not forgotten.

Since the founding of the EM specialty, **our entire field has been increasingly influenced by the corporatization and financialization of medicine**. We have seen financial entities, including private equity, increasingly interested in emergency medicine as a potential source of profits, and have seen emergency medicine companies increasingly focused on maximizing their income and increasing profits for company owners. When the specialty was founded, those company owners were practicing emergency physicians, but increasingly, the owners are shareholders in large medical groups or even private equity companies. The forces driving these trends are much larger than ACEP, and much larger than emergency medicine – they span the entire American economy. While we have always seen ourselves as representing everyone in emergency medicine, **ACEP needs to continue to do more to focus on our roots as the defenders of the emergency physicians themselves**. We may not be able to stop consolidation, but we can be the leading voice for concerns about the negative impacts of EM consolidation and financialization of our patients and our practice. As Chair, I led the board in writing a [statement](#) voicing the threat that these changes pose to physician autonomy. Our work to empower the emergency physician in this landscape must continually increase to counterbalance growing corporate practice interests.

Question #2: What are your ideas for creating and/or providing tangible and indispensable benefits to ACEP members?

The two greatest benefits of ACEP membership will always be our **members** and our **advocacy**. The ability to collaborate and network with fellow members – developing relationships and growing opportunities within our field – is absolutely indispensable and our advocacy team is incredible at speaking out at all levels for the needs of the individual emergency physician. But what can be done to make these benefits more tangible?

- Enhance **networking** opportunities: at the annual meeting and through EngagED
- Update our **educational products** to reflect the needs of the 21st century learner: as Chair of ACEP’s “Tiger Team,” I am leading our efforts to revamp the annual meeting to ensure it is *the* time and place where the global emergency medicine community gathers to connect, evolve and reignite their passion for serving patients
- Expand **leadership development** programs: engaging members early and enhancing their own ability to improve the EM environment including:
 - Training any interested EPs on how to own and run their own practice, expanding on the successful Independent EM Group MasterClass
 - Helping today’s physician leaders in EM become tomorrow’s hospital executives and insurance company CMOs
- **ED Accreditation**: ACEP’s standards – requiring workplaces to provide sufficient resources for EPs to provide excellent care – can help EPs identify workplaces worthy of being their site of practice

- Identify expanded **practice opportunities** for EPs: our attrition rates are staggering, with 1 out of 10 female EPs and 1 out of 13 male EPs leaving the practice of EM within 5 years of graduating from residency. Our skill sets are tremendous and we don't want to lose that talent. Our current strategic plan and New Practice Models Task Force have started this work, and it must be heavily prioritized.
- Educate members about **unionization** and support efforts to unionize: as our employers consolidate, this option should be open to us to counterbalance their size and power
- Optimize **the EM Data Institute**: gather and disseminate data to allow smaller practices to compete with their consolidated brethren with the power of "big data" behind them
- Grow critical **advocacy at the state and hospital level**: some of the most important decisions impacting our practice aren't made in DC, but much closer to home

Realizing these opportunities allows ACEP to continue providing timely resources within our evolving specialty and will provide exceptional, tangible value to our members. While some of these efforts may sound like pipe dreams, I have both the experience and the resolve to actualize these dreams.

Question #3: What new thoughts do you have in balancing board certified emergency physician workforce distribution gaps and safe scope of practice for non-physicians?

No patient should be seen in an emergency department without the involvement of a residency-trained, board-certified (or board-eligible) emergency physician. ACEP defines this as the gold standard in emergency care. However, we cannot forget that rural areas face significant shortages of emergency physicians. Despite the growth we have seen in residency programs, we are not seeing more emergency physicians working in remote EDs. Recent data published in Annals showed that between 2013 and 2019, the percentage of clinicians working in rural areas who were emergency physicians actually dropped slightly. It is critical for our specialty to work on our **rural pipeline**. This means supporting efforts to recruit college students from rural areas in their **pre-med** years and support their transition into medical school, then continuing to expose **medical students** to the experience of rural medicine during their clerkship years. If we wait until residency for trainees from urban areas with only urban experiences to get first hand experience in a rural setting, it may be too late to persuade them of the value of a rural career. This limitation does not mean that rural rotations should not be supported. **Rural rotations for emergency medicine residents** need to be prioritized and made much more accessible. Trainees should be incentivized to participate in these rotations with optimized scheduling, supported housing, and an additional stipend to cover the expense of being away from home. We must work to reduce structural and accreditation barriers to the availability of these rotations through enhanced collaboration with the ACGME, CORD and program directors, rural EPs and rural hospitals. Practicing in a rural area can be deeply rewarding with opportunities to spend more time at the bedside and develop deeper relationships with a smaller cadre of ED staff. The more positive experiences we can create for trainees within rural practices, the more EPs we can attract to these areas.

As the problem of strengthening the rural pipeline cannot be solved overnight, in the interim, we will continue to see some nurse practitioners and physician assistants developing careers in rural emergency departments. Evidence shows that their presence has been increasing in rural EDs, and ACEP's own Rural Task Force identified in 2020 that some rural EDs may not have sufficient volume to support dedicated ED physician staffing. However, both the Rural Task Force (2020) and the Telehealth Task Force (2021) agreed that **telehealth supervision of NPs and PAs in rural practice environments** by board-certified emergency physicians is a viable model for improving patient safety and extending the reach of the BC EP through the use of a physician-led team. A "hub and spoke" model allows a centrally located board-certified EP to collaboratively supervise NPs and PAs in multiple hospitals simultaneously. Continuous improvements in technology and broadband capability mean that this kind of supervision will become easier every year and can allow true team-based care even without an emergency physician physically present at the bedside. To optimize this kind of care, we must ensure that our trainees are learning the skills they will need to be effective in this role, including strategies for effectively supervising NPs and PAs and how to effectively use telehealth technologies to evaluate patients, from building rapport to performing video physical exams.

Finally, in order to incentivize emergency physicians to practice in rural areas where patient volumes may be lower, we must seek out ways to compensate them for the hours they put in standing at the ready for critically ill patients to arrive. We do not fund rural fire departments solely based on the number of fires they respond to per year, and we should not pay rural emergency physicians based solely on the number of patients they see. A rural ED staffed by a well-trained EP is an essential resource in small communities that may be otherwise lacking in readily available healthcare resources. Both rural EDs and rural EPs should receive compensation reflecting the critical nature of that resource. All EPs are currently experiencing the pain of our current boarding crisis, and the **lack of sufficient funding of our safety net and surge capacity** is a contributor to that crisis. We cannot continue to make that mistake in rural America, where our neighbors deserve the same access to high-quality emergency physicians delivered in urban areas.

CANDIDATE DATA SHEET

Alison J. Haddock, MD, FACEP

Contact Information

1973 W McKinney St, Houston, TX, 77019

Phone: (425) 246-6310

E-Mail: ajh2003@gmail.com

Current and Past Professional Position(s)

Current:

Assistant Professor

Department of Emergency Medicine

Also appointed in Department of Education, Innovation and Technology and Center for Ethics and Health Policy
Baylor College of Medicine in Houston, TX

Former: Attending Emergency Physician at Tacoma Emergency Care Physicians (small democratic group in Washington State) and Attending Emergency Physician with CEP America (now Vituity; primarily at Edmonds, WA site with shifts at several hospitals in Sacramento, CA)

Education (include internships and residency information)

Residency: University of Michigan Emergency Medicine Residency, 2007-2011

Medical School: Cornell Medical College, MD, 2007

Undergraduate: Duke University, BS, 2003

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine, Board Certified, 2012

Recertified 2022

Professional Societies

ACEP, TCEP, TMA, CORD, EMRA Honorary/Life Member

National ACEP Activities – List your most significant accomplishments

Vice President, ACEP Board of Directors: 2020-2021

Chair, ACEP Board of Directors: 2021-2022

Elected member, Board of Directors: 2017-2020, 2020-2023

Chair, “Tiger Team” to revamp ACEP’s in-person educational offerings, 2022-present

Board Liaison Positions:

Committees: Education, Emergency Medicine Practice, Well-Being, Bylaws, State Legislative and Regulatory

Sections: AAWEP, YPS, Telehealth, Palliative, Wellness, Critical Care, Undersea and Hyperbaric

Task Forces:

ED Accreditation Task Force, Board Liaison, 2022-2023

EM Telehealth Task Force, Board Liaison, 2021-2022

Awards

ACEP 9-1-1 Network Member of the Year, 2011

Council Horizon Award, 2016

EMRA “45 Under 45”, 2019

National Board Service

NEMPAC Board of Trustees: 3 terms (2012-2015, 2015-2018, 2018-2020)

EMRA Board of Directors: Legislative Advisor (2010-2012)

Committee / Section / Task Force Involvement (prior to Board service):

ACEP State Legislative & Regulatory Committee: Member 2012-2017; **Chair** 2015-2017

ACEP Federal Governmental Affairs Committee 2010-2017

ACEP Education Committee, Educational Meetings Subcommittee: 2013-2017

Member of the AAWEP, Palliative Medicine, Social EM and Young Physicians Sections

Council Participation & Leadership (prior to Board service):

Past Alternate Councilor/Councilor for EMRA delegation, WA Chapter, TX Chapter

Past Council Steering Committee member, Council Reference Committee member

Co-Editor of **EMRA Advocacy Handbook**, 6th edition released at LAC 2023

ACEP Chapter Activities – List your most significant accomplishments

Texas College of Emergency Physicians Board Member: 2016-2019

TCEP Board Liaison to TCEP Government Relations Committee: 2016-2019

TCEP Leadership and Advocacy Fellow: 2015-2016

TCEP Leadership and Advocacy Fellowship Co-Director: 2016-2017

Practice Profile

Total hours devoted to emergency medicine practice per year: ~2200 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 25 % Research 10 % Teaching 45 % Administration 20 %

Other: _____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am employed by Baylor College of Medicine and practice clinically at Ben Taub Hospital, a busy safety-net county hospital and Level One trauma center in Houston, TX. My primary responsibilities include direct patient care, bedside teaching, and several teaching and leadership roles within the medical school. I also work additional hours at Baylor St Luke’s McNair emergency department, a lower-volume community hospital where I provide solo coverage.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Assistant Director of Faculty Development, Dept of EM

Faculty Senator

Co-Director, Master Teachers Fellowship Program

UME Thread Director for PREP (Preparing to Enter the Profession) and MIND (Metacognition, Inquiry and Discovery) threads

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert

0

Cases

Plaintiff Expert

0 Cases

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Alison J. Haddock, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Baylor College of Medicine

Address: 1 Baylor Plaza

Houston, TX 77030

Position Held: Associate Professor, Emergency Medicine

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 Lane

Irving, TX 75063

Type of Organization: National Medical Specialty Society

Chair of the Board of Directors, October 2021 – October 2022

Vice President, October 2020 – October 2021

Leadership Position: Many additional roles including spokesperson, numerous Committees

Term of Service: Board of Directors, 2017-present

Organization: Texas College of Emergency Physicians

Address: 401 W. 15th Street, Suite 695

Austin, TX 78701

Type of Organization: State Medical Specialty Society

Board of Directors (2016-2019), numerous Committees; Co-Chair, TCEP

Leadership Position: Leadership and Advocacy Fellowship Program: 2016-2018

Term of Service: 2014-present

Organization: National Emergency Medicine Political Action Committee

Address: 4950 W Royal Lane

Irving, TX 75063

Type of Organization: Political Action Committee

Leadership Position: Member of Board of Trustees

Term of Service: 2012-2020

Organization: Emergency Medicine Residents Association

Address: 4950 W Royal Lane

Irving, TX 75063

Type of Organization: Medical Specialty Society

Leadership Position: Legislative Advisor – member of Board of Directors

Term of Service: 2010-2012

Organization: Friends of the Texas Medical Center Library

Address: 1133 John Freeman Blvd.

Houston, TX 77030

Type of Organization: Nonprofit 501(c)3

Leadership Position: member of Board of Directors

Term of Service: 2016-2020

Organization: Texas Medical Association

Address: 401 W 15th St

Austin, TX 78701

Type of Organization: Membership organization

Delegate to TMA Council (2016-present); Member (2016-2022) and Chair (2021-22) of Council on Health Promotion; Member Select Committee on Medicaid, CHIP and the Uninsured (2017-present); Alternate Delegate to

Leadership Position: AMA House of Delegates (2017)

Term of Service: 2016-present

Organization: Washington Chapter, ACEP

Address: 2001 6th Ave, Suite 2700

Seattle, WA 98121

Type of Organization: Membership organization

Leadership Position: Member of Government Relations Committee

Term of Service: 2011-2014

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 [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.

2023-2024

Board of Directors

Sandra Williams, DO, MPH, FACEP
President

Doug Jeffrey, MD, FACEP
President Elect

A.J. Kirk, MD, FACEP
Treasurer

Bryan Dunn, MD, FACEP
Secretary

Sterling Overstreet, MD, FACEP
Immediate Past President

Sara Andrabi, MD, FACEP

Jessica Best, MD, FACEP

Ciaura Brown, MD, MBA

Angela Cornelius, MD, FACEP

Abbey Pastorelle

Anant Patel, DO, FACEP

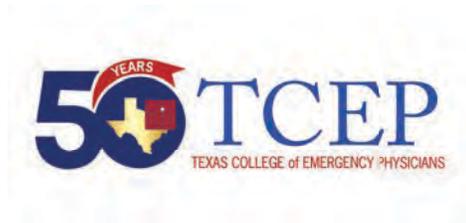
Julien Mahler, MD

Marcus Sims, DO, FACEP

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.*



August 9, 2023

**Sonja Montgomery
ACEP Council
Dallas, TX**

Dear Councillors,

On behalf of the Texas College of Emergency Physicians, we proudly and enthusiastically endorse Alison Haddock, MD, FACEP for President-Elect of the American College of Emergency Physicians. We are confident that Dr. Haddock's skilled leadership will ensure that the College continues to thrive over the next three years.

During her six years on the ACEP Board of Directors, Dr. Haddock has held many leadership roles and supported many key sections, committees, and task forces. Last year, she was a highly effective Board Chair, fostering successful collaboration and ensuring an emphasis on strategy. In the preceding year, she served as Vice President, acting as an effective liaison with developing leaders in the College through her work with the Young Physicians Section and EMRA. Her commitment to mentorship, especially evident in her guidance to young physicians within TCEP, is commendable and reflects her unwavering advocacy for the growth and development of our profession. Dr. Haddock's legacy as a former director of the TCEP Leadership and Advocacy Fellowship underscores her commitment to nurturing the next generation of leaders in Emergency Medicine.

Dr. Haddock has been an astute leader for many years both within TCEP and ACEP, and we enthusiastically endorse her for the position of President-Elect of ACEP.

Sincerely,

A handwritten signature in black ink that reads 'Sandra Williams'.

Sandra Williams, DO, MPH, FACEP

Alison J. Haddock, MD, FACEP

The President with a Plan

At this critical time for our organization, we need an experienced leader.

Emergency physicians know all too well the problems our specialty is facing. ACEP needs a president with a plan – and when ACEP stands up for EM physicians, they will stand up for ACEP.

The Plan:

- **Prioritize emergency physicians** over corporate interests by becoming the leading voice for concerns about the negative impacts of EM corporatization and financialization
- **Set the standard** for what a high-quality emergency department looks like, including important physician-first policies like paid parental leave, through our forthcoming ED Accreditation Program
- **Lead the fight against ED boarding and crowding**, which threatens both the well-being of patients and the wellness of emergency physicians
- **Expand leadership development**, engaging members early and helping today's EM leaders become tomorrow's practice owners and hospital C-suite executives
- **Update our educational offerings** to reflect the needs of the 21st century learner
- **Enhance the presence of sections and chapters** as critical locations for members to find their home within our large organization
- **Grow critical advocacy** at the state and hospital level to help keep decision making in the hands of physicians, not governments or corporations
- **Address membership attrition rates** by intensifying outreach to new residency grads and young physicians – the next generation members we need most
- **Support physician efforts to unionize** and educate our members about unionization as an option to counterbalance our employers' size and power
- **Protect emergency physicians from predatory employment practices** by fighting for fair contracts and due process
- **Address attrition from the specialty** by identifying and highlighting expanded practice opportunities for EPs
- **Educate policymakers and the public** that residency-trained board-certified emergency physicians provide the highest quality unscheduled acute care
- **Strengthen our rural pipeline**, including efforts to recruit students from rural areas as early as undergrad and supporting rural rotations for EM residents
- **Optimize the EM Data Institute** to help smaller practices compete with their consolidated brethren with the power of "big data" behind them
- **Unite emergency physicians from across the globe** at an updated annual meeting that offers the ultimate gathering place for all

As I conclude my sixth year of service on the ACEP Board of Directors, I am proud to have represented you as a board member, Vice President, Chair of the Board, and liaison to committees, sections, and task forces. With the practical knowledge I have gained through these experiences, I am ready to lead. ACEP must rapidly evolve to meet the needs of our members amidst the ever-shifting health care landscape, and I am the right choice to meet this challenge.

ELECT

ALISON HADDOCK

**for ACEP
President**



THE PRESIDENT WITH A PLAN.

AT THIS CRITICAL TIME, WE NEED AN EXPERIENCED LEADER.

Emergency physicians know all too well the problems our specialty is facing. ACEP needs a president with a plan – and when ACEP stands up for EM physicians, they will stand up for ACEP.

ELECT

ALISON HADDOCK

**HERE'S
THE
PLAN:**

**PASSION FOR OUR SPECIALTY.
PASSION FOR PROGRESS.**

- **Prioritize emergency physicians** over corporate interests by becoming the leading voice for concerns about the negative impacts of EM corporatization and financialization
- **Set the standard** for what a high-quality emergency department looks like, including important physician-first policies like paid parental leave, through our forthcoming ED Accreditation Program
- **Expand leadership development**, engaging members early and helping today's EM leaders become tomorrow's practice owners and hospital C-suite executives
- **Enhance the presence of sections and chapters** as critical locations for members to find their home within our large organization
- **Grow critical advocacy** at the state and hospital level to help keep decision making in the hands of physicians, not governments or corporations
- **Address membership attrition rates** by intensifying outreach to new residency grads and young physicians – the next generation members we need most
- **Educate our members about unionization** as an option to counterbalance our employers' size and power
- **Protect EPs from predatory employment practices** by fighting for fair contracts and due process
- **Address attrition from the specialty** by identifying and highlighting expanded practice opportunities for EPs
- **Educate policymakers and the public** that residency-trained board-certified emergency physicians provide the highest quality unscheduled acute care
- **Unite emergency physicians across the globe** at an updated annual meeting offering the ultimate gathering place for all

Alison J. Haddock, MD, FACEP

1973 W McKinney St

Houston, TX 77019

(425) 246-6310

alison.haddock@bcm.edu

I. GENERAL BIOGRAPHICAL INFORMATION

A. Personal

1. Full Name: Alison Jonelle Haddock

B. Education

1. Undergraduate Education
Bachelor of Science, Program II Major in Biolinguistics
Duke University, Durham, N.C.
Cum Laude Graduate
August 1999 – May 2003
2. Medical Education
Doctor of Medicine
Weill Cornell Medical College, New York City, N.Y.
August 2003 – May 2007
3. Postgraduate Training
Residency, Emergency Medicine
University of Michigan, Ann Arbor, M.I.
June 2007 – June 2011

C. Academic Appointments

1. Current Faculty Positions at BCM
 - a. Assistant Professor
 - 1) Co-Primary Appointments:
 - a) Department of Education, Innovation and Technology, 2021 – present
 - b) Henry J.N. Taub Department of Emergency Medicine, 2014 – present
 - 2) Secondary Appointment:
 - a) Center for Medical Ethics and Health Policy, 2021 – present
 - b. Internal Titles, Department of Emergency Medicine:
 - 1) Assistant Director of Faculty Development; Dept of Emergency Medicine, 2019 – present
 - 2) Director of Health Policy: Advocacy; Dept of Emergency Medicine, 2014 – present
 - 3) Co-Director, Emergency Medicine Health Policy Fellowship, 2014 – present
2. Previous Faculty Positions at BCM
 - a. Medical Ethics Scholar, Center for Medical Ethics and Health Policy, 2018 – 2021
3. Previous Faculty Positions at Other Institutions – none
4. Faculty Appointments at Other Institutions While at BCM – none

D. Other Advanced Training

1. Quality Matters Teaching Online Certificate
<https://www.qualitymatters.org/professional-development/toc>
Completed August 2022
Courses include:

- Gauging Your Technology Skills
 - Evaluating Your Course Design
 - Exploring Your Institution’s Policies
 - Orienting Your Online Learners
 - Connecting Learning Theories to Your Teaching Strategies
 - Creating Presence in Your Online Course
 - Assessing Your Learners
2. Baylor College of Medicine Master Teacher Fellowship Program, October 2017 – September 2019
 3. Texas Medical Association (TMA) Leadership College, September 2015 – September 2016
 - a. Selected to participate in this longitudinal multispecialty program which included lectures, workshops, group discussions and coaching; designed to build confident physician leaders by teaching skills in communication, advocacy, negotiation, conflict management and team building

E. Other Information

1. Honors or Awards
 - a. Texas Monthly “Rising Star Super Doctor”, 2021
 - b. Texas Monthly “Rising Star Super Doctor”, 2020
 - c. Baylor College of Medicine Norton Rose Fulbright Faculty Excellence Award in Teaching and Evaluation, 2020
 - d. Emergency Medicine Residents Association (EMRA) 45 under 45, 2019
 - e. Texas Monthly “Rising Star Super Doctor”, 2019
 - f. Baylor College of Medicine Early Career Faculty Award for Excellence in Patient Care, 2019
 - g. Houston Business Journal Health Care Hero, “Rising Star Award”, 2018
 - h. American College of Emergency Physicians Council Horizon Award, 2016
 - i. American College of Emergency Physicians 9-1-1 Network Member of the Year, 2011
 - j. Khare Award Academic Scholar, University of Michigan EM Residency, 2010
2. Board Eligibility/Certification
 - a. Certified by the American Board of Emergency Medicine, 2012
 - b. Completed recertification, 2022
 - c. Active Maintenance of Certification
3. Other Non-academic Positions (Historical)
 - a. Tacoma Emergency Care Physicians, Tacoma, WA
 - 1) Attending Emergency Physician, 2011-2013
 - b. CEP America (now Vituity), Edmonds, WA
 - 1) Attending Emergency Physician and Partner, 2013-2014

II. RESEARCH INFORMATION

A. Research Support

Active Research Support n/a

Completed Research Support

Technical Title of Project: Biomarkers in Acute Stroke (BASE)
 Name of Funding Agency: Ischemia Care, LLC
 Investigator Relationship or Role on Project: site PI
 Funding: research staff funded, PI not funded
 2015 – 2018

B. National Scientific and Professional Participation

1. Editorial Contributions
 - a. Peer Reviewer
 - 1) Emergency Medicine Reports, 2018 – present

- 2) Annals of Emergency Medicine, 2018 – present
- 3) PLOS One, 2020 – present
- 2. Review Panels and Selection Committees
 - a. Chair, *JACEP Open* Editor-in-Chief Evaluation Task Force, 2021
- 3. Professional Societies
 - a. Membership in Professional Societies
 - 1) International Association of Medical Science Educators (IAMSE), 2022 – present
 - 2) Texas Medical Association (TMA) and Harris County Medical Society (HCMS), 2014 – present
 - 3) Council of Emergency Medicine Residency Directors (CORD), 2016 – present
 - 4) American College of Emergency Physicians (ACEP), 2007 – present
 - 5) Emergency Medicine Residents Association (EMRA), member + alumni member, 2007 – present
 - b. Leadership in Professional Societies (excluding Elected Positions, noted below)
 - 1) National Emergency Medicine Political Action Committee (NEMPAC) Board of Trustees: 2012 – 2020
 - a) Leadership role in ACEP’s PAC, the 4th largest physician PAC in the US
 - b) Assisted with allocation of almost \$1mil per year in national political contributions
 - 2) National Task Forces
 - a) ACEP ED Accreditation Task Force, Board Liaison, 2022-present
 - b) ACEP Emergency Medicine Telehealth Task Force, Board Liaison, 2021-2022
 - c) ACEP Residency Visit Program Task Force, 2019-2020
 - d) ACOG (American College of Obstetrics & Gynecology) Pregnancy & Heart Disease Presidential Task Force ACEP representative, 2018-2019
 - e) ACEP Joint Task Force on Reimbursement Issues, Balance Billing group: 2016-2019
 - f) National Perinatal Association workgroup on first trimester pregnancy loss in the ED: 2016-2017
 - g) ACEP Alternative Payment Models Task Force: 2015-2018
 - h) ACEP Advisory Group Task Force: 2012-2014
 - i) ACEP Delivery System Reform Task Force: 2011-2012
 - 3) National Committees
 - a) ACEP State Legislative Committee
 - 1. Board Liaison: 2017-2019, 2022-present
 - 2. Chair: 2015-2017
 - 3. Member: 2012-2019
 - b) ACEP Bylaws Committee Board Liaison, 2020-2021
 - c) ACEP Awards Committee Member, 2019-2020
 - d) ACEP Well-Being Committee Board Liaison, 2019-2020
 - e) ACEP Emergency Medicine Practice Committee Board Liaison, 2018-2020
 - f) ACEP Membership Committee Board Liaison, 2017-2018
 - g) EMRA Awards Committee, 2012-2016
 - h) ACEP Federal Governmental Affairs Committee, 2010-present
 - i) EMRA Health Policy Committee, 2009-2012
 - 4) National ACEP Sections (interest groups)
 - a) Palliative Medicine Section, Board Liaison, 2018-2021, 2022-present
 - b) Telehealth Section, Board Liaison, 2017-present
 - c) American Association of Women Emergency Physicians (AAWEP), Board Liaison, 2017-present
 - d) Young Physicians Section, Board Liaison 2020-2021, member 2011-2021
 - 5) ACEP Council
 - a) Leadership

1. Nominating Committee: 2018-2019
 2. Council Steering Committee: 2015-2017
 3. Council Reference Committee: 2013, 2015 (Committee B on policy issues)
 - b) Participation
 1. Councilor, representing Texas State Chapter: 2015-2017
 2. Alternate Councilor, representing Washington State Chapter: 2013
 3. Alternate Councilor, representing EMRA: 2011, 2012
 - 6) ACEP Chapter Involvement (State-Level Leadership)
 - a) Co-Chair, TCEP Leadership and Advocacy Fellowship Program: 2016-2018
 - b) TCEP Government Relations Committee: 2015-present
 - c) TCEP Education Committee: 2015-present
 - d) TCEP Leadership and Advocacy Fellow: 2015-2016
 - e) Washington ACEP Chapter Legislative Affairs Committee: 2011-2014
 - 7) American Medical Association
 - a) Delegate, Texas Delegation to the Young Physicians Section at AMA Meeting, June & November 2017
 - b) Alternate Delegate, Texas Delegation to the House of Delegates at AMA Meeting, June & November 2017
 - 8) Texas Medical Association / Harris County Medical Society (state/local leadership)
 - a) TMA Council on Health Promotion: 2016-2022
Chair, 2021-2022
 - b) TMA Select Committee on Medicaid, CHIP and the Uninsured, 2017-present
 - c) Harris County Medical Society (HCMS) Quality Committee: 2016
 - d) TMA Council
 1. Delegate, HCMS at TMA Council, 2020 – present
 2. Delegate, Young Physicians Section and HCMS at TMA Council, 2017 & 2019
 3. Alternate Delegate, Harris County Medical Society at TMA Council, 2016
4. Elected Positions
- a. American College of Emergency Physicians (ACEP) Board of Directors
 - 1) Chair of the Board of Directors, October 2021 – October 2022
 - 2) Vice President, October 2020 – October 2021
 - 3) Board Member, October 2017 – present (elected to two three-year terms)
 - a) ACEP is the largest national organization of emergency medicine physicians with nearly 40,000 members. Board members oversee all aspects of the organization including setting organizational policy, developing clinical policies, and overseeing educational activities and quality management programs.
 - b. Texas College of Emergency Physicians (TCEP) Board of Directors, April 2016 – April 2019 (three-year term)
 - c. Emergency Medicine Residents Association (EMRA) Board of Directors
 - 1) Legislative Advisor, two-year term, October 2010 – October 2012
5. Invited Lectures, Presentations, Research Seminars
- a. International: no presentations completed outside of US; ACEP annual meeting has an international audience
 - b. National
 - 1) American College of Emergency Physicians Annual Meeting (October 2022)
“Practicing Medicine Without A Law Degree: Emergency Care in a Post-Roe Era”
Delivered twice, both in-person in San Francisco, CA and on a virtual platform
 - 2) American College of Emergency Physicians Annual Meeting (October 2022)

- San Francisco, CA
“Telemedicine Regulatory Challenges Zooming to Your Practice”
- 3) Florida Atlantic University Grand Rounds Distinguished Speaker (May 2022)
Boca Raton, FL – Virtual due to Covid-19
“Become an Advocate: How Residents Can Improve Health Care”
“Health Policy Hot Topics”
 - 4) Council of Residency Directors Annual Meeting (February 2022)
San Diego, CA
“Clinical Pathologic Case Conference: Metabolic Acidosis”
 - 5) American College of Emergency Physicians Annual Meeting (October 2021)
Boston, MA – Virtual due to Covid-19
“#InsuranceFail: Who is Covering these Surprise Bills?”
 - 6) American College of Emergency Physicians Virtual Grand Rounds (June 2021)
Virtual with national audience
“How Advocacy Today Will Shape the Workforce of Tomorrow”
 - 7) FeminEM Idea Exchange (October 2020)
Chicago, IL – prepared, but cancelled due to Covid-19
“Workshop: Your personal roadmap to professional organization leadership”
 - 8) Illinois ACEP Resident Career Day (August 2020)
Chicago, IL – virtual due to Covid-19
“Become an Advocate: How Residents Can Improve Health Care”
 - 9) American College of Emergency Physicians Annual Meeting (October 2019)
Denver, CO
“#Insurance Fail: Who is Covering these Surprise Bills?”
 - 10) Arrowhead Regional Medical Center Emergency Medicine Residency Grand Rounds (June 2019)
Colton, CA
“Basic Billing and Coding for EM Residents” & “ACEP Update” & “Federal Advocacy in EM”
 - 11) Kent Emergency Medicine Residency Grand Rounds (June 2018)
Warwick, RI
“Getting Sued One Month Out of Residency: A True Story”
 - 12) Leadership and Advocacy Conference, American College of Emergency Physicians (May 2018)
Washington, DC
“Hot Topics: Prudent Layperson” & “State Level Advocacy” Panel
 - 13) FeminEM Idea Exchange (October 2017)
New York City, NY
“Don’t Just Get Mad: Get Involved – Advocacy for the FeminEM”

- 14) Leadership and Advocacy Conference, American College of Emergency Physicians (March 2017)
Washington, DC
“Out of Network / Balance Billing: Where Are We?”
- 15) Minnesota ACEP Annual Meeting: Keynote Lecture (November 2016)
Edina, MN
“Emergency Care and the Changing Political Landscape”
- 16) University of Michigan Grand Rounds (August 2016)
Ann Arbor, MI
“Getting Sued One Month Out of Residency: A True Story”
- 17) Leadership and Advocacy Conference, American College of Emergency Physicians (May 2016)
Washington, DC
“State Strategies to Deal With Out of Network / Balance Billing”
- 18) Leadership and Advocacy Conference, American College of Emergency Physicians (May 2013)
Washington, DC
“Current Issues in Health Policy”
- 19) New York Emergency Medicine Health Policy Assembly (November 2012)
New York City, NY
“20 Things EM Residents Can Do to Improve U.S. Healthcare”

c. Regional

- AAMC Southern Group on Educational Affairs (SGEA) Regional Conference (March 2022)
Virtual
“A Novel Approach to Curriculum Renewal through Student-Faculty Co-Creation.” [workshop]
Collaboration with Reusch RT, Khan N, Smith EE, Ismail N
- Policy Prescriptions Health Policy Symposium (April 2018)
Houston, TX
“Universal Coverage: Getting There from Here”
- Texas College of Emergency Physicians (TCEP) Annual Conference (April 2016)
Houston, TX
“Health Policy Current Events” with Cedric Dark

C. Publications

1. Full Papers in Peer Review Journals

Hameed AB, **Haddock A**, Wolfe DS, Florio K, Drummond N, Allen C, Taylor I, Kendig S, Presumey-Leblanc G, Greenwood E. Alliance for Innovation on Maternal Health: Consensus Bundle on Cardiac Conditions in Obstetric Care. *Obstet Gynecol.* 2023 Feb 1;141(2):253-263. doi: 10.1097/AOG.0000000000005048. Epub 2023 Jan 4. PMID: 36649333;

Zhu M, Srinivasan N, Karpe A, Bui A, Wang D, **Haddock A**. Characteristics of Healthcare Financial Assistance Programs Serving the Most Populous US Counties. *Journal of Health Care for the Poor and Underserved*. Aug 2022. PMID: 36245157. DOI: [10.1353/hpu.2022.0106](https://doi.org/10.1353/hpu.2022.0106)

Mitchell K, **Haddock A**, Husainy H, Walter L, Rajapreyar I, Wingate M, Smith C, Tita A, Sinkey R. Care of the Postpartum Patient in the Emergency Department: A Systematic Review with Implications for Maternal Mortality. *American Journal of Perinatology*. 2021 Jul 29. doi: 10.1055/s-0041-1732455. Epub ahead of print. PMID: 34327686.

Eppes C, Han S, **Haddock A**, Buckler G, Davidson C, Hollier L. Enhancing Obstetric Safety through Best Practices. *Journal of Women's Health*. 30(2): 265-269, Nov 2020. PMID: 33227226

ACOG Presidential Task Force on Pregnancy and Heart Disease (including **Alison Haddock MD**). ACOG Practice Bulletin No 212: Pregnancy and Heart Disease. *Obstetrics & Gynecology*. 133(5):e320–e356, May 2019. DOI: 10.1097/AOG.0000000000003243 PMID: 31022123

Boulee D, Kalra S, **Haddock A**, Johnson TD, Peacock WF. Contemporary stethoscope cleaning practices: What we haven't learned in 150 years. *American Journal of Infection Control*. 2019 March 47(3): 238-242. DOI: <https://doi.org/10.1016/j.ajic.2018.08.005> PMID: 30396696

Dark C, Pillow M, **Haddock A**. Teaching Health Policy in Graduate Medical Education: Proposed Curricular Components. *Med Ed Publish*. November 14th, 2018. DOI: <https://doi.org/10.15694/mep.2018.0000260.1>

Jauch EC, Barreto AD, Broderick JP, Char DM, Cucchiara BL, Devlin TG, **Haddock AJ**, Hicks WJ, Hiestand BC, Jickling GC, June J, Liebeskind DS, Lowenkopf TJ, Miller JB, O'Neill J, Schoonover TL, Sharp FR, Peacock WF. Biomarkers of Acute Stroke Etiology (BASE) Study Methodology. *Transl Stroke Res*. 2017 May 5. PMID: 28477280

Paulsen M, **Haddock A**, Silbergleit R, Meurer W, Macy M, Haukoos J, Sasson C. Empirical Hospital and Professional Charges for Patient Care Associated with Out of Hospital Cardiac Arrest Before and After Implementation of Therapeutic Hypothermia for Comatose Survivors. *Resuscitation*. 83(10): 1265-70. October 2012. PMID: 22410427

2. Full Papers Without Peer Review: None

3. Abstracts

Thadani A, Chen Z, Huang A, Van Benschoten V, Wang D, Gupta R, Huang X, Stagers Andrews K, **Haddock A**, Jaung M. Medical and Social Resources at Emergency Department Discharges: A Prospective Analysis of the Impact of a Volunteer Patient Discharge Initiative on Emergency Department Revisits. *Annals of Emergency Medicine*. October 2021. 78(4): S7–S8

Turner, A, **Haddock, A**, Bicette, R, Andrabi, S, Tran, T, & Dark, C. (2021, October 25). A Team-Based Learning Approach to Charting and Coding Education for Emergency Medicine Residents. [Poster Abstract]. 2021 American College of Emergency Medicine Academic Assembly, Boston, MA, United States.

Thadani A, Huang A, Van Benschoten V, Chen Z, Gupta R, Wang D, **Haddock A**, Jaung M. Social Resources at Emergency Department Discharges: Evaluation of Patients Request and Utilization. BCM Health Policy Research Day, Judges 1st Choice Winner. May 2020.

Haddock A, Song A, Gaber H, Pillow M. Diversity in Media Representation of Physicians: An Analysis of Stock Images. BCM Center of Excellence in Health Equity, Training and Research (COE) Research Summit. June 2018.

4. Books

a. Complete Books Written: none

b. Books Edited

1) **Haddock A** & Schlicher N. [Editors-in-Chief.] Emergency Medicine Advocacy Handbook, 6th edition. *Emergency Medicine Resident's Association*. Currently in editorial process; anticipated publication 2023.

2) **Haddock A** & Schlicher N. [Editors-in-Chief.] Emergency Medicine Advocacy Handbook, 5th edition. *Emergency Medicine Resident's Association*. 2019.

3) **Haddock A** & Schlicher N. [Editors-in-Chief.] Emergency Medicine Advocacy Handbook, 4th edition. *Emergency Medicine Resident's Association*. 2016.

c. Book Chapters Written:

1) **Haddock A** & Uren B. "Politics of a State System". *Strauss & Mayer's Emergency Department Management, 2nd edition*. American College of Emergency Physicians. January 2021.

5. Other Works: Communication To Scientific Colleagues

a. Turner A, **Haddock A**, Bicette R, Andrabi S, Tran T, Dark C. "Experimental Curriculum: Team-Based Learning for New AMA Charting and Coding Guidelines" EM Resident. March 10th, 2023.

b. **Haddock A**. New Legislation on DNR Orders: Now in Effect. TCEP Member Alert. April 19th, 2018.

c. **Haddock A** & Monroe H. Vermont to Launch All-Payer Accountable Care Organization Model for Financing Health Care. ACEPNow. January 10th, 2017
<https://www.acepnow.com/article/vermont-launch-payer-accountable-care-organization-model-financing-health-care/>

6. Other Works: Communication To General Public

1) Sheldon, M. and Mauro, E. (Feb 16, 2023) "In Texas, where abortion is already a crime, more roadblocks to access could be coming." CBC News, Canada.
<https://www.cbc.ca/news/world/texas-abortion-access-1.5957451>

2) Ungar, L and Hollingsworth, H. (Nov 20, 2022) "Despite dangerous pregnancy complications, abortions denied." Associated Press (widely disseminated)
<https://apnews.com/article/abortion-science-health-business-890e813d855b57cf8e92ff799580e7e8>

3) Zernike, K. (Sept 20, 2022) "Medical impact of Roe reversal goes well beyond abortion clinics, doctors say." New York Times.
<https://www.nytimes.com/2022/09/10/us/abortion-bans-medical-care-women.html>

- 4) Vestal, C. (Sept 1, 2022) "Some abortion bans put patients, doctors at risk in emergencies." Pew Stateline.
<https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/09/01/some-abortion-bans-put-patients-doctors-at-risk-in-emergencies>
- 5) Ali, S. (Aug 15, 2022) "State laws could be jeopardizing care in emergency rooms." The Hill.
<https://thehill.com/changing-america/well-being/prevention-cures/3603199-state-laws-could-be-jeopardizing-abortion-care-in-emergency-rooms/>
- 6) Meyer, H. (Aug 9, 2022) "Patients and Doctors navigate conflicting abortion and emergency care laws." Kaiser Health News (national distribution includes Scientific American) <https://www.scientificamerican.com/article/patients-and-doctors-navigate-conflicting-abortion-and-emergency-care-laws/>
- 7) Quijano, E. (Oct 12, 2021) "CDC: 65.5% of population partially vaccinated." CBSN, CBS News' 24/7 digital streaming news service. <https://www.cbsnews.com/video/average-pace-of-first-dose-coronavirus-vaccinations-in-us-reaches-december-lows/>
- 8) Ogilvie, J. (Sept 20, 2021) "COVID medical costs leave families in dire straits." DAME Magazine.
- 9) Guzman, Z. (Sept 15, 2020) "We need a vaccine that's medically effective & trusted." Yahoo! Finance.
<https://au.finance.yahoo.com/news/bill-gates-coronavirus-response-154702039.html>
- 10) Gray, L. (Aug 8, 2020) " 'This stuff is hard.' How one Houston ER doc keeps her family safe." Houston Chronicle.
- 11) King, J. (July 20, 2020) "Dr. Alison Haddock Discusses Rising Coronavirus Cases Pushing Hospitals to Breaking Point." CNN.
- 12) Brock, S. (July 19, 2020) "Miami sets curfew as Florida's coronavirus cases surge to 350,000; Record numbers in Texas as 85 babies test positive in one county." NBC Nightly News.
- 13) Reeves, J. (July 18, 2020) "As virus surges in some US states, emergency rooms are swamped." Associated Press. (widely disseminated, both nationally and internationally)
- 14) Berman, J. (July 17, 2020) "What's better: masks with filters or without?" FOX26 Houston.
- 15) Guzman, Z. (July 10, 2020) "Dow jumps as Gilead says drug reduces COVID-19 death risk." Yahoo! Finance.
- 16) Hernandez, H. (July 7, 2020) "Face masks vs face shields for teachers." KPRC-TV, Click2Houston.
- 17) Amroliwala, M. (July 7, 2020) "Coronavirus: Cases surge in the US." BBC World News.
- 18) Tur, K. (July 6, 2020) "Texas breaks COVID-19 case record over July 4th weekend." MTP Daily: MSNBC.

- 19) Tozzi, J et al. (June 24, 2020) “Hospitals are counting beds again with cases rising.” Bloomberg.
- 20) Johnson, S. (May 29, 2020) “CDC underestimates COVID’s toll on healthcare workers, experts say.” Modern Healthcare.
- 21) Galvin, G. (April 14, 2020) “CDC: Nearly 10,000 Health Care Workers Had Coronavirus – But There’s Probably More.” US News & World Report.
- 22) Grieder, E. (April 8, 2020) “Face masks are latest example of ‘new normal’ in coronavirus era.” Houston Chronicle.
- 23) Moritz, M. (April 7, 2020) “Are you wearing your face mask correctly? Keeping your hands off the mask is key.” KSAT, San Antonio.
- 24) Hernandez, H. (April 6, 2020) “Are you wearing your cloth mask the right way? Here are the most common mistakes.” KPRC-TV, Click2Houston.
- 25) McArdle, J. (April 1, 2020) “Dr. Alison Haddock on U.S. Coronavirus Response.” Washington Journal, CSPAN.
- 26) Deam, J. (March 22, 2020) “As cases mount, Texans tackle the reality of the pandemic.” Houston Chronicle.
- 27) Deam, J. (March 19, 2020) “Texas doctor on pandemic’s ‘front line’ wages harrowing, 8-hour battle to get tested for COVID-19.” Houston Chronicle.
- 28) George, C. (Aug 7, 2019) “Physicians call for policy solutions following mass casualty shootings.” Texas Medical Center News.
- 29) Lee, A. (Aug 6, 2018) “Blue Cross Blue Shield of Texas’ Controversial ER Claims Process Begins.” Houston Public Media.
- 30) Lee, A. (June 4, 2018) “Blue Cross Blue Shield of Texas Delays Controversial Change After Backlash). Houston Public Media.

III. TEACHING INFORMATION

A. Educational Leadership Roles

1. Thread Director, PREP (Preparing to Enter the Profession) and MIND (Metacognition, Inquiry and Discovery) (January 2022 – present)
 - a. Responsible for coordination of curricular content throughout MS1-MS4 year in multiple subject areas, including clinical skills, communication, ethics, health systems science, professionalism, self-directed learning, inquiry/research and more. Role includes defining learning outcomes and objectives, ensuring continuity and completeness without redundancy across the four-year curriculum, collaboration with content experts to develop assessments and learning experiences. Reporting to the Assoc Dean of Curriculum and Vice Dean of the Medical School.
 - b. FTE support from the Curriculum Office
2. Master Teachers Fellowship Program Co-Director (July 2021 – present)

- a. Role includes developing monthly customized curricula of 4 hours of educational programming to improve the knowledge, skills, and attitudes of BCM faculty in the field of education. Conducting individual meetings with fellows to support them in their educational research projects. Collaborating with co-director and advisory team on curriculum renewal to shift from time-based to competency-based curriculum. 22 fellows enrolled in current class of program (2021-2023).
- b. FTE support from the Dept of Education, Innovation and Technology
3. Curriculum Renewal Workgroup Member (November 2019 – January 2022)
 - a. *Chair of Metacognition, Inquiry and Discovery (MIND) Subgroup and Pathways ad hoc Subgroup of (CREW)*. Led a team of multiple faculty members and medical students in developing learning outcomes and curricular plans for pertinent subject matter in the new curriculum. Areas covered include self-directed learning, evidence-based practice, and forthcoming mandatory student research project. Also involved in development of various system blocks in the new MS1 curriculum.
 - b. FTE support from Office of the Provost
4. Course Director, Climate Change and Human Health pre-clinical elective (Fall 2020)
In collaboration with student leaders, developed course, recruited participants
5. Emergency Medicine Health Policy GME Curriculum and Fellowship Co-Director (2015 – present)
 - a. Fellowship initiated in 2015 with first fellow successfully recruited in '21-'22 AY
6. American Board of Emergency Medicine: Oral Examiner (2017-2019)
 - a. Served as examiner for new residency graduates to become board certified in EM
 - b. On hold currently due to conflict-of-interest concerns with other leadership roles
7. Chair, ACEP Education “Tiger Team” 2022-present
Selected to lead a team of staff and members in developing an innovative new model for ACEP’s annual meeting, which draws thousands of emergency physicians from around the globe
8. ACEP Education Committee, Educational Meetings Subcommittee member (2013-2017)
9. ACEP Education Committee, Board Liaison (2019-present)
 - a. Responsible for planning Health Policy and Risk Management tracks (total 20hrs of content) more than 6,500 annual attendees at this largest national conference in Emergency Medicine

B. Didactic Coursework

1. Courses Taught at BCM Within the Primary Department
 - a. Regularly precept BCM and external elective students during their EM rotations
 - b. BCM EM Residency Didactics Presentations: Audience includes EM residents, PA fellows and faculty colleagues
 - 1) Ethics, Professionalism and Policy (EP3) “Lifelong Learning” – May 2022
 - 2) Malpractice Mock Trial – April 2022
 - 3) Clinical Pathologic Case Conference: Hemolytic Anemia – October 2021
 - 4) Hot Topics in Health Policy – September 2021
 - 5) Wellness and Sleep – January 2021
 - 6) Reimbursement Workshop Follow-Up – January 2021
 - 7) Code Status Discussions Zoom Simulation – December 2020
 - 8) Clinical Pathologic Case Conference: Multiple Sclerosis – October 2020
 - 9) Intern Orientation: Risk Mitigation – June 2020
 - 10) Cognitive Biases – April 2020
 - 11) EP3 “Making Medical Choices” Unit Leader – April 2020
 - 12) EP3 “Professionalism in Practice” Unit Leader – October 2019
 - 13) Reimbursement Workshop – August 2019
 - 14) Intern Orientation: Risk Mitigation – July 2019
 - 15) EP3 “Health Economics” Unit Leader – May 2019
 - 16) Reimbursement: Medical Decision Making – April 2019

- 17) EP3 “Lifelong Learning” Unit Leader – January 2019
- 18) Clinical Pathologic Case Conference: Rickettsial Disease – September 2018
- 19) Communications Simulation: Code Status Discussions – July 2018
- 20) Intern Orientation: Risk Mitigation – June 2018
- 21) EP3 “End of Life” Unit Leader – May 2018
- 22) How Residents Can Improve Health Care – March 2018
- 23) “Business of Medicine” Panel – February 2018
- 24) Malpractice Mock Trial – January 2018
- 25) “Getting Sued One Month Out of Residency” – January 2018
- 26) Intern Orientation: Risk Mitigation – June 2017
- 27) Death Notification Role-Playing Didactics – June 2017
- 28) Billing & Coding Workshop – May 2017
- 29) Adverse Events / Medical Errors – March 2017
- 30) Wellness Small Groups – December 2016
- 31) Approach to Abnormal Vitals – September 2015
- 32) Simulation: Wide Complex Tachycardia – January 2015
- 33) Journal Club Leader – annually, 2016-2022
- 34) Mock Oral Boards Examiner – March 2015, March 2016 & March 2017

2. Courses Taught at BCM External to the Primary Department

a. Core Coursework

Learning Community Advisor – Indigo Quad (July 2019 – December 2021)

Provide 1:1 formal advising for medical school students 2x per year for one hour per meeting; additional informal advising through informal sessions, texts/phone calls, emails and social events throughout the year. Total of 50 students, ranging from MS1 to MS4, over my three years as an advisor.

FTE support from Office of Student Affairs

Critical Thinking and Problem Solving (CTAPS) Facilitator (2018 – present)

Designed several curricular units in inaugural year, 2018-2019

FTE support from Office of the Provost

Team based learning course designed to expose MS1s to case-based learning, early clinical decision-making and principles of learning science

Small group leader for MS1 Ethics Course – Spring 2016 & Spring 2017 & Spring 2019

Spring 2018: redesigned one unit of the curriculum with Christi Guerrini (course director)

Spring 2022: served as substitute facilitator

Small group facilitator for MS1 Integrated Problem Solving Course – Fall 2017 – Spring 2018

Problem-based learning course for MS1s to develop student skills in self-directed learning and understanding of clinical application of basic science

PARTAKE Curriculum Facilitator – July 2017, July 2020, July 2021

Educational program to explore social determinants of health with MS1s during orientation

b. Elective Coursework

1) Faculty Participant with two pre-clinical electives primarily led by Dr Cedric Dark:

a) “Business of Medicine” combined BCM/UT elective for MS1/MS2

Spring 2015, Spring 2016, Spring 2017

- b) “Health Policy Journal Club” BCM elective for MS1/MS2
Fall 2017, Spring 2018, Fall 2019
 - 2) Course Director, Climate Change and Human Health Elective – October 2020
 - a) “Become an Advocate: Climate Change Advocacy”
 - 3) Faculty Guest Speaker:
 - a) “Health Policy Analysis: Physicians Shaping Policy” Elective, invited by Prof Majumder
April 2022, December 2022
 - b) “Physician as Advocate: Beyond the Exam Room” Elective, invited by Dr Joey Fisher
June 2018, June 2022
 - c) “From Clinic to Capitol: Physicians as Advocates” Elective, invited by Dr Claire
Bocchini September 2017
 - d) “The Policy Process” with Cedric Dark, General Surgery Residency Didactics February
2015
- 3. Courses Taught at Other Institutions While at BCM: n/a
- 4. Courses Taught Prior to BCM: n/a

C. Curriculum Development Work

- 1. Emergency Medicine Residency Health Policy & Advocacy Curriculum (2014-present)
 - a. Work to develop residency curriculum, including experiential learning and active learning, to develop program of education over three years for residents. Includes integration with BCM-wide EP3 program as well as departmental curricula in administration and social EM
 - b. Co-track leader with Dr Cedric Dark. Have recently added additional collaborators.
 - c. Audience includes 42 EM residents as well as PA fellows and some rotating medical students.

D. Non-didactic Teaching While at BCM

- 1. Resident Training
 - a. Every clinical shift at Ben Taub Hospital includes residency training and development
 - b. Active participant in daily white board rounds, weekly residency conference
 - c. Formal mentor to EM residents: Moises Gallegos (Class of 2018), Shehni Nadeem (Class of 2019), Pranali Koradia (Class of 2020)
- 2. Clinical Fellow Training: Health Policy Fellows
 - a. 2021-2022: Brianna Wapples
 - b. 2022-2023: Hannah Gordon
- 3. Graduate Student Training: n/a
- 4. Medical Student Mentoring
 - a. Informal mentor to multiple medical students
 - b. Have presented to EMIG on Health Policy and Organized Medicine Leadership
- 5. Undergraduate Student Mentoring
 - a. Mentor to the Rice Patient Discharge Initiative, 2016-present
 - 1) Role includes support for undergraduate volunteer program providing resources in the ED to address patient’s social determinants of health.
 - 2) Also provide research mentoring and career advice for pre-medical students

E. Faculty Development / Continuing Medical Education

- 1. Faculty Retreat Coordinator, Department of Emergency Medicine (2018 – present)
 - a. Planned curriculum and organized retreats in collaboration with other faculty members
 - b. Mini-retreats: December 2018, February 2019, December 2019, February 2020
 - c. Full-day retreats: May 2019, October 2019, May 2020 (cancelled due to COVID), May 2022
 - d. Quarterly faculty development sessions from Fall 2020 – Spring 2022 for junior faculty
- 2. TCEP Track Planner, 2017-2019
 - a. Responsible for Health Policy Track for Texas College of Emergency Physicians annual meeting

F. Lectures and Presentations, national

1. Association of American Medical Colleges Group on Faculty Affairs and Group on Women in Medicine and Science Joint Professional Development Conference, Hosted “Table Topic” on “Finding Fulfillment through Advocacy,” July 2019

IV. PATIENT CARE AND CLINICAL CONTRIBUTIONS

A. Patient Care Responsibilities

1. Provide patient care at Ben Taub in the Emergency Center, 2014-present
2. Currently provide care via telehealth for Harris Health emergency patients, typically 1 shift per month
3. Provide patient care at Baylor St Luke’s McNair campus on a PRN basis
4. Harris Health Ethics Committee Member, 2015-present
assist with clinical Ethics Consult service 4 weeks/year, 2017 – 2019

B. Clinical Leadership or Business Development

1. Assisted with development and rollout of telehealth programs at both BCM/BLSMC and Harris Health
 - a. Role included regular meetings with BCM leadership in 2020-2021 to develop Baylor Medicine emergency telehealth program (in partnership with Integrated Emergency Services)
 - b. Served as one of the initial pilot providers of emergency telehealth at Harris Health via the Ask My Nurse telehealth program, giving feedback to leadership and helping optimize program

C. Voluntary Health Organization Participation

1. See “Leadership in Professional Societies”

D. Contributions, Initiatives of Recognition Related to Patient Safety and Healthcare Quality

1. Co-Chair, Alliance for Innovation on Maternal Health Patient Safety Bundle: Cardiac Conditions in Obstetrical Care: <https://safehealthcareforeverywoman.org/aim/patient-safety-bundles/maternal-safety-bundles/cardiac-conditions-in-obstetrical-care/>
 - a. Have participated in ongoing efforts to develop quality programs to improve maternal mortality nationwide
 - b. Representing emergency medicine clinicians and our perspective on both prenatal and postpartum care

E. Contributions to Health and Science Policy (institutional, regional, state, or federal level)

1. State
 - a. Texas Medical Association
 - 1) TMA Task Force on Health Care Coverage: 2021-2022
Participated in special group convened to respond to any legislative initiatives related to Medicaid expansion in TX in the 2021 Legislature; successfully helped advocate for the expansion of Medicaid coverage from 2 months to 6 months postpartum
 - 2) HCMS Board on Medical Legislation: 2016-2020
Discussed state legislative and policy issues impacting Harris County, particularly providing the perspective of a physician working in a public hospital and in emergency medicine
 - 3) TMA First Tuesdays: 2014-present
Regularly participate in annual lobby days in Austin, including bringing Harris County medical students along to learn about the legislative process
 - b. Texas College of Emergency Physicians

- 1) Active in varied issues through committee work, including advocacy for SB1264 in 2019, to resolve billing disputes between physicians and insurance companies while protecting patients from balance billing
2. Federal
 - a. American College of Emergency Physicians
 - 1) Annual attendance at Leadership and Advocacy Conference since 2009
Includes meeting with federal legislators on policy issues pertinent to emergency medicine; specifically advocating for:
 1. More resources to address physician mental health; legislation passed includes Lorna Breen Act (2022)
 2. Solution to balance billing which protects patients while requiring insurance companies to provide fair coverage; legislation passed includes No Surprises Act (2021), ongoing regulatory activity in 2022-present
 3. Enhanced access to buprenorphine, particularly to help patients in the ED with Opioid Use Disorder, with regulatory activity including the repeal of the X-waiver requirement (Consolidated Appropriations Act, 2023)
 - 2) Developed relationships with my representatives, Dan Crenshaw (R-TX) and Lizzie Fletcher (R-TX), including episodic meetings and contact with health staffers

V. SERVICE CONTRIBUTIONS

A. Administrative Assignments and Committees

1. Faculty Senate
 - a. Faculty Senate Delegate, Department of Emergency Medicine (2017-2018)
 - b. Faculty Senator, Department of Emergency Medicine (2018-2020, 2020-2023)
 - c. Participant in Strategic Planning, Faculty Affairs & Benefits, and Communication Committees
2. Medical Executive Committee, Department of Emergency Medicine (2017 – 2022)
 - a. Includes monthly meetings of 1-2 hours, assisting Chair in his leadership of our department
 - b. Faculty Diversity Task Force member and Exec Committee Liaison, 2018 – 2020

B. National, Regional or Local Participation in Professional or Voluntary Organizations

1. Co-Founder, FEM@BCM (2018-present)
 - a. Organization within the department created with a mission “to promote the advancement and equity of women in emergency medicine by mentoring and inspiring leadership”
 - b. Events have included faculty and residents including social events and service projects
2. Member, Board of Directors, Friends of the Texas Medical Center Library: 2016-2020

C. Other Pertinent Information

1. Completed BCM “Career Advancement Series: Assistant Professor Women” – 2018
2. Representative from Department of EM to BCM Faculty Development Forum – 2018-2019

2023 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Ryan A. Stanton MD, FACEP

Question #1: How would you address concerns that ACEP may be unduly influenced by corporate practice interests?

The impact of the corporate practice of medicine (CPOM) has been a narrative that has been propagated for decades yet escalated over recent years with broad consolidation within medicine. CPOM is a very important topic for our college and physicians and deserves ongoing focus.

During my four years on the board and all the meetings during my tenure, I have never felt there was any outside corporate or industry influence in the boardroom. The ACEP Board of Directors and our officers are held to the highest standard of ethical behavior and representation through our organizational documents, fellow members of the board, the representative body of our college, and our global membership. Our leaders know that their responsibility is to the college and our physicians, not to their own employers and interests outside of ACEP. We are an organization OF emergency physicians FOR emergency physicians.

I do acknowledge that imagery and perception are very powerful and feel we have significant opportunity within the college. It may be difficult to dispel a specific narrative when it is highly visible within the college. Subject matter displayed prominently on banners and advertisements can distract from the primary purpose of the gathering. We have made significant steps with the removal of corporate sponsorship of ACEP official gatherings such as the opening/closing sessions at SA and within the educational settings. We continue to strengthen the transparency of employers with the checklists and disclosures available to all attendees to SA.

As for me personally, I would like to see us take several more steps to separate ACEP from the “business of medicine”.

- 1) Remove employer advertisements and banners from high visibility areas of SA and our publications. These should be areas to promote the college and the wonderful work of our emergency physicians.
- 2) Redesign the vendor areas with a separate setting for employment opportunities like we see with EMRA, giving them all equal footing and opportunity, focusing on the job itself rather than flashy spaces and fleeting perks. This also provides a concentrated location for those in search of a job to focus on that alone. This also allows the remainder of the vendor area to be focused on other aspects of EM practice outside of employment.
- 3) Continue to strengthen transparency and expectations with employers across the board. As “The American College of Emergency Physicians”, our role is to advocate as a component body for our physicians which means helping every one of them with the accurate and details information on employment opportunities no matter the setting in which they choose to work.
- 4) Continue to build and embolden resources for physicians, including contract review, legal resources, and as an advocate for emergency physicians when there are issues/concerns.
- 5) Continuing to address concerns of our members, providing them with resources, protection, and guidance when there are employment related challenges.

It is our responsibility as ACEP and our leaders to continue to demonstrate a clear separation and independence from outside entities. We must continue and further walk the walk and talk the talk of ACEP as the largest EM organization that will continue to fight and advocate for every emergency physician irrespective of practice model and setting.

Question #2: What are your ideas for creating and/or providing tangible and indispensable benefits to ACEP members?

Our charge is in our name. We are “The American College of Emergency Physicians”. Every decision we make and project we pursue should be to the advancement and benefit of our emergency physicians. As we pivot the college into the future, we must narrow our focus and efforts to the simple idea of “how do we help our physicians/specialty” and by doing so, provide the best possible care to our patients. One of the greatest challenges is that some of the most significant ROI flies under the radar. The work of our reimbursement team has protected emergency physicians from significant cuts, protecting our codes, and ensuring that efforts to whittle away at physician payments are blocked. Legal and advocacy efforts on the state and federal level have protected physicians, our practice, and our patients. ACEP does amazing work on behalf of its physicians and is the organization that can truly move the needle for emergency physicians. There are three main things we must do as a college to address the question.

- 1) We must narrow our focus to projects and efforts that directly benefit the careers and environments of our emergency physicians. Giving our emergency physicians the best opportunities and settings allows them to provide the best care for each and every patient 24/7/365.

- 2) We must connect with our physicians “where they are” and provide the ACEP experience they need to maximize their career, communicating the resources, opportunities, efforts, and successes of ACEP to their specialty. This includes endeavors to update our platforms, IT infrastructure, and engagement to allow an ACEP experience that is tailored to each individual physician no matter their interests, stage of career, or environment of work. I want to see each physician able to connect to “My ACEP”.
- 3) We must continue to foster leadership and opportunities for physicians within EM to utilize their expertise to advance emergency medicine and our specialty. None of us has all the skills sets or answers, but together, we can move mountains
- 4) .

Question #3: What new thoughts do you have in balancing board-certified emergency physician workforce distribution gaps and safe scope of practice for non-physicians?

The workforce study shook the foundation of emergency medicine. After decades of assumptions that we would “never fill all the seats”, we have been faced with the threat of an overabundance of emergency physicians which has led to some of the downstream impacts, including the match struggles. What is even more clear is that we continue to have a significant distribution issue within EM with abundance pushing down larger markets while rural and critical access setting still struggle to fill shifts. More recent data has demonstrated that the initial study significantly underestimated physician career longevity and attrition (which is an issue in itself), but it has provided an opportunity to address challenges that were known and unknown. The workforce efforts must continue with opportunities to guardrail residency growth, raise the bar on the skillsets of emergency physicians, and ensure we continue to recruit the best and brightest to this wonderful specialty. One of the major areas of focus must be on the distribution of EM physicians with opportunities within residency to have substantive rural and critical access experience. This also means advocating for incentives that can assist attracting physicians of all career stages to rural and critical access settings.

I have long felt that every emergency patient deserves access to an emergency physician. Non-physician practitioners have played an important role in the US healthcare system, but ongoing efforts for expanded scope of practice and independence is not in the best interest of our patients. I absolutely believe in the physician led team. Within my own PDG, I continue to push towards more physician coverage with selective NPP coverage where appropriate. I believe the best care is provided by an emergency physician...period. If we truly are experiencing saturation of available emergency jobs, then we need to see growing access to emergency physicians in all environments of emergency medicine.

Three take home points for what I believe.

- 1) There is no substitution for the physician led team. Every patient in a US emergency department deserves access to an emergency physician no matter their zip code.
- 2) At no point should a physician role be replaced by a NPP for any reason, but especially as a perceived profit/control strategy.
- 3) ACEP must continue to fight expanded scope of practice or independent practice on the state and federal level. Independent practice is the privilege earned with having a MD or DO after your name.

The workforce dilemma is a challenge we will face for years to come. I am proud that ACEP has been willing to tackle tough questions and work towards realistic solutions in the promotion of EM and our physicians.

CANDIDATE DATA SHEET

Ryan A. Stanton MD, FACEP

Contact Information

106 Stonewall Dr. Nicholasville KY, 40356

Phone: 859-948-2560

E-Mail: RStanton@acep.org

Current and Past Professional Position(s)

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

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: 1200 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 single hospital physician owned democratic group with 14 physicians serving a community hospital with a volume of 50k per year. 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

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: Central Emergency Physicians

Address: 1740 Nicholasville Rd.

Lexington KY 40503

Position Held: Emergency Physician

Type of Organization: Private Democratic Group

Employer: Lexington Fire/EMS

Address: 219 E. 3rd Street

Lexington KY 40502

Position Held: Medical Director

Type of Organization: LFUCG Fire Department

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: Kentucky Statewide Opioid Stewardship Program - KHA

Address: 2501 Nelson Miller Parkway

Louisville, KY 40223

Type of Organization: Medical Society/Association

Leadership Position: Emergency Department/Acute Care Lead

Term of Service: 2019-Present

Organization: Kentucky American College of Emergency Physicians

Address: PO Box 2831

Louisville, KY 40201

Type of Organization: State Chapter – Medical Association

Leadership Position: President, PR Chair, Education Chair

Term of Service: 2008-Present

Organization: Everyday Medicine LLC

Address: 106 Stonewall Dr.

Nicholasville, KY, 40356

Type of Organization: Media/Education

Leadership Position: Founder/CEO, Host, Producer

Term of Service: 2012-Present

Organization: Kentucky Naloxone Project

Address: _____

Type of Organization: Not for Profit

Leadership Position: Kentucky Lead

Term of Service: 2022-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

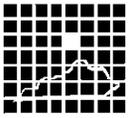
YES

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

6/18/23



**KENTUCKY CHAPTER OF THE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS**



**ACEP
PAIN MANAGEMENT
AND ADDICTION
MEDICINE
SECTION**

KACEP
PO Box 2831
Louisville, KY 40201-2831

August 6, 2023
Chair, Nominating Committee
P.O. Box 619911
Dallas, TX 75261-9911

OFFICERS

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Hugh Shoff, MD, FACEP

Immediate Past President
Christopher Pergrem, MD, FACEP

President-Elect
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Timothy Price, MD, FACEP

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Danielle Graff, MD
Beth Spurlin, MD, PhD, MBA

Public Relations
Ryan Stanton, MD, FACEP

Emergency & Preparedness
Andrew Facitti, DO

Medical Reimbursement
Karan Shah, MD

Wellness
Martin Huecker, MD, FACEP

Young Physicians
Patrick Grace, MD
Diana Labrada, MD

Councillors
Jan. '21 - Dec. '22
Chris Pergrem, MD, FACEP
Melissa Platt, MD, FACEP
Hugh Shoff, MD, FACEP

Alternate Councillors
Jan. '21 - Dec. '22
Beth Spurlin, MD
Steven Stack, MD, FACEP
Salvator Vicario, MD, FACEP
Daniel O'Brien, MD, FACEP
Timothy Price, MD, FACEP

Staff
Executive Director
Ashlee Melendez, MSPH, BSN

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 of 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; Councillor, 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, AMR/NASCSR Safety Team, AirMed International, and Infield Care Team for NASCAR events.

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. 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 and its importance.

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



Donald Stader, MD, FACEP
Chair
Pain Management and Addiction

Ryan A. Stanton MD, FACEP

Fellow emergency physicians, we are in a time of significant change within our profession and college. We are facing significant challenges, but these obstacles also present equal opportunities. Our members and fellow physicians are hungry for a strong voice and advocate for our profession. Pressures from all sides willing to take advantage of our environment, departments, and physicians. We as ACEP must be the unifying voice willing speak and fight for our physicians. We have two major roles as the American College of Emergency Physicians. We serve as the “union” of EM, fighting as the body of emergency medicine physicians to move the needle in a positive direction for our physicians, patients, and profession. We also serve to facilitate each physician’s “WHY”. Every member has unique interests and skills. We must leverage our expertise and resources to help EVERY emergency physician achieve their best career possible.

I offer to this esteemed collection of emergency physicians 32 years of media experience, passionate advocacy on the state and federal levels, as well as platforms that help us reach far outside the membership rolls of ACEP. I have been driven throughout my career on a foundation of the emergency physician and our relationship with our patients. With this as the guiding principle, we can build the emergency medicine of the future that builds up our physicians and allows each and every one of us to provide the best care to every patient in their time of need.

The key is that “the college” can’t do it alone. The president-elect and president represent the direction, will, and voice of the members. We must lean into our members and their expertise across the breadth of EM to advance the specialty into the future. I am fully prepared to be that voice and promote the greatness of our 39k+ members. Whether it is our medical students, residents, attendings, or legacy physicians, we are a community of individuals that together, can change the landscape of healthcare.

We are the American College of Emergency Physicians, individuals that serve every man, woman, and child in this country. Together, we are the safety net of this countries healthcare system and together, we can guide the future of emergency medicine.

VOTE

DR. RYAN STANTON

**FOR
ACEP
PRESIDENT
ELECT**



THIS IS A TURNING POINT FOR ACEP AND EMERGENCY MEDICINE. OUR PHYSICIANS ARE STARVING FOR A STRONG VOICE AND ADVOCATE TO LEAD THE WAY INTO THE FUTURE FOR OUR SPECIALITY. OUR NUMBERS ARE OUR STRENGTH. WE WILL UNIFY AS A COLLEGE TO FIGHT FORWARD AND BUILD THE SPECIALITY WE WANT TO SEE AND ONE OUR PATIENTS NEED. OUR FUTURE AS ACEP AND MY DRIVE IS HELPING PHYSICIANS FIND THEIR "WHY" AND HELPING EMERGENCY PHYSICIANS BUILD THE CAREER THAT IS BEST FOR THEM BASED ON THEIR SKILLS, INTERESTS, AND PASSIONS. WE CATER TO THE EMERGENCY PHYSICIAN AND THEN UNITE AS THE VOICE, STRENGTH, AND ADVOCATE OF EMERGENCY MEDICINE.

DR. RYAN A.

STANTON, MD, FACEP



**Ryan A. Stanton MD,
FACEP, FAAEM**

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WEB

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Profile

Board certified emergency physician in Lexington, Kentucky with involvement in community, pre-hospital, and motorsports medicine. Interests in media and public education through internet, podcast, print, and television. Active in leadership with local and national organizations through work with Central Emergency Physicians, KACEP, ACEP, AMR, and NASCAR.

Experience

EMERGENCY PHYSICIAN, CENTRAL EMERGENCY PHYSICIANS, LEXINGTON, KY – 11/2013-PRESENT

Emergency Physician at Baptist Health Lexington

MEDICAL DIRECTOR, LEXINGTON FIRE/EMS LEXINGTON, KY - 3/2013-PRESENT

Medical Director for one of the premier fire departments and EMS services in Kentucky, overseeing the EMS operations for over 48,000 EMS runs annually.

MEDICAL DIRECTOR, AMR/NASCAR SAFETY TEAM– 4/2017-PRESENT

On-track response physician for NASCAR as part of the AMR/NASCAR Safety Team at tracks throughout the country. Named team Medical Director as of 1/1/20.

KENTUCKY/FLORIDA STATE MEDICAL DIRECTOR, AIRMED INTERNATIONAL – 1/2014-PRESENT

Kentucky and Florida state medical director for AirMed International which provides air medical services throughout the world.

EVERYDAY MEDICINE AND ACEP FRONTLINE PODCASTS, 1/2010-PRESENT

Production of two emergency medicine based podcasts. Everyday Medicine in conjunction with Emergency Medicine News and ACEP Frontline with the American College of Emergency Physician

EMSCoconnect- 5/2019-Present

EMS part-owner and educator for EMSConnect. One of four physician educators for this nationwide company.

**INFIELD CARE CENTER FOR NASCAR SANCTIONED AND OTHER RACING EVENTS
KENTUCKY SPEEDWAY AND TALLADEGA SUPER SPEEDWAY – 6/2006-4/2017**

Medical Services for Kentucky Speedway 2006-2014 and Talladega Super Speedway 2015-2017

"DOCTOR ON CALL" FOR ABC-36, LEXINGTON, KY – 1/2009-12/2016

On-Air physician for weekly "ask the doc" segments, weekly "what's going around" segments, and as needed for health-related interviews.

EMERGENCY PHYSICIAN, MESA/TEAMHEALTH, LEXINGTON, KY -7/2008-7/2014

Emergency Physician and past Medical Director at UK Good Samaritan Hospital in Lexington, KY

**ASSISTANT PROFESSOR OF EMERGENCY MEDICINE, UKHEALTHCARE, 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 Eligible, 2019-Present

American Board of Emergency Medicine, Board Eligible, 2008-2009

Medical Licensure

Kentucky, 6/26/2008-Active -License #41963

Resident License- 1/2007-6/2008

Alabama, 9/25/2014-Active- License #MD.33740

Tennessee, 4/7/2016-Active- License #54178

Florida, 2017-Active- License #ME.134262

New York, 2018-Active- License #293995-1

Delaware, 2018-Active- License #C1-0012583

Georgia, 2018-Active- License #079785

Pennsylvania, 2018-Active- License #MD465496

Virginia, 2018-Active- License #0101264445

North Carolina, 2018-Active- License #2018-00671

Nevada, 2020-Active- License #19571

Indiana, 12/9/2004-Active- License #01060023A

Residency Training

University of Kentucky, Emergency Medicine, 7/2005-6/2008

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

Medical Director, AMR/NASCAR Safety Team, 1/2020-Present

Medical Director, Lexington Fire/EMS, Lexington-Fayette Urban County Government, 3/2013-Present

President, KACEP(Kentucky Chapter of the American College of Emergency Physicians), 1/2013-12/2014

Chairman of Public Relations Committee, American College of Emergency Physicians, 10/2014-10/2016

Assistant Medical Director, AirMed International, 1/2014-Present

Director of PR, Media, and Education, Mesa Medical Group, Lexington, KY, 1/2013-7/2014

Medical Director, UK Good Samaritan Emergency Room, University of Kentucky Healthcare, 7/2008-7/2013

Assistant Medical Director, Kentucky Motor Speedway Emergency Medical Services, 2010-2013

President Elect, KACEP(Kentucky Chapter of the American College of Emergency Physicians), 1/2010-12/2012

Vice President, KACEP, 1/2010-12/2012

Public Relations Committee Chairman, KACEP, 7/2008-Present

Vice Chairman UK ED Executive Committee, UK Healthcare, 1/2010-6/2013

Counselor, American College of Emergency Physicians, 10/2011- Present

PR Committee, American College of Emergency Physicians, 10/2008-Present

National Spokesman, American College of Emergency Physicians, 10/2008-Present

Medical Operations Subcommittee Member, UK Good Samaritan Hospital, 2008-2013

Emergency Medical Advisory Board, Lexington/Fayette County, KY, 7/2008-Present

Chief Resident, UK Healthcare Emergency Medicine, 7 / 2007-6/2008

Awards/Honors

ACEP 911 Network Member of the Year, American College of Emergency Physicians, 2014

Spokesman of the Year, American College of Emergency Physicians, 2011-2012

Preceptor of the Year, UK Physician Assistant Program, 2010-2011

UK Leadership Legacy Mentor, University of Kentucky, 2011-2012

Gatton School of Business Executive Leadership Program, University of Kentucky, 2009-2010

Publications/Presentations/Talks

Recurring Media Productions

ACEP Frontline Podcast- 10/2015-Present

StantonMD TV Show- 3/2016-9/2018

The Doc is In TV Segment- 2012-Present

Six television markets around the southeast United States

Chief Medical Contributor- WKYT-TV Lexington- 1/2017-Present

WVLK 97.3FM/590AM- Weekly Medical Contributor and Guest Host(Various Shows)- 2010-Present

American College of Emergency Physicians- Spokesperson- 2008-Present

Everyday Medicine for Physicians Podcast- 1/2010-12/2019

Everyday Medicine Podcast- 1/2006-12/2015

Presentations/Talks

ACEP19- Moderator: SoMe in EM- Denver, CO 10/29/19

Emerald Coast Conference- Mythbusting: EM Medication Myths- Destin, FL 6/3-5/2019

Emerald Coast Conference- Law and Order: EM Medical Malpractice- Destin, FL 6/3-5/2019

Emerald Coast Conference- He Said, She Said: Vaccine Refusals- Destin, FL 6/3-5/2019

Kentucky Hospital Association- KY Statewide Opioid Stewardship- ALTO in EM and Beyond, Multiple Sites in KY 2019

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 KY, 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



American College of
Emergency Physicians®

ADVANCING EMERGENCY CARE 

Board of Directors Candidates



Scientific Assembly

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23

2023 Board of Directors Candidates



William B. Felegi, DO, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



Abhi Mehrotra, MD, MBA, FACEP

- Written Questions
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- Disclosure Statement
- Endorsement
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- Campaign Flyer
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Robert J. Hancock, MD, FACEP

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Henry Z. Pitzele, MD, FACEP

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Chadd K. Kraus, DO, DrPH, FACEP

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James L. Shoemaker, Jr., MD, FACEP

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2023 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

William B. Felegi, DO, FACEP

Question #1: How can ACEP optimize its financial resources to ensure future stability?

I was not a business or finance major in college, but my hospital CEO always reminds me that in order to balance the books and to remain financially viable, you either need to increase revenue or decrease expenses – simpler said than done! Our organization relies heavily on dues from our membership to remain solvent. **A strong membership is key to our financial survival.**

The landscape for the practice of emergency medicine has evolved over the last 30+ years where the priority was to have properly trained emergency physicians replace “rent a doc” and establish a foothold in ED’s. Practices changed and many “democratic” EM groups were successfully organized. For many reasons, the corporatization of medicine emerged and many of us now work as employees of hospitals, publicly traded national companies, or mega contract management groups owned by private equity. **Our college is no longer our grandfathers’ College.** The employee model has evolved and has changed the needs of many of our members. Physicians continue to be economically strapped. With some transitioned to the **employed model**, funds for dues and CME’s have been reduced and physicians are looking to reduce professional expenses.

We are not alone as many organized medical groups are also struggling and competing for membership. Gone are the days where the majority of physicians belong to the AMA or AOA, a state medical society, a county medical society and specialty organization. Quite frankly, it has gotten very expensive to continue membership in these groups. Some physicians have not had raises in years and others do not even receive a cost of living increase despite being an employee like other employed health care workers.

We are also experiencing early retirement of physicians from our work force or physicians pursuing alternatives outside of our specialty and I allude to some of those reasons in question #3. As money gets tighter, physicians are increasingly asking, “What am I getting for my dues?” The college must continue to advertise the benefits of membership. However, ACEP still has the resources to be able to address changes and ensure that **our members’ sustainability is just as important as our patients.** **We always do the right thing for our patients and we need to have the courage to do the right things for members and focus on emergency physicians and their immediate needs.** Physician wellness is not just about going to the gym for a workout. For some, wellness does not mean how much time he or she has at home but rather what the work environment is like. Do our colleagues even have enough energy left after their shift to enjoy so little free time, or are they sucked dry of all their vital juices every day because of difficult working conditions?

Physician burnout is a reflection of physicians’ job satisfaction— a vital exhaustion, characterized by loss of enthusiasm from work, depersonalization, lack of purpose, and low sense of accomplishment. We are all entitled to decent working conditions and to have the necessary resources to perform our jobs well to optimize patient care. We will either continue to lose members or fail to attract new graduates unless we continue to focus on physician burnout as a reflection of physician job satisfaction. **Our focus to attract more members is to change our mantra from “physician burnout” to “moral injury.” We are the victims and the term “physician burnout” connotes that what we did or do, is our fault! Burnout suggests that the problem resides within the individual, who is in some way deficient. Let’s place the blame where it belongs.**

Some residencies have had their members join unions. Unions clearly have advantages and disadvantages and historically have been organized to protect employees’ rights and improve the work environment. **Unless our college continues to focus on the individual physicians working conditions, we will lose members to other organizations or lead to the unionization for some of our members.** In fact, we are now seeing this trend.

A part of continued financial success and fiscal responsibility is a strong and well-planned investment program. The current status of the economy has made this difficult. I think many of us have had similar experience with our retirement plans, but we need to be cautious and avoid being frivolous in making the wrong investment decisions.

It is imperative that the college continue to recognize that in order to fulfill our important responsibilities in caring for this nation’s emergency needs, we must ensure that every emergency physician has a safe and secure working environment, adequate resources to perform our vital role, and fair compensation. ACEP needs to refocus our priorities and we need to say “No” to a project that does not take this into consideration as our financial resources are limited.

Our CME conferences also need to focus on remote learning. Where our national conference is important for networking, collegiality, and reinvigorating our work force, COVID has taught us that distant learning and meetings are successful.

Any future service needs to demonstrate profitability including the ED accreditation program. Moving forward, serious consideration needs to be made whether to continue programs or services deemed to be “loss leaders.”

Question #2: Describe how your election to the Board of Directors would enhance ACEP's ability to speak for and represent all emergency physicians.

The majority of my professional time was spent in the northeast as an emergency medicine faculty member and chairman in a high volume suburban tertiary care center for over 20 years. I then transitioned to a smaller non-teaching community hospital and practice, for the last 5 years, in a rural critical access hospital in an economically underserved area in the Midwest. I understand how demanding the volumes can be in a busy urban and suburban ED where the majority of EM trained physicians work, but I don't think the majority of EM physicians understand what it's like to work in a hospital that has very limited resources and no consultants available. I am referring to those rural and critical access hospitals that provide care to 40% of this nation's population. I refer to it as doing a fellowship in "**austere emergency medicine.**"

For my first job, I was a partner in a democratic emergency physician group with multiple hospital contracts. We were led to believe that we may not survive given the resources of large CMG's so we sold out to a publicly traded mega-managed contract group which was then sold to a private equity firm. I currently work as a hospital employee and also as a private contractor (outside of emergency medicine). I have had exposure to many different employment models.

I have also held various leadership roles in organized medicine on the national, state, regional, and local levels. My interests have always been in political advocacy and grass roots campaigns. My experience for approximately the last 15-20 years in working with the Federal Governmental Affairs and State Legislative Committees has given me continued understand in our legislative successes and failures. I had the opportunity to complete a Health Care Policy Fellowship which has provided me great insight into overall national policy concerns.

ACEP needs to maintain its integrity with our membership. A long time ago, I learned at an ACEP leadership event that **integrity was doing the right thing at the right time for the right reasons.** Our college needs satisfied members and **physician satisfaction starts in the workplace** regardless of location – urban, suburban, rural and regardless of the physician model – independent contractor, locums, hospital – community or academic, contract management group owned by a democratic group, publicly traded company, or private equity firm. No one else in America has been given the privilege with dealing and caring for the sickest and most critically injured.

Question #3: From your perspective, what would you do to ensure that emergency medicine remains an attractive specialty?

With the decline in applicants for emergency medicine residencies, the number of physicians either retiring or deciding to leave our field to pursue other interests, and our aging work force, it is imperative that we **prioritize making emergency medicine attractive for a rewarding career.** We must focus on exploring why individuals have lost interest in our specialty and why practicing physicians have left to pursue other interests.

We can make some assumptions as to why our specialty has become less attractive and why physicians are leaving or retiring early. Our work can be very rewarding whether we resuscitate a cardiac arrest patient who is discharged neurologically intact, save the life of a badly injured individual, or render pain control to a child with an earache. During COVID, we were heroes. But after COVID, many physicians felt physically and emotionally exhausted due to the volume of patients, high acuity, and the lack of supplies, medication, etc. **We are victims of moral injury not burnout.**

Post COVID, some of our partners left. More importantly, nurses and ancillary care professionals left which led to increased overcrowding, closure of inpatient beds, and a further lack of resources. I read an article where a physician thought that we could offer a fellowship in emergency "hallway" medicine. I did appreciate the satire, but the reality is, in many emergency departments, we do practice "hallway" medicine which frequently results in sub-optimal care and leads to poor patient outcomes and experience for not only the patient but also their families.

Evidence suggests that physicians would rather have better working conditions than additional income. Yes, fair reimbursement is important, but it may not be the primary driver for dissatisfaction. **Unless we focus on the quality of work life for all of us, more individuals will no longer want to practice our specialty.** Better work life equals better personal life where you can enjoy more personal freedom and rejuvenation.

ACEP needs to continue to advocate for better working conditions. We have always been the saviors because of a fragmented and broken health care delivery system but our specialty continues to suffer. We need to be more forceful and vocal in advocating for drastic reforms. Why do we think that long waits resulting in deaths and delay in care, "hallway" medicine, overcrowding, longer turnaround times, left without being seen rates, the lack of resources especially in rural hospitals, and the difficulty in finding a bed for a transfer patient is acceptable?

No elected official or VIP who comes to an ED would have to endure what our patients experience. VIP's always go to the front of the line. We need to stand firm and aggressively advocate for change. This is not an easy task, but I fear, **unless we improve our work life, we will lose more physicians to attrition and less students will join our specialty.** This will have an even greater impact on emergency medicine and lead to a further decrease in our membership which will ultimately make it harder for our organization to survive.

CANDIDATE DATA SHEET

William B. Felegi, DO, FACEP

Contact Information

731 Red Lion Way
Bridgewater, New Jersey 08807-1668
Phone: 908-227-3484 (cell)
E-Mail: William.felegi@ahsys.org

Current and Past Professional Position(s)

- Chief Medical Officer Van Buren County Hospital
- Medical Director Van Buren County Hospital Emergency Department
- Medical Director Van Buren County Hospital Ambulance
- EMS Medical Director Farmington Ambulance
- Medical Director, Atlantic Health, Morristown Medical Center, Travel MD, Corporate Health
- Life Member Bound Brook Rescue Squad, Inc.
- American Board of Emergency Medicine Senior Board Examiner (Approximately 27 exams)
- Iowa Osteopathic Medical Association Board of Directors – Vice President 2023
- State of New Jersey Gubernatorial Commission Appointments
 - Rationalizing Health Care Resources, Subcommittee Hospital/Physician Relations & Practice Efficiency Commission (Gubernatorial Appointment), 2007-2008
 - Health Care Access Commission (Gubernatorial Appointment), 2006-2008
 - Advisory Council for Basic & Intermediate Life Support (EMTFF), (Gubernatorial Appointment), 2002-present
 - State of New Jersey Influenza Pandemic Action Committee, 1999-2006
- Assistant Clinical Professor Emergency Medicine, Sidney Kimmel Medical College - Thomas Jefferson University, Philadelphia, Pennsylvania, 2015-2018
- Assistant Clinical Professor Emergency Medicine, Mount Sinai School of Medicine, New York, New York 2008-2015
- Department of Emergency Medicine, Hackettstown Medical Center, Hackettstown, NJ, 2016-2017
- Morristown Medical Center Advisory Board, 2014-2016
- Department of Emergency Medicine, Morristown Medical Center, Morristown, NJ
 - Chairman, 2015-2016
 - Interim Chairman, 2014-2015
 - Vice Chairman, 2001-2013
 - Attending & Faculty Member, Residency in Emergency Medicine, 2001-2016
 - Associate Attending & Faculty Member, Residency in Emergency Medicine, 1996-2001
 - Assistant Attending & Faculty Member, Residency in Emergency Medicine, 1994-1996
 - Clinical Medical Director Fast Care & Work Med, 1995-2016
 - Medical Review Officer, Work Med, 1995-2016
 - Associate Director Emergency Department 1995-2014
 - Chairman, Trauma Quality Improvement Committee, 2002-2003, 2004 -2005
 - Member, Atlantic Health Sepsis Initiative Committee, 2011-2016
 - Member, Quality & Patient Safety Committee, 1998-2016
 - Member, Department of Cardiovascular Medicine, STEMI Team Committee, 2007-2016
 - Member, Radiology Task Force, 2005-2006
 - Member, ED Peer Review Committee, 2005-2016
 - Member, Clinical Resource Management Committee, 2001-2005
 - Member, CPR Committee 1994-1998

- Chairman, ED/Radiology Performance Improvement Team, 1998-2003
- Chairman, ED Performance Improvement Committee, 1996-1998
- Member, Hospital Wide Performance Improvement Committee, 1995-2008
- Member, MI Critical Pathway Committee, 1995-2003
- Chairman, CPR Committee, 1994-1998
- ACLS Course Medical Director, 1994-1997
- Member, Trauma Quality Improvement Committee, 1994-2002, 2003-2
- Trauma Liaison, Dept. EM to Dept. Surgery, Section of Trauma for Level I Designation, 1994-2016
- Member, Trauma/Radiology CQI committee, 1994
- New Jersey Association of Osteopathic Physicians & Surgeons (NJAOPS) Board of Directors, 2014-2017

Education (include internships and residency information)

- Bachelor of Arts, Major: Psychology, Rutgers College of Rutgers University New Brunswick, New Jersey, 1979
- Internship, St. Michael's Medical Center Seton Hall University School of Graduate Medical Education Newark, New Jersey, July, 1989-90 (AOA approved rotational/transitional type)
- PGY 1 - Somerset Medical Center Residency in Family Practice Somerville, New Jersey, July, 1990-91
- PGY 1-3 - Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1991-94
- Chief Resident, Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1993-94
- American Osteopathic Association (AOA) Health Policy Fellowship, Ohio University College of Osteopathic Medicine, Athens, Ohio, September 2012-2013

Doctor of Osteopathic Medicine, University of New England College of Osteopathic Medicine Biddeford, Maine, May, 1989

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

- American Board of Emergency Medicine (ABEM) - Continuously certified since initial certification 1995

Professional Societies

American College of Emergency Physicians (ACEP)

- New Jersey Chapter of ACEP
- Iowa Chapter ACEP

American College of Osteopathic Emergency Physicians (ACOEP)

American Medical Association (AMA)

American Osteopathic Association (AOA)

Iowa Osteopathic Medical Association (IOMA)

International Society of Travel Medicine (ISTM)

American Association for Physician Leadership (AAPL) formerly ACPE

National ACEP Activities – List your most significant accomplishments

- Member, Council Reference Committee B 2016 Council Meeting
- Board of Governors, Emergency Medicine Action Committee (EMAF), 2011-13
- Chairperson, Federal Governmental Affairs Committee (FGA), 2011-14
- Team Captain, 911 Legislative Network, 2007-present
- Member, Federal Governmental Affairs Committee (FGA), 2003-present
- 911 Legislative Network, 2003-present.
- Board of Directors National Emergency Medicine Political Action Committee (NEMPAC), 2003-2008
- Member, State Legislative/Regulatory Committee, 2006-present
- ACEP National Awards - During the last 16 years serving with national ACEP, my time has been devoted to becoming well versed in national and state political agendas and the art of political advocacy working with numerous groups and our members. Were we have achieved many wins and assisted other

chapters, I have always felt that just because one is a leader, the credit goes to the group of individuals that you work with in the committees and subgroups since leadership and emergency medicine are a team effort. No one person can be credited with our success stories. That's why when your peers honor you with a prestigious award one does feel that in some way, they have made a significant accomplishment on behalf of the group.

- o ACEP 2009 911 Legislative Network Member of the Year
- o ACEP 2008 911 Legislative Network Member of the Year

ACEP Chapter Activities – List your most significant accomplishments

NJ ACEP

- Immediate Past Present, 2006
- President, 2005-2006
- President-Elect, 2004-2005
- Secretary/Treasurer, 2003-2004
- Councilor or Alternate Councilor, 2003-present
- Treasurer, 2002-2003
- Board of Directors, 1999-2006
- Chairman, Political Action Committee, STATPAC, 2002-2013
- Government Affairs/STATPAC, 2001-2003
- Co-Chair, Government Affairs STATPAC, 2000-2001
- NJ ACEP State Awards - During the last 22 years serving with NJACEP, my time has been devoted to becoming well versed in the state political agendas and the art of political advocacy working with numerous groups and members including our state Political Action Committee - STATPAC. Whether it was collecting record breaking PAC donations or achieving exemption from ACLS for board certified emergency medicine physicians to perform procedural sedation, we have achieved many wins. I have always felt that just because one is a leader, the credit goes to the group of individuals that you work with in the committees and subgroups since leadership and emergency medicine is a team effort. No one person can be credited with our success stories. That's why when your peers honor you with prestigious awards one does feel that in some way, they have made a significant accomplishment on behalf of the group.
 - o NJ ACEP Distinguished Service Award, 2009
 - o NJ ACEP Good Government Award, 2003

Practice Profile

Total hours devoted to emergency medicine practice per year: 2496* Total Hours/Year*includes paid on-call time

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 80% Research 0% Teaching 5% Administration 15%

Other: _____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I practice full time rural emergency medicine for the last five years at a small independent 25 bed licensed critical access hospital in Southeast Iowa. The nearest tertiary care facility is 90 minutes away and the ED has four beds. I am a full-time salaried employee working for the hospital and the only residency trained, board certified emergency medicine physician who works in the Emergency Department in a 500 square mile county of 7,203 residents. The remainder of the time, the ED is staffed with either a board-certified family medicine physician, AP, or PA and either me or another family medicine trained physician who is on call for back-up as needed. We also have the 24/7 availability of a telemedicine service staffed by board certified emergency physicians 24/7 and tele-psychiatry consultation provided by an independent third party paid for by the hospital.

The remainder of my career was spent at a level one trauma center (ACS Designated), regional pediatric hospital, cardiac center and emergency medicine residency training program with 25 years' experience as a faculty member,

attending, and various administrative rules including the Chairperson of the Department of Emergency Medicine. Originally a physician shareholder in an emergency medicine owned group at multiple hospitals in the tristate area in the Northeast, our company was sold to a large national contract management group which was then purchased by a multi-specialty private equity firm.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Van Buren County Hospital, Keosauqua, Iowa

Chief Medical Officer

Emergency Department Medical Director

Medical Staff Secretary, 2019-2020

Quality & Patient Safety Committee, 2018-present

Pharmacy & Therapeutics Committee, 2018-present

Trauma Committee, 2018-present

Utilization Review Committee, 2018-present

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert

0

Cases

Plaintiff Expert

0 Cases

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

William B. Felegi, DO, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Van Buren County Hospital

Address: 304 Franklin Street

Keosauqua, Iowa 52565

Chief Medical Officer, Emergency Department and Ambulance Medical
Position Held: Director

Type of Organization: Critical Access Hospital

Employer: Atlantic Health (as an independent contractor)

Address: 101 Madison Avenue, Suite 202

Morristown, New Jersey 07960

Position Held: Medical Director, Travel MD[®], Corporate Health

Type of Organization: Non-Profit Hospital System

Employer: Envision Physician Services formerly EmCare's Partners Group, formerly
Emergency Medical Associates

Address: 3 Century Drive

Parsippany, New Jersey 07054

Per diem contract employee with privileges at Hackettstown & Morristown
Position Held: Medical Centers, NJ. No income generated for the last 5 years

Type of Organization: Private equity owned physician management organization

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Iowa Osteopathic Medical Association

Address: 6919 Vista Drive

West Des Moines, Iowa 50266

Type of Organization: State organized medical society

Duration on the Board: 2011-present, Vice President 2023

Organization: New Jersey Association of Physicians & Surgeons (NJAOPS)

Address: 666 Plainsboro Road, Suite 356

Plainsboro, New Jersey 08536

Type of Organization: State organized medical society

Duration on the Board: 2014-2017

Organization: Morristown Medical Center Advisory Board

Address: 100 Madison Avenue

Morristown, New Jersey 07960

Type of Organization: Non-Profit Hospital

Duration on the Board: 2014-2016

Organization: Board of Governors Emergency Medicine Action Committee (EMAF)

Address: 1125 Executive Circle

Irving, Texas 75038-2522

Type of Organization: Nationally organized group to financially support advocacy efforts for ACEP

Duration on the Board: 2011-2013

Organization: Board of Directors National Emergency Medical Political Action Committee (NEMPAC)

Address: 2121 K Street, Suite 325

Washington, DC 20037

Type of Organization: Physician National Political Action Committee

Duration on the Board: 2003-2008

Organization: NJACEP Board of Directors

Address: c/o 201 East Main Street

Lexington, Kentucky 40507

Type of Organization: State organized medical society

Duration on the Board: 1999-2006

Organization: Office of the New Jersey Governor

Address: 125 West State Street

Trenton, New Jersey 08608

Type of Organization: State of New Jersey Rationalizing Health Care Resources, Subcommittee
Hospital/Physician Relations & Practice Efficiency Commission

Duration on the Board: 2007-2008

Organization: Office of the New Jersey Governor

Address: 125 West State Street

Trenton, New Jersey 08608

Type of Organization: Health Care Access Commission

Duration on the Board: 2006-2008

Organization: Office of the New Jersey Governor

Address: 125 West State Street

Trenton, New Jersey 08608

Type of Organization: Advisory Council for Basic & Intermediate Life Support (EMTFF)

Duration on the Board: 2002-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:

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.

William B. Felegi, DO, FACEP

Date 06/19/2023



Monday, August 14, 2023

Dear Council,

The New Jersey Chapter of the American College of Emergency Physicians (NJ-ACEP) again supports William B. Felegi, D.O., FACEP for the national ACEP Board of Directors. Our chapter enthusiastically endorses Bill's candidacy. His presence on the Board will immensely benefit our college for years to come.

Bill's career spans over 30 years ranging from attending the first state run EMT class as a volunteer rescue squad member at the age of 16, to Chairman and Assistant Clinical Professor of Emergency Medicine at a tertiary care center and trauma center with the oldest emergency medicine residency in NJ.

Bill began his relationship with the NJ Chapter as a resident when he attended our board meetings. He participated in the chapter as an elected board member for two terms and then in the leadership tract holding all leadership offices including **Chapter President**. He decided not to re-run for the Board to allow younger physicians the opportunity to participate in the chapter mentoring future leaders. He has served either as Councilor or Alternate for 18 years.

He has been an ACEP member since 1991 and has embraced service to ACEP with passion and determination over the last 3 decades. For over 15 years he has served on two important national committees - State Regulatory & Legislative Affairs and the Federal Government Affairs Committee where he served as the Chair for 3 years. He has helped guide not only ACEP's positions on critical issues but also many members with similar interests.

Bill has been a fixture at ACEP's annual Leadership & Legislative Conference for over 25 years mentoring young or inexperienced physicians when lobbying with our annual hill visits. For his continued national efforts, he was **twice awarded ACEP's prestigious 911 Member of the Year**.

In NJ, Bill is credited with protecting emergency physicians when he championed a campaign to lobby against regulations that mandated all physicians who provided procedural sedation to have ACLS training well before ABEM publicly supported the "no merit badges" for board certified emergency physicians. In NJ, even anesthesiologists must take

NEW JERSEY ACEP CHAPTER

c/o National ACEP
4950 West Royal Lane
Irving, Texas 75063-2524
ACEP Direct: 469-499-0177
800-798-1822
www.njacep.org

BOARD OF DIRECTORS

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Director
Alternate Councillor
Renee L. Riggs-Fiessler, DO, FACEP
Director

ACLS. Due to his perseverance, emergency physicians are the only specialty exempt from the regulation.

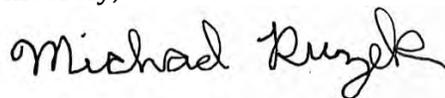
Another accomplishment was his championship to lobby for the contemporaneous reading of CTs for suspected stroke patients with a radiology attending and radiology resident. Prior readings were only offered by residents at hospitals with a radiology residency and often lead to re-reads the following day when an attending was available. Stroke care was compromised. He engaged in a successful grass roots letter writing campaign to the Commissioner of Health to accomplish the change in the regulations.

Bill served as the Chair of our PAC, NJ STATPAC, and under his leadership, was able to collect a record amount donated per election cycle. Our chapter also has recognized his accomplishments with our **NJ-ACEP “Distinguished Service” Award and our “Good Government” Award.**

Bill’s strongest qualities are his highly collaborate management style, a desire and willingness to engage physicians and to improve working environment, and a passion for our specialty. Perhaps one of his greatest attributes are his **humor, honesty, and integrity.** His greatest asset is his ability to participate in a discussion of a critical issue with a group, synthesize the discussion, summarize the important elements, and then offer a broad review of the pros and cons. It is not uncommon for a group to change their decision based on his synopsis of **unintended consequences** which are often overlooked.

Our proud chapter stands behind Dr. Felegi as he seeks to advance emergency medicine through our vital organization.

Sincerely,

A handwritten signature in black ink that reads "Michael Ruzek". The signature is written in a cursive, flowing style.

Michael Ruzek, DO, FACEP
President
New Jersey ACEP Chapter

William B. Felegi, DO, FACEP

My Fellow Councillors:

The foundation of our College is strengthened with satisfied physicians contributing to our robustness and diversification. Our work has become more difficult because of changes in employment models; inadequate compensation and staffing resources; and, a complex and dangerous environment.

Recently, we experienced COVID-19 and the vulnerability and frailty of our health care system and staff. Most of us have suffered... **better work life equates to better personal life** where you can enjoy personal freedom and opportunity for rejuvenation.

Physician satisfaction starts in the workplace regardless of location - urban, suburban, rural; regardless of physician model - independent contractor, locums, hospital – critical access, community or academic; or, contract management group owned by a democratic group, publicly traded company, or private equity firm. No one else has been given the privilege to care for the sickest and most critically injured. Many have not been treated fairly by our employers. Democratic physician run companies are becoming sparse.

Physician burnout reflects physicians' job satisfaction – a final exhaustion, characterized by loss of enthusiasm from work, depersonalization, lack of purpose, and low sense of accomplishment. We are entitled to decent working conditions and to have the necessary resources to perform our jobs well for the benefits of our patients.

We will fail to attract students to our specialty, attract new graduates to the College, or continue to lose members unless we **focus on OUR EXPLOITATION as a reflection of the “moral injury” we have all suffered.** We need to **change our mantra from “physician burnout” to “moral injury.”** We are the victims, and the term physician burnout connotes that what we did or do is our fault! Burnout suggests that the problem resides within the individual who is in some way deficient. Let's place the blame where it belongs!

ACEP must focus on the individual physician and a “Physician Bill of Rights” for adequate and safe working conditions. If hospitals and managed contract groups cannot treat physicians fairly despite our dedication to our patients, then we need a better organized approach to focus on these inequities. Decades ago, unions were established because employees were mistreated. Should a viable alternative be available, members will leave unless ACEP does more. Physician union membership is growing.

We can no longer try to do the right thing because of fear from political consequences. **By choosing the easy way out, we avoid conflicts with others but create conflicts within. It's time we pay attention and heal the healers, we cannot continue to neglect ourselves.**

Huge health care disparities exist in rural America. Where it is ideal to have a residency trained emergency physician in every ED, it may not be practical. ACEP needs to continue to advocate for EM physician lead teams and to **aggressively question the training of any advanced practitioner who works in any ED.** Many rural hospitals are not accredited by the Joint Commission and CMS has no desire to police the care in rural America. We need to advocate for our profession and **all** our patients.

We know that the majority of residents attend a program where they want to practice or choose to practice in bigger cities or suburban areas. **We will continue to have a mismatch in the concentration of EM physicians regardless of any surplus of physicians. We need to explore the reasons behind residents' choices to practice and work on viable solutions.**

We always do the right thing for our patients. We need to maintain our integrity and courage and **focus on emergency physician's issues and work needs.**

I look forward to further discussion with you.

William B. Felegi, D.O, FACEP

Board of Directors Candidate

Clinical Practice

- Residency trained Board Certified Attending & Faculty Member EM Residency 24 years in NJ
- Past Chairman, EM tertiary care hospital, trauma center & pediatric hospital in NJ
- Currently at Rural Critical Access Hospital in Iowa as ED & Ambulance Service Medical Director
- Travel MD® Medical Director

State Leadership

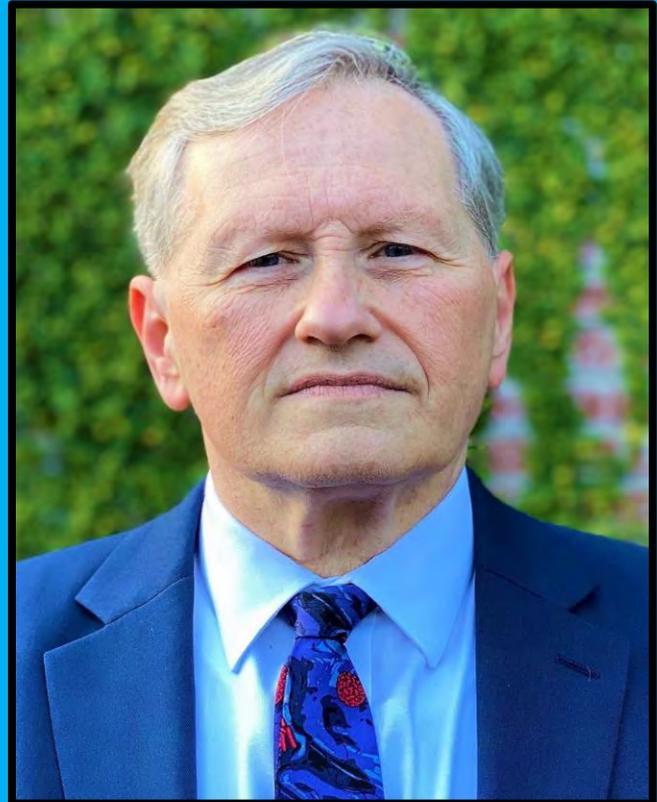
- NJACEP Past Board Member
- Past President NJ ACEP
- Councilor or Alternate 19 years
- Past Chairman NJACEP STATPAC
- Past Chairman NJACEP Government Affairs
- Board Member Iowa Osteopathic Medical Society & Current VP

National Activities & Leadership

- Past Chairman FGA
- Member FGA & State Legislative/Regulatory Committees
- Past Board of Governors EMAF
- Past Board of Directors member NEMPAC
- ABEM Board Examiner – 29 Exams

Awards

- ACEP 911 Legislative Network Member of the Year 2008 & 2009
- NJACEP Distinguished Service Award
- NJACEP Good Government Award
- 5 Faculty Teaching awards



Work Experience

- Morristown Medical Center, NJ – Envision Physician Services formerly– EmCare’s Partners group formerly Emergency Medicine Associates of NJ (Prior 24 years)
- Van Buren County Hospital, Iowa – current for the last 5 years

About Me

- Extensive experience with regulatory and federal issues germane to EM
- Health Care Policy Fellowship
- No longer on the payroll of a CMG
- Exclusive fulltime rural ED work

Strengths

- Integrity – doing the right thing at the right time for the right reason
- Collaboration
- Consensus building
- Examining unintended consequences

Reasons for Seeking Election

- **We have inadequately protected our members. You are the most important patient** and we cannot neglect the fact that physicians who are employed providers are entitled to basic employment rights and safe working conditions just like any other employee.
- With so many physicians employed by either a hospital or managed contract group the **membership of ACEP has changed to the employed physician model in the majority and we need to recognize that this has changed the landscape of our membership and priorities.**
- **Disparity exists in rural America and care models in emergency medicine must adapt to the rural environment. Once size does not fit all.** Where I spent the majority of my career in an academic program, I now practice full time in a small rural critical access hospital and the only board-certified emergency physician in a county of 9,000.

Significant Issues & ACEP Mission

- **ACEP needs to develop an EM physician's "Bill of Rights" that encompasses a fair and safe employment environment.** We have rights spelled out for contracts and billing practices but not basic rights for fair working benefits and safety like many other employees. Unions were developed to protect workers who were being abused. ACEP needs to advocate for our physicians.
- **We need to focus on physician satisfaction with the work environment just like we have focused on patient satisfaction.** We too need to be satisfied with our jobs and workplace.
- **Recognize that many of us have been exploited as reflected by the "moral injury" suffered. Our mantra needs to change from "physician burnout" to "moral injury."** We are the victims, and burnout connotes that what we did or do is our fault! Burnout suggests that the problem resides within the individual who is in some way deficient. **Let's place the blame where it belongs!**
- **Disparities in rural America need to be addressed.** Many ED's are staffed by AP's and we need to question their training and advocate for physician lead teams with emergency physician oversight. AP training programs must be held accountable.
- **Work force issues are paramount and need viable and reasonable solutions.** Regardless, we will continue to experience a mismatch in the concentration of EM physicians regardless of any surplus of EM physicians. We need to explore the reasons behind residents' choices to practice and work on viable solutions.

Curriculum Vitae

William B. Felegi, D.O., FACEP
731 Red Lion Way
Bridgewater, New Jersey 08807
908.227.3484 (Cell)
william.felegi@ahsys.org

RESIDENCIES

Chief Resident, Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1993-94

PGY 1-3 - Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1991-94

PGY 1 - Somerset Medical Center Residency in Family Practice Somerville, New Jersey, July, 1990-91

Internship, St. Michael's Medical Center Seton Hall University School of Graduate Medical Education Newark, New Jersey, July, 1989-90
(A.O.A. approved rotational/transitional type)

EDUCATION

American Osteopathic Association (AOA) Health Policy Fellowship, Ohio University College of Osteopathic Medicine, Athens, Ohio, September 2012-13

Emergency Medicine Foundation (EMF) & American College of Emergency Physicians (ACEP) Teaching Fellowship Program, Dallas, Texas, 2002

Doctor of Osteopathic Medicine, University of New England College of Osteopathic Medicine Biddeford, Maine, May, 1989

University of New England College of Osteopathic Medicine Dean's Summer **Research Fellowship**, 1986, "Gastric Laceration and Rupture As a Complication of Cardiopulmonary Resuscitation."

Bachelor of Arts, Major: Psychology, Rutgers College of Rutgers University New Brunswick, New Jersey, May, 1979

LICENSE & CERTIFICATION

State of New Jersey 10/26/90, No. 25MB05562100, Expiration: 6/30/2023

State of Iowa 2/13/2018, No. DO-05145, Expiration: 1/01/2024

NJ DEA Registration, No. FF7427188, Expiration: 9/30/2023

IA DEA Registration, No. BF2583690, Expiration: 9/30/2023

NJ CDS Registration, No. DO53599, Expiration: 10/31/2023

**LICENSE &
CERTIFICATION**
(con't.)

IA CSA Registration, No. 1307596. Expiration 9/30/2023

Diplomate National Board of Osteo. Medical Examiners, No. 18031, 7/1/1990

Diplomate American Board of Emergency Medicine, No. 23557, 12/31/2025

Diplomate Amer. Osteo. Board of Emergency Medicine, No. 4448, 12/31/2022

Fellow, American College of Emergency Physicians, 1997

Certificate in Travel Health™, International Society of Travel Medicine, 2011-present

Fundamental Critical Care Support Instructor, Society of Critical Care, 9/04

Civil Defense Radiological Monitor, United States Department of Defense

**PROFESSIONAL
ORGANIZATIONS**

American College of Emergency Physicians (**ACEP**), No. 360717, 1991-present
New Jersey Chapter (**NJACEP**), 1991-present
Iowa Chapter (**Iowa ACEP**), 2018-present

American Medical Association, (**AMA**), 2011-present

American Association for Physician Leadership (**AAPL**) formerly **ACPE**, 2011-present

International Society of Travel Medicine (**ISTM**), 2003-present

American Osteopathic Association (**AOA**), No. 52018, 1989-present

American College of Osteopathic Family Practitioners (**ACOFP**), No. 52018, 1989-2016

Iowa Osteopathic Medical Association (**IOMA**), 2017-present

New Jersey Association of Osteopathic Physicians and Surgeons (**NJAOPS**), 1989-2017

Medical Society of New Jersey (**MSNJ**), 1990-2017

Morris County Medical Society, 2004-2017

Somerset County Medical Society, 1990-2004

Morris & Sussex County Society of Osteopathic Physicians, 2002-2017

Member Emergency Medical Associates Research Foundation, 1997-2017

Psi Sigma Alpha Society (National Osteopathic Scholastic Honorary Society), 1989-present

**PROFESSIONAL
ORGANIZATIONS**
(con't.)

Sigma Sigma Phi, Grand Chapter (National Honorary Osteopathic Fraternity),
1989-present

Life Member, University of New England College of Osteopathic Medicine
Alumni Association, 1989-present

AWARDS

Morristown Memorial Hospital Residency in Emergency Medicine, **Most
Valuable Contributor, 2009-10**

American College of Emergency Physicians – **2009 911 Legislative Network
Member of the Year**

NJ ACEP **Distinguished Service Award, 2009**

American College of Emergency Physicians – **2008 911 Legislative Network
Member of the Year**

Morristown Memorial Hospital Residency in Emergency Medicine, **Clinical
Instructor of the Year, 2005-06**

Morristown Memorial Hospital Residency in Emergency Medicine, **Most
Valued Contributor to the Residency Program, 2004-05**

NJ ACEP **Good Government Award, 2003**

Morristown Memorial Hospital Residency in Emergency Medicine, **Most
Valued Contributor to the Residency Program, 2001-02**

Morristown Memorial Hospital Residency in Emergency Medicine, **Teacher of
the Year, 2000-01**

Special Advisor, The Advisory Board, Clinical Initiatives Center, "The
Clockwork ED - Expediting Diagnosis," 1999

Morristown Memorial Hospital Residency in Emergency Medicine, **Most
Valuable Contributor, 1997-98**

Psi Sigma Alpha Society (National Osteopathic Scholastic Honorary Society)

Sigma Sigma Phi, Grand Chapter (National Honorary Osteopathic Fraternity)

Student Osteopathic Medical Association (SOMA) Scholarship, 1987

Howard G. Lapsley Memorial Scholarship, Muhlenberg Hospital, Plainfield,
New Jersey, 1987

New Jersey State First Aid Council State Championship - First Aid Competition,
Youth Group, 1976

Commendation from N. J. State First Aid Council 5th District - 5/19/91 for
service to first aid & rescue squads

**NATIONAL
ACTIVITIES**

American Board of Emergency Medicine (**ABEM**):
Oral Board Examiner, 2002-2013 (4 Terms)
Senior Oral Board Examiner, 2014–present (30 Exams)

American College of Emergency Physicians (**ACEP**):
Board of Governors, Emergency Medicine Action Fund (**EMAF**),
2011-2013
Chairman, Federal Governmental Affairs Committee (**FGA**), 2011-
2014
Team Captain, 911 Legislative Network, 2007-present
Federal Governmental Affairs Committee (**FGA**), 2005-present
911 Legislative Network, 2003-present
Board of Directors National Emergency Medicine Political Action
Committee (**NEMPAC**), 2003-08.
State Legislative/Regulatory Committee, 2006-present

STATE ACTIVITIES

American College of Emergency Physicians, New Jersey Chapter (**NJACEP**):
Immediate Past President, 2006
President, 2005-06
President-Elect, 2004-05
Secretary/Treasurer, 2003-04
Councilor or Alternate Council, 2003-present
Treasurer, 2002-03
Board of Directors, 1999-2006
Chairman, Political Action Committee, **STATPAC**, 2002-2013
Government Affairs/STATPAC, 2001-2003
Co-Chair, Government Affairs/STATPAC, 2000-01

Iowa Osteopathic Medical Association
Board of Trustees, 2021-present

New Jersey Association of Osteopathic Physicians and Surgeons (**NJAOPS**):
Board of Directors, 2014-2018
Government Affairs Committee, 2014-2018
Grassroots Committee, 2014-2018

State of New Jersey Commission on Rationalizing Health Care Resources,
Subcommittee Hospital/Physician Relations & Practice Efficiency Commission
(Gubernatorial Appointment), 2007-08

State of New Jersey Health Care Access Commission (Gubernatorial
Appointment), 2006-08

State of New Jersey Advisory Council for Basic & Intermediate Life Support
(EMTTF), (Gubernatorial Appointment), 2002-present

State of New Jersey, Influenza Pandemic Action Committee, 1999-2006

**EMPLOYMENT
EXPERIENCE**

Van Buren County Hospital, Keosauqua, Iowa, 2016-present

Envision Physician Services, formerly EmCare (EmCare's Partners Group-EPG), formerly Emergency Medical Associates (EMA), Parsippany, NJ – Employed Physician, 1994-present

Current Base Hospital – Hackettstown Medical Center, Hackettstown NJ, 2016-present

Prior Base Hospital - Morristown Medical Center, Morristown, NJ, 1994-2016

Atlantic Health, Morristown Medical Center, Travel MD™, Corporate Health - Clinical Medical Director, 1995-present (Independent Contractor Status)

**PROFESSIONAL
EXPERIENCE**

Emergency Department, Van Buren County Hospital (**VBCH**), Keosauqua, IA
Emergency Department Director
Medical Director VBCH Ambulance

Department of Emergency Medicine, Morristown Medical Center, Morristown, NJ:

Chairman, Department of Emergency Medicine 2015-2016
Interim Chairman, Department of Emergency Medicine 2014-2015
Vice Chairman, Department of Emergency Medicine 2001-2013
Attending & Faculty Member, Residency in Emergency Medicine, 2001-2016
Associate Attending & Faculty Member, Residency in Emergency Medicine, 1996-2001
Assistant Attending & Faculty Member, Residency in Emergency Medicine, 1994-96
Clinical Medical Director Fast Care & Work Med, 1995-2016
Medical Review Officer, Work Med, 1995-2016
Associate Director Emergency Department, 1995-2014

Staff Physician - Your Doctor's Care, Somerville, NJ, 1994

Team Physician Sports Coverage Parsippany-Troy Hills High School, Parsippany, NJ 1993

Morristown Memorial Hospital Mt. Kimball Division Work Med - Occupational Medicine Clinic Morristown, NJ, 1993-94

**HOSPITAL
ACTIVITIES**

Van Buren County Hospital, Keosauqua, IA
Medical Staff Secretary, 2019-2020
Member, Quality and Patient Safety Committee, 2018-present
Member, P&T Committee, 2018-present
Member, Trauma Committee, 2018-present

Morristown Medical Center, Morristown, NJ:

Morristown Medical Center Advisory Board Member, 2014-2016
Member, Atlantic Health Sepsis Initiative Committee, 2011-2016
Member, Quality and Patient Safety Committee, 2008-2016

**HOSPITAL
ACTIVITIES**
(con't.)

Member, Department of Cardiovascular Medicine, STEMI Team Committee, 2007-2016
Member, Radiology Task Force, 2005-06
Member, ED Peer Review Committee, 2005-2016
Member, Clinical Resource Management Committee, 2001-05
Co-Chairman, Trauma Quality Improvement Committee, 2005-2016
Chairman, Trauma Quality Improvement Committee, 2002-03, 04-05
Member, CPR Committee, 1999-2013
Chairman, ED/Radiology Performance Improvement Team, 1998-2003
Chairman, ED Performance Improvement Committee, 1996-98
Member, Hospital Wide Performance Improvement Committee, 1995-2008
Member, MI Critical Care Pathway Committee, 1995-2003
Chairman, CPR Committee, 1994-98
ACLS Course Medical Director, Advanced Cardiac Life Support American Heart Association, 1994-97
Member, Trauma Quality Improvement Committee, 1994-2002, 2003-2004
Trauma Liaison, Department of Emergency Medicine to Department of Surgery, Section of Trauma for Level I Trauma Center designation, 1994-2016
Member, Trauma/Radiology CQI Committee, 1994

**ACADEMIC
APPOINTMENTS**

Assistant Clinical Professor Emergency Medicine, Sidney Kimmel Medical College – Thomas Jefferson University, Philadelphia, Pennsylvania, 2015-2018

Assistant Clinical Professor Emergency Medicine, Mount Sinai School of Medicine, New York, New York, 2008-2015

**FUNDED
RESEARCH**

Program Title: Expanded Access IND Program to Provide Stamaril® Vaccine to Persons in the United States for Vaccination Against Yellow Fever
Program #: STA00011
Sponsor: Sanofi Pasteur
Sponsor's Primary Investigator: Dr. Riyadh Muhammad
Sub-Investigator: William B. Felegi, D.O.

PUBLICATIONS

Felegi WB, Silverman M, Allegra, J. (2003). Does **the distribution of written guidelines with accompanying educational information for appropriate use of meperidine change emergency department physicians' prescribing habits?** *Annals of Emergency Medicine* (abstract), 42, s101.

Felegi, W.B., Lavery, W.B., Oh, D., Tortella, B.J.: **Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?** (Abstract). *Prehospital Emergency Care*, 1(3): 179.

Lavery, R.L., Felegi, W.B., Oh, D., Tortella, B.J.: **Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?** (Abstract). *Academic Emergency Medicine*, 4(5): 436.

Felegi, W.B, Doolittle, R.L., Conston, A.S., Chandler, S.V.: **Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation** (Abstract). *Prehospital and Disaster Medicine*, 1996, 11(3): 103.

PRESENTATIONS

(con't.)

Felegi, W.B, Doolittle, R.L., Conston, A.S., Chandler, S.V.: **Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation** (Abstract). Academic Emergency Medicine, 1996, 3(5).

Allegra, J.R., Brennan, J., Felegi, B., Fields, L., Grubiner, F, Kiss, G., Lavery, B., Pruzik, T.: **Use of Time-Temperature Indicators to Monitor the Storage Temperature of Medications in the Prehospital Setting** (Abstract). Annals of Emergency Medicine, 1996, 27(1): 147.

Felegi, W.B.: **The Silent Killers, Part II - Methane**. Emergency Medical Services, 1983, 12(3):62-64.

Felegi, W.B.: **The Silent Killers, Part I - Carbon Monoxide**. Emergency Medical Services, 1983, 12(2):54-59.

Nirmala, A., W. Felegi, J.M. Stern: ***In Utero* Alcohol Heightens Juvenile Reactivity**. Pharmacology, Biochemistry & Behavior, 1980, 13:531-535.

Arizona College of Osteopathic Medicine, Phoenix, AZ, **“Escape Fire” – Panel Discussion with Questions and Answers by the 2012-13 AOA Health Policy Fellows**, March 14, 2013

Givaudan Fragrances, Ridgedale Site, East Hanover, NJ, **“International Travel Medicine – Protect Your Health Before You Go,”** October 16, 2012

Schindler Elevator, Randolph, Morristown, NJ, **“‘Hot’ Tips for the Prevention and Treatment of Heat Emergencies,”** August 14, 2012

Schindler Elevator, Morristown, NJ, **“‘Hot’ Tips for the Prevention and Treatment of Heat Emergencies,”** June 28, 2012

Bi-Annual Overlook Family Medicine Reunion and Update, “Global Health and Medical Volunteerism” - Overlook Hospital, Summit, NJ, **“Don’t Become a Patient: Preparation for International Travel,”** May 16, 2008

Grand Rounds/Visiting Professor Lecture Series, Department of Emergency Medicine, SUNY – Stony Brook, **“Emergency Medicine Billing & Reimbursement,”** June 5, 2007

American College of Emergency Physicians 2006 Leadership & Advocacy Conference, **“Leveraging the ACEP State Report Card to Advance Your State Advocacy Agenda”** with Panel Discussion, May 23, 2006

American College of Emergency Physicians 2006 Leadership & Advocacy Conference, **“Power-Packed Ideas to Empower Your State PAC”** with Panel Discussion, May 23, 2006

NJ Emergency Nurses’ Association (ENA) Emergency care Conference, **“Illness in unexpected places – Travel Related Medicine in the ED,”** May 17, 2006

St. Joseph’s Regional Medical Center Emergency Medicine Residency Governmental Affairs Conference Day, **“State Liability Issues and Update”** with Panel Discussion, August 11, 2004

PRESENTATIONS
(con't.)

2004 Bridgewater Township Middle School Career Day, **"Emergency Medicine & Osteopathic Medical Education."**

2003 American College of Emergency Physicians Research Forum, Boston, Massachusetts, abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"**: W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, October, 2003

2003 Atlantic Health System Annual Research Day abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"** W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, June, 2003

2003 New Jersey Chapter of the American College of Emergency Physicians Scientific Assembly, Woodbridge, New Jersey abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"** W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, May, 2003

2003 7th Annual New England Regional Society for Academic Emergency Medicine, Shrewsbury, Massachusetts, abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"** W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, April, 2003

2003 6th Annual Mid-Atlantic Regional Society for Academic Emergency Medicine, Washington, DC, abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"** W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, March, 2003

1999 Institute for Health Care Improvement 11th Annual National Forum on Quality Improvement & Health Care storyboard entitled **"Decreasing X-Ray Turnaround Time in the Emergency Department"**: W.B. Felegi, Department of Emergency Medicine, Morristown Memorial Hospital, December, 1999

1998 Institute for Healthcare Improvement, National Congress on Reducing Waits & Delays & Improving Patient Satisfaction in the Emergency Department, Orlando, Florida, oral lecture entitled, **"Reducing X-Ray Times in the Emergency Department,"** W.B. Felegi, Department of Emergency Medicine, Morristown Memorial Hospital, November, 1998

PRESENTATIONS

(con't.)

1998 Morristown Memorial Hospital Annual Research Day Competition, abstract poster presentation entitled, "**Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?**": R. Lavery, W.B. Felegi, D. Oh, B. Tortella, Department of Emergency Medicine, Morristown Memorial Hospital, Morristown; Department of Surgery, University of Medicine & Dentistry, Newark, New Jersey, June, 1998

1998 Emergency Medicine Clinical Pathological Conference (CPC) Region D (Central Region) Competition, Society of Academic Emergency Medicine, Chicago, Illinois, May, 1998

1997 National Association of Emergency Medical Services Physicians Mid-Year Meeting and Scientific Assembly, Incline Village, Nevada, abstract oral presentation entitled, "**Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?**": R. Lavery, W.B. Felegi, D. Oh, B. Tortella, Department of Emergency Medicine, Morristown Memorial Hospital, Morristown; Department of Surgery, University of Medicine & Dentistry, Newark, New Jersey, July, 1997

1997 Annual Meeting Society for Academic Emergency Medicine, Washington, D.C., oral poster presentation entitled, "**Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?**": R. Lavery, W.B. Felegi, D. Oh, B. Tortella, Department of Emergency Medicine, Morristown Memorial Hospital, Morristown; Department of Surgery, University of Medicine & Dentistry, Newark, New Jersey, May, 1997

1997 1st Annual New England Regional Society for Academic Emergency Medicine Conference & Brown University School of Medicine, Providence, Rhode Island, abstract poster presentation entitled, "**Does Point-of-**

Care Testing in the Out-of-Hospital Setting Influence Patient Care?" R. Lavery, W.B. Felegi, D. Oh, B. Tortella, Department of Emergency Medicine, Morristown Memorial Hospital, Morristown; Department of Surgery, University of Medicine & Dentistry, Newark, New Jersey, April, 1997

1996 Special Guest Speaker for Emergency Medical Services Paramedics "**Gynecological, Obstetrical & Neonatal Emergencies**" - New Jersey State First Aid Council 68th Annual Convention, Educational Symposium & Trade Show, Lake Kiamesa, New York, October, 1996

1996 American College of Emergency Physicians Research Forum, Cincinnati Ohio, abstract presentation entitled "**Use of Time - Temperature Indicators to Monitor the Storage Temperature of Medications in the Prehospital Setting**": J.R. Allegra, J. Brennan, B. Felegi, L. Fields, F. Grubiner, G. Kiss, B. Lavery, T. Pruzik; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Lifeline Technologies, Inc.; and, University & Dentistry of New Jersey, February 1996

PRESENTATIONS
(con't.)

1996 Annual Meeting Society for Academic Emergency Medicine, Denver, CO, abstract poster presentation entitled, "**Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation**": W. B. Felegi, R.L. Doolittle, A.S. Conston, S.V. Chandler; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Department of Pathology, Somerset Medical Center, Somerville, New Jersey, May 1996

1996 New Jersey Chapter of the American College of Emergency Physicians Scientific Assembly, Atlantic City, NJ, abstract poster presentation entitled, "**Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation**": W. B. Felegi, R.L. Doolittle, A.S. Conston, S.V. Chandler; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Department of Pathology, Somerset Medical Center, Somerville, New Jersey, June 1996

1996 National Association of Emergency Medical Services Physicians Mid-Year Meeting and Scientific Assembly, San Diego, CA, abstract oral presentation entitled, "**Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation**": W. B. Felegi, R.L. Doolittle, A.S. Conston, S.V. Chandler; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Department of Pathology, Somerset Medical Center, Somerville, New Jersey, July 1996

Special Guest Speaker for Emergency Medical Services Paramedics Gynecological, Obstetrical & Neonatal Emergencies" 1995 - New Jersey State First Aid Council 67th Annual Convention, Somerset, New Jersey

Special Guest Speaker for Emergency Medical Services Paramedic Personnel: Morris County Fire & Police Academy Emergency Medical Technician Core Lecturer EMT Basic & Refresher Courses, 1991- 1994

Introduction to Emergency Nursing Lecture Series of Morristown Memorial Hospital Guest Speaker, 1992

13th Annual Maine Biological and Medical Services Symposium poster presentation entitled "**Gastric Ruptures, Gastric Mucosal Lacerations, and Gastric Dilation Following Cardiopulmonary Resuscitation in the Prehospital Environment,**" June 1987

Special Guest Speaker for Emergency Medical Services Personnel and their response to the Crime Scene for:

1984 - St. Peter's Medical Center Area First Aid Council, New Brunswick, N.J.

1984 - Plainfield Rescue Squad, New Jersey

1984 - Essex County and the Cedar Grove Rescue Squad, New Jersey

1984 - New Jersey State First Aid Council 56th Annual Mid-Year Assembly, Cherry Hill, New Jersey

1983 - New Jersey State First Aid Council 55th Annual Convention, New York

**COMMUNITY
SERVICE**

Medical Director, Farmington EMS, Farmington, IA, 2018-present

Life Member Bound Brook Rescue Squad, Inc., 1974-present

Delegate-at-Large to the 5th District of the New Jersey State First Aid Council, 1983-present

Community Member, Bridgewater Township Emergency Medical Services Committee, 2001-03

Vice-President 5th District of the New Jersey State First Aid Council, 1983-85

Democratic Male Committee Member, Bridgewater Township District 26, 2004-2008

Former ACLS (American Heart Association) Instructor 1994-2007

Former Instructor American Red Cross Standard & Advanced First Aid & Emergency Care (10 years)

Former Instructor American Heart Association C.P.R. (8 years)

Former Instructor NJ State First Aid Council Extrication (4 years)

Former member Somerset County's Citizen Advisory Task Force on Domestic Violence for Battered Spouses & Child Abuse (1 year)

Former member Bound Brook School District Citizen's Advisory Thoroughness & Efficiency Committee (2 years)

2023 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Robert J. Hancock, DO FACEP

Question #1: How can ACEP optimize its financial resources to ensure future stability?

The future stability of ACEP is largely dependent on the organization's ability to recruit and retain members. Recent years have seen a decline in membership which is largely multifactorial. While the number of board-certified emergency physicians continues to increase, ACEP membership has been flat or declined in recent years. This pattern must be reversed in order to secure the financial stability of the organization.

In order to increase and stabilize membership, ACEP needs to focus on issues that affect the greatest number of practicing emergency physicians. These issues include reimbursement, workplace violence, due process, EMTALA, tort reform, and physician wellness/mental health. Additionally, ACEP needs to clearly communicate to the average member how our advocacy efforts benefit them on a daily basis. Unfortunately, many former members of ACEP have communicated to me that they chose to leave the organization because they no longer felt ACEP was focused on the issues that affect them most. While I feel that these thoughts are often misguided, it does demonstrate that the organization needs to demonstrate its focus on these core issues. I think it is fair to say that the average member wants to clearly understand what they are getting in return for the substantial dues they pay to ACEP.

Additionally, the organization must be a good steward of its financial resources. This includes making prudent investments and also demonstrating to membership that money spent is going towards issues that matter to the average member. Additionally, continuing to pursue and expand non-dues income adds another component of financial stability which will ultimately benefit members.

Question #2: Describe how your election to the Board of Directors would enhance ACEP's ability to speak for and represent all emergency physicians.

During my time as a board-certified emergency physician, I have worked in a diverse group of environments. I currently serve as core faculty in an emergency medicine residency in rural Oklahoma and also practice in a large suburban trauma center in the Dallas area. Previously, I have worked in large urban trauma centers, academic centers, freestanding emergency departments, EMS, and critical access hospitals. This has allowed me to personally experience the unique challenges faced by emergency physicians in all of these environments.

As TCEP President, I led the organization during the early part of the Covid pandemic. This was a challenging but valuable experience in which I learned new skills that ranged from handling conflicting viewpoints from members to conducting local and national media interviews. These experiences definitely made me a better leader in emergency medicine, and I hope to bring these same skills to the ACEP Board of Directors.

I currently serve as the Board Chair of the Texas Alliance for Patient Access. This is the organization that successfully lobbied for tort reform in Texas in 2003. As board chair, I lead an organization comprised of physicians, healthcare systems, medical malpractice providers, and professional associations. The current mission of this organization is to protect tort reform in Texas. This is a position that requires me to interact with lobbyists, legislators, trial lawyers, and leaders of many medical organizations. This position has taught me how to work collaboratively among groups with competing interests and identify the best path forward for the organization.

My diverse background and experience would enhance the ACEP Board of Directors if I were elected. I have personally experienced the frustrations and unique challenges in many different areas of emergency medicine, and I am prepared to address these challenges should I be elected to the ACEP Board of Directors.

Question #3: From your perspective, what would you do to ensure that emergency medicine remains an attractive specialty?

The decline in the popularity of emergency medicine and the subsequent significant decline in the match statistics should be very concerning for all of us. The underlying causes of the decline are multifactorial and many were significantly worsened during Covid.

The issue with boarding evolved into a crisis during Covid. This required many of us to see a significant percentage of our patients in the waiting room or hallway chairs. While this was a necessity during Covid, it definitely had a negative impact on medical students during rotations; and I actually had several medical students tell me that they did not want to train and practice under those conditions. This resulted in many students choosing specialties that were in a more controlled environment with fewer variables.

While many of us were initially treated as “healthcare heroes” during Covid, this quickly deteriorated into angry patients and families who vented their frustration at the emergency department staff. The increase in hostility and workplace violence also has driven medical students to reconsider if emergency medicine is truly their calling. I have had medical students tell me they were leaning away from emergency medicine because of safety concerns.

The Covid pandemic also exposed massive holes in the “healthcare safety net”. For those of us that work in critical access hospitals with variable specialty coverage, Covid created massive patient safety issues. Every facility cited “capacity” and was blanketly declining every transfer unless it was trauma, STEMI or stroke. In many cases, patients deteriorated and died from conditions requiring specialists while we begged for anyone to help. Medical students witnessed our absolute frustration with the system and I am certain it made them question their decision to pursue emergency medicine.

ACEP is already taking steps to address boarding and workplace violence. However, I still think there is much more that can be done and these are two issues that we must continue to pursue through advocacy and legislation. Additionally, I feel ACEP should lead the way on pursuing revisions to EMTALA that would update an outdated statute and guarantee that critically ill patients have access to definitive care.

Unfortunately, these issues have also caused many emergency physicians to become frustrated and speak negatively in front of medical students. It is imperative that we not only work to fix these issues, but also encourage our members to support our specialty and attract quality candidates for emergency medicine. They are the future of emergency medicine!



CANDIDATE DATA SHEET

Robert J. Hancock, DO FACEP

Contact Information

Robert J. Hancock, DO FACEP

Phone: 972-740-0079

E-Mail: robhancock73@att.net

Current and Past Professional Position(s)

Clinical Assistant Professor – Oklahoma State University

Core Faculty – Emergency Medicine Residency – Comanche County Memorial Hospital – Lawton, OK

Board Chairman – Texas Alliance for Patient Access

BEST EMS – EMS Medical Director

Texas Governor's EMS and Trauma Advisory Council – Past

Co-Medical Director – Methodist Dallas Medical Center - Past

Education (include internships and residency information)

University of North Texas Health Science Center at Fort Worth – Doctor of Osteopathic Medicine - Graduated 2004

UT Southwestern/Parkland Memorial Hospital – Emergency Medicine Residency – Graduated 2007

Doctor of Osteopathic Medicine - 2004

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine (Initial 2008, Recert 2018)

Professional Societies

American College of Emergency Physicians

Texas Medical Association

Texas Alliance for Patient Access

National ACEP Activities – List your most significant accomplishments

Served on ACEP council for over 5 years

ACEP Chapter Activities – List your most significant accomplishments

Texas Chapter – President 2020-2021

Practice Profile

Total hours devoted to emergency medicine practice per year: 1680 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 80 % Research 0 % Teaching 20 % Administration 0 %

Other: _____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I currently am an attending physician at a busy rural facility in Lawton, Oklahoma. I am core faculty in the emergency medicine residency program which is affiliated with Oklahoma State University. The facility is staffed by American Physician Partners. However, I have no leadership role with APP. We are compensated for our direct clinical care by APP and by the hospital for academic time.

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.)

Core Faculty – Comanche County Memorial Hospital EM Residency
Clinical Assistant Professor – Oklahoma State University

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases Plaintiff Expert 0 Cases

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Robert J. Hancock, DO FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: American Physician Partners

Address: 3401 W. Gore Blvd

Lawton, OK. 73505

Position Held: Emergency Medicine Physician, Core Faculty

Type of Organization: Contract Management Group

Employer: Integrative Emergency Services

Address: 1650 W College St

Grapevine, TX. 87051

Position Held: Part-Time Emergency Medicine Physician

Type of Organization: Contract Management Group (Physician Owned)

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: Texas Alliance For Patient Access

Address: 2301 South Capital of Texas Highway, Building J-101

Austin, Texas. 78746

Type of Organization: Coalition of physicians and organization that work to protect tort reform in Texas

Leadership Position: Board Chair

Term of Service: Since 2021

Organization: Texas College of Emergency Physicians

Address: _____

Type of Organization: State Chapter of ACEP

Leadership Position: President 2020-2021, Board Member 2015-2022

Term of Service: 2015-2022

Candidate Conflict of Interest Disclosure Statement

Page 2

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 [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.

Robert J. Hancock

06/13/2023

2023-2024
Board of Directors

Sandra Williams, DO, MPH,
FACEP
President

Doug Jeffrey, MD, FACEP
President Elect

A.J. Kirk, MD, FACEP
Treasurer

Bryan Dunn, MD, FACEP
Secretary

Sterling Overstreet, MD, FACEP
Immediate Past President

Sara Andrabi, MD, FACEP

Jessica Best, MD, FACEP

Ciaura Brown, MD, MBA

Angela Cornelius, MD, FACEP

Abbey Pastorelle

Anant Patel, DO, FACEP

Julien Mahler, MD

Marcus Sims, DO, FACEP

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 5, 2023

Dear Councillors,

On behalf of the Texas College of Emergency Physicians (TCEP), it is my great pleasure to endorse Robert Hancock, DO, FACEP as a candidate for the ACEP Board of Directors.

As a college, we give this endorsement with our full support. Dr. Hancock has been a member of ACEP/TCEP since 2000 and brings experience and accomplishments in clinical practice (both rural and community), national ACEP, and our Chapter that, at this time of challenge to our profession, will be of great value in advancing emergency care. Within ACEP, Dr. Hancock has served with distinction as a Councilor since 2018, and the 911 Network.

Dr. Hancock has served in every capacity on the TCEP Board, moving up through the offices to President in 2020-21. It was his service as President that really set the bar. When he served as President of the Chapter, it was a time of great turmoil for the nation and Emergency Medicine, as the COVID pandemic was changing the world.

For the entire duration of his term as President and continuing as he served as Past President, Dr. Hancock was the TCEP spokesperson regarding the pandemic, vaccines, testing, addressing patient fears, and dispelling miscommunication. While we did not track every TV, radio and zoom interview that he had, he did well over 120 media interviews statewide, nationally and even internationally. His dedication to handling several interviews in one day/night was truly phenomenal. To further emphasize how important this was, ACEP chose to recognize Dr. Hancock as the recipient of ACEP's Spokesperson of the Year Award, 2021.

His leadership service within TCEP and the medical community exemplify the skills that will be of value to the ACEP Board of Directors. You can see from his CV, that he has served on many committees and in leadership positions. Within TCEP, he continues to serve on the Finance committee, EMPACT board, the Search Committee, and the Government Relations committee.

In looking at collaboration outside of the House of Medicine, Dr Hancock has been a leader in tort reform for EM in Texas. After serving on the TAPA board for several years as a liaison for emergency medicine, Dr. Hancock now serves as the President of the Texas Alliance for Patient Access (TAPA) which is the organization which helped tremendously with our tort reform success.

The Texas Chapter is proud to give him our highest endorsement.

Thank you for your consideration, and please do not hesitate to reach out to me or our Executive Director Beth Brooks, (tcep@texacep.org) with any questions.

Sincerely,

Sandra Williams DO, FACEP
President

Robert J. Hancock, DO FACEP

I believe that the best path to emergency physician wellness and career longevity is to support policy that makes it easier and less stressful for the average emergency physician to practice emergency medicine. ACEP needs to concentrate on those issues that unite us as emergency physicians and affect the greatest number of our members and patients. These include reimbursement, medical liability, clinical guidelines, due process, ED violence, boarding and psych holds. While ACEP is already working on some of these issues, I feel there is still more that can be done. Given my experience in virtually every area of EM (Inner City, Suburban, Rural, Academic, FSED, EMS) I feel that I can offer a unique perspective on many of these issues.

Additionally, I am concerned about the increasing tendency for hospitals who claim to be “full” to refuse transfers for higher level of care based on “lack of capacity”. I feel ACEP should work with relevant stakeholders to determine what actually constitutes “lack of capacity” under EMTALA. This significantly worsened during the Covid pandemic and hospitals are continuing to use this excuse to refuse transfers from outside facilities while accepting patients from inside their own hospital system. In my opinion, this isn’t a “lack of capacity” but rather a lack of compassion.

By concentrating on those issues most relevant to the average member, ACEP can increase new membership and improve member retention. I look forward to the opportunity to serve an organization that has meant so much to my own career. I greatly appreciate this opportunity, and I respectfully ask you to entrust me with your vote.

Robert J. Hancock, DO FACEP
ACEP Board of Directors Candidate



Background

Baylor University – Undergraduate
UNT Health Science Center – Medical School
Parkland Hospital – Emergency Medicine Residency
Diplomate – American Board of Emergency Medicine

Goals as an ACEP Board Member

Expand and retain members
Advocate for those issues most relevant to the majority of ACEP membership

Leadership

| | |
|--|--------------|
| ACEP Councilor | 2018-Present |
| Board Chair – Texas Alliance for Patient Access | 2021-Present |
| Texas College of Emergency Physicians – President | 2020-2021 |
| Texas College of Emergency Physicians – Board Member | 2015-2022 |
| ACEP Spokesperson of the Year | 2021 |
| Texas Governor’s EMS/Trauma Advisory Committee | 2021-2022 |
| Texas State Board of Medical Examiners – Expert Panelist | 2017-Present |

Clinical Practice

I have practiced in inner city trauma centers, academic medical centers, rural critical access hospitals, free-standing emergency departments, and community emergency departments. I am currently core faculty in an emergency medicine residency program in Lawton, Oklahoma. Additionally, I work part-time in a busy community hospital (Level 2 trauma center) in the Dallas/Fort Worth metroplex; and I currently serve as an EMS Medical Director for 7 Fire/EMS departments and 2 large corporations.

Robert Hancock, DO, FACEP

robhancock73@att.net

MEDICAL SPECIALTY

Diplomate of the American Board of Emergency Medicine
Fellow of the American College of Emergency Physicians

PREMEDICAL EDUCATION

1996-2000: Bachelor of Science in Biology
Baylor University, Waco, Texas

MEDICAL EDUCATION

August 2000 – May 2004: Doctor of Osteopathic Medicine with Honors
University of North Texas Health Science Center, Fort Worth, Texas

RESIDENCY

June 2004- June 2007: Emergency Medicine
Parkland Hospital, Dallas, Texas

LEADERSHIP POSITIONS

Clinical Assistant Professor, Emergency Medicine, Oklahoma State University Center for Health Sciences, Comanche County Emergency Medicine Residency Program, 2021-Present

Texas College of Emergency Physicians, President, 2020-2021

Medical Director Committee, Texas Governor's EMS/Trauma Advisory Council, 2020-2022

Texas Alliance for Patient Access, Board Chair, 2021-Present

Interim Medical Director, NWT Medical Center, Amarillo, TX, 2019

Texas College of Emergency Physicians, Board of Directors, 2017-2022

Methodist Dallas Medical Center Emergency Department, Co-Medical Director, March 2010 - October 2013

Assistant Clinical Professor, Department of Surgery, UT Southwestern Medical School, January 2010 – March 2014

Chief Resident, Parkland Hospital, June 2006 – June 2007

HOSPITAL STAFF POSITIONS

Comanche County Memorial Hospital, Lawton, OK, 2019-Present

Northwest Texas Medical Center, Amarillo, TX, 2018-Present

Baylor Scott & White Regional Medical Center - Grapevine, Grapevine, Texas, 2014-Present

Baylor Scott & White Regional Medical Center – McKinney, McKinney, Texas, 2017-Present

Texoma Medical Center, Denison, Texas, February 2013-2022

John Peter Smith Hospital, Fort Worth, Texas, 2013-2015

Parkland Memorial Hospital, Dallas, Texas, 2010 – 2014
Methodist Dallas Medical Center, Dallas, Texas, 2006 – 2013
Methodist Charlton Medical Center, Dallas, Texas, 2006 – 2013
Methodist Mansfield Medical Center, Dallas, Texas, 2006 – 2013

PUBLICATIONS

Robert Hancock, DO and Timothy Rupp, MD. “Evaluation and Management of Foot Pain in the Emergency Department”. Emergency Medicine Reports. January 21, 2007.

2023 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Chadd K. Kraus, DO, DrPH, CPE, FACEP

Question #1: How can ACEP optimize its financial resources to ensure future stability?

ACEP's financial vision, resources, stability, and growth must focus on a single mission – to serve and to support members. The fiscal discussions and decisions by the Board and staff must always answer the guiding question: “How does this provide value to our members?” The current economic environment and ACEP's traditional reliance on revenue from membership dues and educational programs have put significant stress on the College's finances. Optimizing the finances of the College is among the biggest issues facing the Board. As a Board member, I will take my fiduciary responsibility to members and the organization seriously, focusing on financial stability while prioritizing the value of membership.

Proactive steps have been taken to stabilize ACEP's finances. The Board along with staff leadership have made difficult and sometimes unpopular decisions, including pausing programs and reducing staff. Financial austerity is an opportunity to refocus organizational priorities toward advancing emergency care and providing membership value to emergency physicians. Optimizing ACEP's financial resources and stability should prioritize three themes: *Members*, *Data*, and *Learning Resources*.

Members. Members are the heart, soul, and strength – the “why” – of ACEP. The College must continue to dedicate resources to the recruitment and retention of members. Member dues will continue to be an important part of ACEP's finances, even as the College finds and secures alternative revenue streams. Investment in updated systems and infrastructure to collect and understand both qualitative and quantitative data on what members want and need and to use that information to refine and improve the delivery of member services is critical to our financial success. My experiences on the Member Engagement Strategic Planning team, as well as my service as a large chapter President and Past Chair of the YPS, have prepared me to be a Board member who is focused on increasing ACEP's membership and on maximizing value for members.

Data. ACEP must continue to grow its data capabilities as a source of revenue, particularly through E-QUAL and the Emergency Medicine Data Institute (EMDI). As an early member of the Clinical Emergency Data Registry (CEDR) Committee and now as a member of the Innovation Advisory Group (IAG) of the EMDI, I have the experience to generate the ideas and to define the goals, strategies, and tactics for ACEP to utilize data and analytics most effectively. As current Chair of the Emergency Medicine Foundation (EMF), I have firsthand experience with the positive impact and opportunity for ACEP to secure external grants from foundations, governmental agencies, and the private sector as a revenue source.

Learning Resources. ACEP provides best-in-class education for emergency physicians. In delivery and in revenue potential, the ACEP education of yesterday will not be the same tomorrow. New approaches to in-person meetings and exploration of other resources such as real-time, bedside clinical applications can generate revenue while being responsive to members' needs. I bring the experience to help achieve these goals to the ACEP Board. As PACEP President, working with a group of dedicated PACEP leaders, we reinvigorated the PACEP Annual Meeting to have its largest attendance on record in 2023.

We have a difficult, yet promising road ahead. Together, we can and will optimize ACEP's finances. As an ACEP Board member, I commit to you to use ACEP's strengths to secure the College's finances for the benefit of emergency physicians.

Question #2: Describe how your election to the Board of Directors would enhance ACEP's ability to speak for and represent all emergency physicians.

As an ACEP Board member, my priority will be to represent you, my fellow emergency physicians. In turbulent times, leadership requires strength, stability, awareness, and a willingness to make difficult decisions in a proactive, responsive way. I am that leader. I have demonstrated a sustained commitment to ACEP and have spent time in many “neighborhoods” in the city of ACEP, learning about our shared challenges and opportunities. I have worked with the talented ACEP staff, affirming for me the importance of providing staff with the necessary resources to execute the strategic priorities of the Board on behalf of emergency physicians. As an ACEP Board member, I will be *Committed*, *Dependable*, and *Tenacious* in representing you.

Committed. We are colleagues. We share unique experiences. I am enthusiastic and excited to learn from you. I have worked in many different clinical and academic settings, as an employed physician and independent contractor, from freestanding EDs, to remote and rural critical access hospitals in Pennsylvania, to academic medical centers, and as a researcher and educator. I understand the breadth of practice environments where ACEP members work and want to help to improve those workplaces. My public health training and background will be an asset to the Board, to the College, and to you as we continue to create value and impact populations in the ED and beyond the walls of the ED. The practice of EM will look different in a decade – let's make sure it is better for patients, for the public, and for us.

The ACEP Board, like the College, is composed of emergency physicians with a variety of perspectives, a diversity that helps to ensure that the Board represents ACEP members as the voice for all emergency physicians. I have the experience to be

that voice. As PACEP President, I helped to reenergize our leadership fellows program, to redesign our nominations process to develop diverse leaders, and to successfully build consensus in a very “purple” Chapter. Working beside many of you as a Councillor, I have helped to strengthen the voice of the Council by serving on Reference Committees, on Steering Committee, and, for the past two years, as Chair of the Tellers, Credentials and Elections Committee. These Council experiences have prepared me to be a Board member who actively contributes to the debate, discussion, and deliberation that guides our decision-making as the Board. There are times when incremental changes are the right approach and times when we need to entirely reimagine our strategy. As an ACEP Board member, I will hear you and I will translate listening into action.

Dependable. Membership is the bedrock of ACEP. Members are why ACEP exists. Fostering membership and mentoring emergency physicians to leadership roles are skills that I bring to the ACEP Board. In my time on the EMRA Board of Directors, as Past Chair of the ACEP Young Physicians’ Section (YPS), and as a faculty in an EM residency program, I have gained an understanding of the pressures, anxieties, and uncertainties facing emergency physicians, no matter one’s career stage. We can turn those challenges into a positive future for emergency physicians. Through my work on EMRA’s documentary, *24/7/365*, on PACEP’s 50th Anniversary film, *Missing Square to Shining Star*, and as a member of ACEP’s 50th Anniversary Task Force, I was fortunate to meet many of our specialty’s founders. Given the current challenges we face, I reflect on what those founders taught me – that a “can-do” attitude forged our specialty in the face of skepticism and against all odds. We need the same approach now. I want to dedicate my “can-do” attitude, my time, and my energy as an ACEP Board member because emergency physicians are worth fighting for. We deserve the best specialty.

Tenacious. Advocacy by and for emergency physicians is ACEP’s strength and is a fundamental responsibility of a Board member. As Past Chair of ACEP’s State Legislative/Regulatory Committee (SLRC), and a Past PACEP President, I understand that “all politics is local.” State advocacy efforts and collaboration between Chapters are the most effective ways to find common solutions and to inform national advocacy discussions. As a member of ACEP’s Strategic Plan Advocacy group, I joined other leaders to integrate ACEP’s federal, state, and professional advocacy efforts. As PACEP President, I was an effective spokesperson for my fellow emergency physicians when interacting with the media and with partner organizations.

When you ask, “Chadd, as an ACEP Board member, what will you do for me?” my response is, “I will listen, I will discuss, and I will act on behalf of emergency physicians.” Together, we will move our specialty forward, we will define the future of acute care deliver, and we will enjoy fulfilling careers in the process.” It is the right time to be an emergency physician. It is the right time to be an ACEP member. I am excited and optimistic about emergency medicine and about us as emergency physicians. Optimists take more chances. Now is our time to think big, to be bold, to build on our past and to capture the future that we deserve. I look forward to the opportunity to represent you and to amplify your voice. Thank you!

Question #3: From your perspective, what would you do to ensure that emergency medicine remains an attractive specialty?

Aside from our founding, this is the most exciting time in the history of Emergency Medicine – a time of volatility, uncertainty, complexity, and ambiguity – a time for us, as emergency physicians, to forge a bright future to become the most attractive specialty. Together, we have navigated turbulent times the last few years. Uplifted by public cheers during COVID’s peak, now we are burdened by a broken system. Boarded inpatients, inadequate resources for patients with psychiatric needs, violence against emergency physicians and ED staff, payers refusing to fairly reimburse us, and non-physicians maneuvering for independent practice have left us feeling unappreciated, morally injured, and ready to quit what feels like an unsustainable career. As an Associate Residency Program Director during the 2022 and 2023 Match, I experienced the impact of these headwinds firsthand. And, contrary to exaggerated media reports claiming that Emergency Medicine is “no longer cool” to medical students, we can become the most attractive specialty by being *Adaptable, Accessible, and Engaged*.

Adaptable. Leadership expert John Maxwell says, “The pessimist complains about the wind, the optimist expects it to change, the leader adjusts the sails.” Adaptability is key to our success – in developing novel practice models extending care beyond the walls of the ED, in embracing new directions for careers in Emergency Medicine, in creating value in alternative payment models, and in rightsizing our workforce.

Accessible. Care delivered 24/7/365, “no shoes, no shirt, no problem” – this is us; this is Emergency Medicine. As an emergency physician who lives and works in rural Pennsylvania, I appreciate that emergency physicians are the cornerstone of care in low-resource settings. Rural EDs can be incubators of innovation that serve as examples of accessible emergency care in every community. In keeping Emergency Medicine attractive, we will re-imagine the delivery of acute, unscheduled, “no wrong door” care, while creating satisfying, desirable, and fulfilling careers for emergency physicians.

Engaged. Our engagement in advocacy, particularly at the local and state levels where employers and legislators influence how we deliver care, is critical to building a viable and sustainable workplace – a practice environment with emergency physician-led teams, adequate staffing, fair employment policies, provisions for our wellness, and functional clinical processes. All emergency physicians benefit from ACEP’s success. Our voices are amplified, and we achieve more when we support one another as members of the ACEP community. Together, we shoulder our burdens, and we celebrate our victories.

What we do matters, and the good that we do is why Emergency Medicine has been, and can be, the most attractive specialty. Now is the time to adjust the sails. In doing so, we will reach the greater heights for Emergency Medicine that patients and the public need and that we, as emergency physicians, deserve.

CANDIDATE DATA SHEET

Chadd K. Kraus, DO, DrPH, CPE, FACEP

Contact Information

1495 Smoketown Road
Lewisburg, PA 17837

Phone: 443-722-9625

E-Mail: chaddkraus@gmail.com

Current and Past Professional Position(s)

***Until September 2023**

Attending Emergency Physician, Geisinger

System Director of Research, Emergency Medicine, Geisinger

Associate Program Director, Geisinger Medical Center Emergency Medicine Residency, Danville, PA

Professor, Geisinger Commonwealth School of Medicine, Scranton, PA

***Beginning September 2023**

Attending Emergency Physician, Lehigh Valley Health Network (LVHN), Allentown, PA

Vice Chair, Research, Department of Emergency and Hospital Medicine, LVHN

Director, USF-LVHN SELECT Scholarly Activity Capstone

Professor, University of South Florida (USF) Morsani College of Medicine, Tampa FL

Director of Research (part-time), American Board of Emergency Medicine (ABEM), Lansing, MI

Education (include internships and residency information)

Emergency Medicine Residency (Dual AOA/ACGME accredited program, PGY1-4)
Lehigh Valley Health Network (LVHN), Bethlehem/Allentown, PA, 2014

Doctor of Public Health (DrPH), concentration Health Policy and Management
Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, 2014

Master of Public Health (MPH), concentration in Health Policy and Management
Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, 2005

Doctor of Osteopathic Medicine (DO), Philadelphia College of Osteopathic Medicine, Philadelphia, PA, 2010

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

List Certifications (e.g., ABEM, AOBEM, AAP, etc.) Here

Board Certification: American Board of Emergency Medicine (ABEM), initial certification 2015

Certified in Public Health (CPH), National Board of Public Health Examiners

Certified Physician Executive (CPE), American Association for Physician Leadership (AAPL)

Professional Societies

American College of Emergency Physicians (ACEP)

Pennsylvania College of Emergency Physicians (PACEP)

Emergency Medicine Residents' Association (alumni member) (EMRA)

Society for Academic Emergency Medicine (SAEM)

Pennsylvania Medical Society (PAMED)

Pennsylvania Osteopathic Medical Association (POMA)

American Medical Association (AMA)

American Academy for Physician Leadership (AAPL)

National ACEP Activities – List your most significant accomplishments

| | |
|--|----------------|
| ACEP Strategic Planning, Advocacy Team | 2021 |
| ACEP Strategic Planning, Member Engagement Team | 2021 |
| ACEP Emergency Medicine Data Institute, Innovation Advisory Group | 2022 – present |
| Senior Editor, <i>Journal of American College of Emergency Physicians Open</i> | 2021 – present |

ACEP Council

| | |
|--|-------------------------------------|
| Councillor | 2012, 2013, 2015, 2017 – present |
| Alternate Councillor | 2014, 2016 |
| Reference Committee B (Advocacy and Public Policy) | 2014, 2018 |
| Tellers, Credentials and Elections Committee | 2015 – 2019, 2021 |
| Committee Chair | 2021, 2022 |
| Council Steering Committee | 2016 – 2019 |
| Annual Meeting Subcommittee | 2018 |
| Candidate Forum Subcommittee | 2018 |
| Chair, Bylaws Subcommittee | 2018 – 2019 |
| Moderator, Candidate Forum | 2019 |

ACEP Committees, Sections, and Task Forces

| | |
|--|----------------|
| Research Committee | 2021 – present |
| 911 Network | 2013 – present |
| State Legislative and Regulatory Committee | 2013 – present |
| Committee Chair | 2017 – 2019 |
| Chair, Advocacy Objectives | 2016 – 2017 |
| Ethics Committee | 2013 – 2022 |
| Subcommittee Chair, <i>ACEP Ethics Compendium Review</i> | 2013 – 2015 |
| Clinical Data Registry Committee (CEDR) | 2015 – 2020 |
| Data Integrity and Research Subcommittee | |
| Clinical Resources Review Committee | 2019 – 2020 |
| Academic Affairs Committee | 2011 – 2013 |
| Cost-Effective Care Task Force (ACEP Choosing Wisely® Recommendations) | 2011 – 2014 |

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Chadd K. Kraus, DO, DrPH, CPE, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Geisinger (until September 2023)

Address: 100 N. Academy Avenue

Danville, PA 17822

System Director Emergency Medicine Research; Associate Residency Program
Director; Professor (Geisinger Commonwealth School of Medicine);

Position Held: Emergency Physician

Type of Organization: Integrated Health System (tax-exempt)

Employer: Lehigh Valley Health Network (beginning September 2023)

Address: 1200 South Cedar Crest Blvd

Allentown, PA 18103

Vice-Chair Research, Dept of Emergency and Hospital Medicine; Professor
(Univ. South Florida Morsani College of Medicine); Emergency Physician

Position Held:

Type of Organization: Health System (tax-exempt)

Employer: American Board of Emergency Medicine (ABEM)

Address: 3000 Coolidge Road

East Lansing, MI 48823

Position Held: Director of Research

Type of Organization: Specialty Certification Board

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 Medicine Foundation (EMF)

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: 501(c)3 non-profit

Chair, Board of Trustees (2023); Chair-Elect (2022); Board of Trustees (2019-
2025)

Leadership Position:

Term of Service: Listed in leadership position above

Organization: Pennsylvania College of Emergency Physicians (PACEP)

Address: 800 N. 3rd Street

Harrisburg, PA 17102

Type of Organization: Emergency Medicine Specialty Organization (non-profit)

Immediate Past President (2023-24); President (2022-2023); President-Elect (2021-2022); Vice-President (2020-2021); Secretary (2019-2020); Board of

Leadership Position: Directors (2018-2024)

Term of Service: Listed in leadership position above

Organization: Journal of the American College of Emergency Physicians (JACEP) Open

Address: n/a

Type of Organization: Peer-Reviewed Scientific Journal

Leadership Position: Senior Editor (2021-present); Editorial Board (2019-2021)

Term of Service: Listed in leadership position above

Organization: Pennsylvania Medical Society (PAMED)

Address: 400 Winding Creek Blvd

Mechanicsburg, PA 17050

Type of Organization: State Medical Society (non-profit)

Leadership Position: Alternate Delegate for PAMED to AMA House of Delegates

Term of Service: 2020-2023

Organization: Emergency Medicine Residents' Association (EMRA)

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Emergency Medicine Specialty Organization (non-profit)

Board of Directors (Academic Affairs Representative, position now called

Leadership Position: Director of Education)

Term of Service: 2011-2013

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:

Ad hoc (paid) research consulting for Cytovale, Inc.

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:

Investor in Sycamore Independent Physicians

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.

Handwritten signature of Chadd K. Kraus in blue ink, with the name "CHAD KRAUS DO" written in small letters below the signature.

Chadd K. Kraus

6/20/2023



**Endorsement for
Chadd Kraus, DO, DrPH, CPE, FACEP
Candidate for ACEP Board of Directors**

Dear Councilors,

On behalf of the **Pennsylvania College of Emergency Physicians (PACEP)**, and the **ACEP Young Physicians' Section (YPS)** we enthusiastically endorse Chadd Kraus, DO, DrPH, CPE, FACEP for the ACEP Board of Directors.

Dr. Kraus is a clinical emergency physician and Vice Chair of Research in the Department of Emergency and Hospital Medicine at Lehigh Valley Health Network in Allentown, Pennsylvania, Professor at the University of South Florida Morsani College of Medicine, and Director of Research at the American Board of Emergency Medicine (ABEM). He was previously System Director of EM Research at Geisinger and Associate Program Director of the Geisinger Medical Center EM Residency, where he was selected by EM residents as the 2019 “Teacher of the Year.” Dr. Kraus brings first-hand experience on the workforce, reimbursement, and operational challenges of emergency care and the value of emergency physicians in rural areas – the same issues that are important to our specialty in all practice settings.

A committed leader, Dr. Kraus has been active in Council for over a decade, serving on Council Steering Committee, on two Council Reference Committees, and most recently as Chair of the Tellers and Credentials Committee. Dr. Kraus has been a leader in multiple ACEP Committees and Sections, including as past Chair of the State Legislative/Regulatory Committee (SLRC). He is currently Chair of the Emergency Medicine Foundation (EMF), leading EMF as it surpassed \$20 million in total grants awarded during its history. He was a member of ACEP’s 50th Anniversary Task Force and participated in ACEP’s 2021 strategic planning as a member of the Advocacy and Member Engagement workgroups. He is on the Innovations Advisory Group of the ACEP Emergency Medicine Data Institute (EMDI).

Dr. Kraus has a long and distinguished record of being a leading voice and tenacious advocate for his fellow emergency physicians at all stages in their careers. As a resident, he served on the EMRA Board of Directors as Academic Affairs Representative, and contributed to creating the award-winning documentary film, *24/7/365: The Evolution of Emergency Medicine*. He has been a faculty mentor author for several editions of the *EMRA Advocacy Handbook*. EMRA has recognized Dr. Kraus as a *25 Under 45: Influencer in Emergency Medicine*.

As YPS Chair, Dr. Kraus built on the work of the YPS Chairs before him, accelerating the momentum of leadership development, increasing member engagement, and growing YPS into one of the largest and most active Sections of ACEP. As part of the Member Engagement strategic planning team, he helped develop approaches to personalize ACEP membership to meet members’ needs, including bridging the transition from candidate membership to regular membership following residency training.

As PACEP President, Dr. Kraus focused on increasing PACEP’s visibility and impact in legislative advocacy, on creating formal processes to develop diverse leaders within PACEP, and on reimagining PACEP’s educational offerings, resulting in record attendance at PACEP’s 2023 annual Scientific Assembly. In Pennsylvania, he has been a skilled spokesperson interacting with media outlets, testifying before PA General Assembly Committees, and engaging in advocacy with members of Pennsylvania’s US Congressional delegation.

Dr. Kraus has proven himself through sustained commitment, tireless dedication, and tangible results to be the type of leader who is well-prepared to represent emergency physicians as an ACEP Board member. PACEP and the YPS give our strongest endorsement and ask for your vote for Chadd Kraus, DO, DrPH, CPE, FACEP for the ACEP Board of Directors.

Sincerely,

A handwritten signature in black ink, appearing to read 'RH' followed by a stylized flourish.

Richard Hamilton, MD, FACEP
President
Pennsylvania College of Emergency Physicians (PACEP)

A handwritten signature in black ink, appearing to read 'ED' followed by a stylized flourish and 'M.D.'.

Edward Descallar, MD, FACEP
Chair
ACEP Young Physicians Section (YPS)

Chadd K. Kraus, DO, DrPH, CPE, FACEP

Dear Colleagues,

It is an honor to be a candidate for your ACEP Board of Directors.

As an ACEP Board member, my priority will be to represent you, my fellow emergency physicians. I will be a Board member who listens and who is an effective voice advocating for our needs as emergency physicians and as ACEP members. I will hear you and I will translate listening into action to accomplish our vision for what emergency medicine should be and for how acute, unscheduled, and emergency care should be delivered.

Our specialty, the College, and us as emergency physicians are facing multiple challenges. In turbulent times, leadership requires strength, stability, awareness, and a willingness to make difficult decisions in a proactive, responsive way. I am that leader. I have been fortunate to work with many of you on ACEP Committees, Task Forces, Sections, and Council. In the process, I have learned the “everyday” governance skills that board members need – leading with strategic vision, creating sound budgets, and developing future leaders to name a few. I ask that you consider my sustained dedication to and effective contributions on behalf of ACEP and you, my colleagues, as a preview of what I will bring as an ACEP Board member. For those of you who do not know me, I look forward to meeting you at Council, giving you the opportunity to get to know me, and giving me a chance to listen to your concerns, your perspectives, and your ideas about how we can continue to strengthen ACEP and our specialty.

The ACEP Board, like the College, is composed of emergency physicians with a variety of perspectives, a diversity that helps to ensure that the Board represents ACEP members as the voice for all emergency physicians. I have the experience to be that voice. As PACEP President, I was successful at building consensus in a very “purple” Chapter. Working beside many of you as a Councilor, I have helped to strengthen the voice of the Council by serving on Reference Committees, on Steering Committee, and, for the past two years, as Chair of the Tellers, Credentials, and Elections Committee. These experiences have prepared me to be a Board member who actively contributes to the debate, discussion, and deliberation that guides our decision-making as the Board.

When you ask, “Chadd, as an ACEP Board member, what will you do for me?” my response is, “I will listen, I will discuss, and I will always act in the best interests of emergency physicians and our patients.” Together, we will move our specialty forward, we will define the future of acute care delivery, and we will enjoy fulfilling emergency medicine careers in the process. Now is the right time to be an emergency physician. Now is the right time to be an ACEP member. I am excited and optimistic about emergency medicine and about us as emergency physicians. We must think big, be bold, and build on our past to capture the future that we deserve. I look forward to the opportunity to represent you and to amplify your voice.

I humbly ask for your vote for me for the ACEP Board of Directors to represent you and to work with you to achieve our collective goals. Thank you!

Chadd K. Kraus, DO, DrPH, CPE, FACEP
chaddkraus@gmail.com

CHADD KRAUS, DO, DrPH, CPE, FACEP

Candidate, ACEP Board of Directors

Endorsed by
Pennsylvania College of Emergency Physicians (PACEP)
ACEP Young Physicians Section (YPS)

Proven Leader

- ! Chair, Emergency Medicine Foundation (EMF) Board of Trustees (2023)
- ! PACEP
 - ! Immediate Past President (2023-24)
 - ! President (2022-23)
 - ! President-Elect (2021-22)
 - ! Vice President (2020-21)
 - ! Secretary (2019-20)
- ! Chair, ACEP Young Physicians Section (2018-19)
- ! Chair, ACEP State Legislative/Regulatory Committee (2017-19)
- ! EMRA Board of Directors (2011-13)
- ! ACEP EMDI, Innovations Advisory Group (2022-present)
- ! ACEP Cost-Effective Care Task Force (2011-14)
- ! ACEP 50th Anniversary Task Force (2018)
- ! ACEP Committee Member
 - ! Research (2021-present)
 - ! SLRC (2013-present)
 - ! Ethics (2013-22)
 - ! CEDR (2015-20)
 - ! Academic Affairs (2011-13)
- ! ACEP Strategic Planning (2021)
 - ! Member Engagement Team
 - ! Advocacy Team
- ! Councillor/Alternate (2012-present)
 - ! Steering Committee (2016-19)
 - ! Reference Committee B (2014, 2018)
 - ! Chair, Tellers, Credentials, Election Committee (2021,2022)

Tenacious Advocate

- ! Promoting Emergency Physician-Led Teams
- ! Protecting the Prudent Layperson Standard
- ! Addressing Psychiatric Boarding
- ! Ensuring Access to Rural Emergency Care
- ! Fighting Against Malpractice Venue Changes

Pennsylvania must act to avert another medical liability crisis | Opinion By Dr. Chadd K. Kraus

Committed Colleague

- ! Clinical experience in a variety of EDs
 - ! Rural, critical-access hospitals
 - ! Tertiary-regional referral academic/university hospitals
 - ! Freestanding EDs
- ! Experience in large, integrated health systems

CHADD KRAUS, DO, DrPH, CPE, FACEP

Candidate, ACEP Board of Directors



Endorsed by
Pennsylvania College of Emergency Physicians (PACEP)
ACEP Young Physicians Section (YPS)

Effective Spokesperson

- ! Experienced in media engagements in print, television, radio, online
- ! Local, regional, and national outlets including ABC, Fox, and NBC affiliates, NPR and PBS stations
- ! Production teams for EMRA 24/7/365 and PACEP 50th Anniversary Documentary films



Respected Researcher

- ! Professor of EM
- ! Vice Chair, Research
- ! Director of Research
- ! Senior Editor, *JACEP Open*
- ! Top Reviewer, *Annals of EM*
- ! Publications in *JAMA*, *Lancet*, *NEJM*



Dedicated Mentor

- ! EMRA "25 Under 45" (2021)
- ! Geisinger EM Residency, "Teacher of the Year" (2019)
- ! Associate Residency Program Director (2017-18; 2021-2023)
- ! Faculty mentor, *EMRA Advocacy Handbook* (4th, 5th, 6th eds.)



Thank you for your vote!

Chadd K. Kraus, DO, DrPH, CPE, FACEP



Chadd K. Kraus, DO, DrPH, CPE, FACEP is an emergency physician, System Director of Emergency Medicine Research at Geisinger, Professor of Emergency Medicine at the Geisinger Commonwealth School of Medicine, and Associate Program Director of the Geisinger Medical Center Emergency Medicine Residency where he has been recognized as “Teacher of the Year.”

At Geisinger, Dr. Kraus is a Clinical Advisor to the Steele Institute for Health Innovation, a member of the Institutional Review Board (IRB), the Scientific Review Committee (SRC), and the Medicine Institute Clinic Research Fund Advisory Committee. He is a member of the ProvenCare® Pneumonia and Asthma Steering Committee workgroups aimed at optimizing pulmonary care in acute care settings.

Dr. Kraus is the physician champion for the implementation of a universal HIV screening program in Geisinger’s Emergency Departments and an emPATH (Emergency Psychiatric Assessment, Treatment, and Healing) unit at Geisinger Medical Center designed to meet the needs of patients in the ED with behavioral health and psychiatric needs.

An experienced clinician, educator, scientist, and proven leader, Dr. Kraus has expertise in health policy topics at the intersection of emergency care and population health, including rural healthcare delivery, behavioral health, infectious diseases, substance use disorders, clinical ethics, Medicaid reimbursement, and emergency preparedness and response. He is Senior Editor of the *Journal of the American College of Emergency Physicians Open (JACEP)* and is Chair of the Board of Trustees of the Emergency Medicine Foundation (EMF).

Dr. Kraus has been awarded numerous research grants, has lectured extensively in the United States and internationally, and has authored/co-authored over 80 peer-reviewed papers, abstracts, and book chapters, many in leading scientific journals including the *Journal of the American Medical Association*, the *Lancet*, and the *New England Journal of Medicine*. He is the Inaugural Director of Research for the American Board of Emergency Medicine (ABEM).

Dr. Kraus is President of the Pennsylvania College of Emergency Physicians (PACEP), past Chair of the Tellers, Credentials, and Elections Committee of the American College of Emergency Physicians (ACEP) Council, past Chair of ACEP State Legislative and Regulatory Committee, and past Chair of the ACEP Young Physicians’ Section. He has represented the Pennsylvania Medical Society (PAMED) as an alternate delegate to the American Medical Association (AMA) House of Delegates. He serves on the ACEP Emergency Medicine Data Institute Innovations Advisory Group. Dr. Kraus has been honored by the Emergency Medicine Residents’ Association (EMRA) as a “25 Under 45: Influencer in Emergency Medicine.”

A Diplomate of the ABEM and a Fellow of the American College of Emergency Physicians (FACEP), Dr. Kraus is a Certified Physician Executive (CPE) by the Certifying Commission in Medical Management (CCMM) and is Certified in Public Health (CPH) by the National Board of Public Health Examiners.

Dr. Kraus is a graduate of the Philadelphia College of Osteopathic Medicine in Philadelphia, Pennsylvania. He completed Masters (MPH) and Doctoral (DrPH) degrees in public health (concentration in Health Policy and Management, and certificate in Health and Human Rights) at the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland, where he was awarded the John C. Hume, MD doctoral award. He completed emergency medicine residency training at Lehigh Valley Health Network in Allentown, Pennsylvania, where he was recognized with the “Excellence in Research” Award.

Curriculum Vitae**CHADD K. KRAUS, DO, DrPH, MPH, CPE, FACEP****DOB: 15 April 1978****Citizenship: United States of America**

Cell: 443-722-9625; Fax (HIPAA compliant): 888-959-4307

chaddkraus@gmail.com

<https://www.linkedin.com/in/chadd-kraus-1004651a3/>**CURRENT POSITIONS**

| | |
|---|-------------------|
| Attending Emergency Physician, Geisinger | 08/2017 – present |
| System Director, Emergency Medicine Research, Geisinger | 08/2017 – present |
| Director of Research, American Board of Emergency Medicine (ABEM) | 01/2022 – present |
| President, Pennsylvania College of Emergency Physicians | 04/2022 – present |
| Chair, Emergency Medicine Foundation (EMF) | 01/2023 – present |

ACADEMIC APPOINTMENTS

| | |
|--|-------------------|
| Professor of Emergency Medicine Geisinger Commonwealth School of Medicine, Scranton, Pennsylvania | 12/2022 – present |
| Emergency Medicine Residency, Geisinger Medical Center, Danville, Pennsylvania | |
| Associate Program Director | 08/2017 – 12/2018 |
| Core Faculty | 01/2021 – present |
| Clinical Competency Committee (CCC) | 08/2017 – present |
| Chair, Program Evaluation Committee (PEC) | 08/2017 – present |
| Co-Director, Journal Club | 08/2017 – present |
| Chair, Curriculum Committee | 03/2019 – present |
| Affiliate Faculty, Master of Public Health Program Office of Research and Graduate Studies University of Missouri-Columbia Columbia, Missouri | 07/2016 – 10/2016 |
| Founding Research Director Department of Emergency Medicine University of Missouri-Columbia Columbia, Missouri | 01/2016 – 10/2016 |
| Assistant Professor, Clinical Emergency Medicine Department of Emergency Medicine University of Missouri-Columbia Columbia, Missouri | 01/2016 – 10/2016 |
| Adjunct Assistant Professor, Clinical Emergency Medicine Department of Emergency Medicine University of Missouri-Columbia Columbia, Missouri | 11/2015 – 01/2016 |

Research Scholar (summer) 06/2007 – 09/2007
 National Center for the Study of Preparedness and Catastrophic Event
 Response (PACER), a U.S. Department of Homeland Security (DHS) Center of Excellence
 Johns Hopkins University, Department of Emergency Medicine
 Baltimore, Maryland

PROFESSIONAL MEMBERSHIPS AND ACTIVITIES

American College of Emergency Physicians (ACEP) 2007 – present

Fellow, American College of Emergency Physicians (FACEP) 2017 – present

Leadership Positions (selected by Section Membership)

Young Physicians Section

- Alternate Councilor 2015 – 2016
- Councilor 2016 – 2017
- Chair Elect 2016 – 2017
- Chair 2017 – 2018
- Immediate Past Chair 2018 – 2019

Committee and Task Force Membership

- Research Committee 2021 – present
- 911 Network 2013 – present
- State Legislative and Regulatory Committee 2013 – present
 - Committee Chair 2017 – 2019
 - Chair, Advocacy Objectives 2016 – 2017
- Ethics Committee 2013 – 2022
 - Subcommittee Chair, *ACEP Ethics Compendium Review* 2013 – 2015
- Spokespersons Network 2014 – present
- Residency Visit Ambassador 2014 – 2017
- Clinical Data Registry Committee (CEDR) 2015 – 2020
 - Data Integrity and Research Subcommittee
- Clinical Resources Review Committee 2019 – 2020
- Academic Affairs Committee 2011 – 2013
- Cost-Effective Care Task Force 10/2011 – 08/2014
 - Developed ACEP Choosing Wisely® Recommendations

ACEP Council

- Councillor 2012, 2013, 2015, 2017 – present
- Alternate Councillor 2014, 2016
- Reference Committee B (Advocacy and Public Policy) 2014, 2018
- Tellers, Credentials and Elections Committee 2015 – 2019, 2021
 - Committee Chair 2021 – 2022
- Council Steering Committee 2016 – 2019
 - Annual Meeting Subcommittee 2018
 - Candidate Forum Subcommittee 2018
 - Chair, Bylaws Subcommittee 2018 – 2019
 - Moderator, Candidate Forum 10/25/19

Section Membership

- Young Physicians 2010 – 2020
- Rural 2011 – 2016
- Research 2011 – 2016
- Quality Improvement and Patient Safety (QIPS) 2011 – 2019

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|--|-------------------|
| Palliative Care | 2012 – 2016 |
| EM Practice Management and Health Policy | 2015 – 2016 |
| Research, Scholarly Activity, and Innovation | 2018 – present |
| ACEP Strategic Planning, Advocacy Team | 08/2021– 10/2021 |
| ACEP Strategic Planning, Member Engagement Team | 08/2021 – 10/2021 |
| ACEP Emergency Medicine Workforce, Scholarly Activity workgroup | 08/2021 – 05/2022 |
| Pennsylvania College of Emergency Physicians (PACEP) | 2010 – present |
| <u>Board of Directors</u> (elected by membership, 3-year terms) | 2018 – 2024 |
| President | 2022 – 2023 |
| President-Elect | 2021 – 2022 |
| Vice President | 2020 – 2021 |
| Secretary | 2019 – 2020 |
| Chair, PACEP History Project | 2018 – 2022 |
| Board Liaison to Government Affairs Committee | 2018 – 2019 |
| Executive Director Search Committee | 2018 – 2019 |
| <u>Leadership Positions</u> (selected by Board of Directors) | |
| Co-Chair, Young Physicians Committee | 2013 – 2015 |
| Leadership Fellow | 2014 – 2015 |
| Co-Chair, EM Workforce Taskforce | 06/2021 - present |
| PACEP 2021 Scientific Assembly/Annual meeting planning committee | 01/2021 – 04/2021 |
| PACEP 2022 Scientific Assembly/Annual meeting planning committee | 05/2021 – present |
| <u>PACEP Representative to Outside Organizations</u> | |
| Pennsylvania Provider Advocacy Coalition, Medicaid Committee | 06/2019 – present |
| Pennsylvania Commission on Crime and Delinquency Special Council on Gun Violence | 11/2019 – 03/2020 |
| Pennsylvania Oral Health Coalition | 2019 – 2020 |
| Pennsylvania Joint State Government Commission Advisory Committee on Emergency Room Treatment & Behavioral Health | 08/2019 – 08/2020 |
| American Board of Emergency Medicine (ABEM) | |
| Director of Research, American Board of Emergency Medicine (ABEM) | 01/2022 – present |
| ACEP Emergency Medicine Data Institute – Innovation Advisory Group | 04/2022 – present |
| Oral Examiner | 07/2021 – present |
| Emergency Medicine Foundation (EMF) | |
| Chair | 01/2023 – present |
| Chair-Elect | 01/2022 – 12/2022 |
| Board of Trustees | 01/2020 – present |
| Tangibility Workgroup | 01/2022 – 12/2022 |
| Bylaws Committee (Chair, 01/2022 – 10/2022) | 04/2020 – 10/2022 |
| Nominations Committee (Chair) | 08/2022 – 12/2022 |
| Emergency Medicine Residents' Association (EMRA) | 2007 – present |
| <u>Leadership Positions</u> (elected by peers) | |
| Medical Student Governing Council, Editor | 05/2008 – 05/2010 |
| Board of Directors, <i>Academic Affairs Representative</i> | 10/2011 – 10/2013 |
| <u>Committee and Task Force Membership</u> (appointed by Board) | |
| Education Committee | 10/2011 – 10/2013 |

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| Health Policy Committee | 10/2011 – 10/2013 |
| Critical Care Committee | 10/2011 – 10/2013 |
| Joint Milestones Task Force | 10/2012 – 10/2013 |
| Model of the Clinical Practice of Emergency Medicine, EMRA representative | 01/2013 – 01/2014 |
| <u>EMRA Representative Council</u> | |
| Reference Committee for EMRA Representative Council | 10/2011 |
| Program Representative for LVHN | 10/2011 |
| Health Policy Mentor, EMRA Health Policy Committee | 2017 – 2020 |
| Society for Academic Emergency Medicine (SAEM) | 2007 – present |
| Research Committee | 2019 – present |
| Annual Program Committee | 2019 – 2022 |
| American Association for Physician Leadership (formerly American College of Physician Executives) (AAPL) | 2012 – present |
| American College of Healthcare Executives (ACHE) | 2013 – 2019 |
| American Medical Association (AMA) | 2014 – present |
| Member, House of Delegates (HOD) Reference Committee E | 11/2020 |
| Pennsylvania Medical Society (PAMED) | 2013 – 2022 |
| Legislative Advocacy Task Force | 2019 – 2022 |
| Alternate Delegate to AMA House of Delegates (elected by membership) | 2019 – 2022 |
| Texas Medical Association (TMA) | 2016 – 2020 |
| EDUCATION | |
| Fellowship, Hospice and Palliative Care, University of Pittsburgh (did not complete – accepted CMO position at Penn Highlands-Elk) | 07/2014 – 09/2014 |
| Emergency Department Directors' Academy (EDDA) American College of Emergency Physicians (ACEP), Dallas, TX | 2013 – 2014 |
| Residency, Emergency Medicine, Lehigh Valley Health Network, Allentown, PA | 2010 – 2014 |
| DrPH, Doctor of Public Health: Health Policy and Management Johns Hopkins Bloomberg School of Public Health Baltimore, MD | 2006 – 2014 |
| DO, Philadelphia College of Osteopathic Medicine, Philadelphia, PA | 2006 – 2010 |
| MPH, Master of Public Health: Health Policy and Management Johns Hopkins Bloomberg School of Public Health, Baltimore, MD | 2004 – 2005 |
| Graduate public health coursework, Drexel School of Public Health, Philadelphia | 2003 |
| Graduate Training Program in Clinical Investigation, The Science of Clinical Investigation (Certificate), Johns Hopkins University, Baltimore, MD | 2002 – 2003 |
| Post-baccalaureate pre-medical courses (non-degree) Loyola College in Maryland, Baltimore, MD Case Western Reserve University, Cleveland, OH Pennsylvania State University, University Park, PA | 2001 – 2002 |

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|--|-------------|
| B.A. (cum laude) with Honors; Top graduate in Political Science Minors in Classical Studies and Catholic Studies Loyola College, Baltimore, MD | 1998 – 2000 |
| Undergraduate coursework, Case Western Reserve University, Cleveland OH | 1996 – 1998 |

CERTIFICATIONS AND LICENSURE

Board Certifications

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|--|-------------|
| Diplomate, American Board of Emergency Medicine (ABEM) | 2015 – 2025 |
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State Medical Licenses (Active)

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|------------------------------|-------------|
| Commonwealth of Pennsylvania | 2011 – 2024 |
| State of Missouri | 2015 – 2025 |
| State of Texas | 2015 – 2023 |

Controlled Substances Licenses (Active)

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|---|----------------|
| U.S. Department of Justice, Drug Enforcement Agency | 2011 – present |
| X waiver for Buprenorphine prescribing | 2018 – present |

Other Certifications

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|---|-------------------|
| Certified in Public Health (CPH), National Board of Public Health Examiners | 2014 – present |
| Certified Physician Executive (CPE) | 03/2020 – present |
| Advanced Trauma Life Support (ATLS) | expiration 2020 |
| Advanced Cardiac Life Support (ACLS) | expiration 2015 |
| Pediatric Advanced Life Support (PALS) | expiration 2015 |
| American Heart Association (AHA) Instructor – ACLS | expiration 2015 |
| American Heart Association (AHA) Instructor – PALS | expiration 2015 |

EDITORIAL ACTIVITIES

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|--|-------------------|
| Senior Editor, <i>Journal of American College of Emergency Physicians Open</i> | 04/2021 – present |
| Editorial Board (inaugural), <i>Journal of American College of Emergency Physicians Open</i> | 09/2019 – 04/2021 |
| Editor, Special Issue on Firearms, <i>Western Journal of Emergency Medicine</i> | 2020 – 2021 |
| Associate Editor, <i>Western Journal of Emergency Medicine</i> | 05/2017 – 05/2021 |
| Manuscript reviewer (ad hoc) | |
| <i>Clinical Therapeutics</i> | 2018 – present |
| <i>American Journal of Emergency Medicine</i> | 2018 – present |
| <i>Journal of Pain and Symptom Management</i> | 2018 – present |
| <i>Journal of the American Osteopathic Association</i> | 2017 – present |
| <i>Academic Emergency Medicine</i> | 2016 – present |
| <i>Academic Emergency Medicine, Education and Training (AEM E&T)</i> | 2016 – present |
| <i>Annals of Emergency Medicine</i> | 2012 – present |
| <i>Western Journal of Emergency Medicine</i> | 2012 – present |
| “Top Reviewer” <i>Journal of the American College of Emergency Physicians Open</i> | 2020 |
| “Top Reviewer” <i>Western Journal of Emergency Medicine</i> | 2012, 2013 |
| Abstract reviewer, Society for Academic Emergency Medicine Annual Meeting | 2013 – 2020 |
| Abstract reviewer, Council of Residency Directors in EM Academic Assembly | 2013 – 2020 |
| Abstract reviewer, ACEP Annual Scientific Assembly | 2018 |
| Abstract reviewer, American Public Health Association Annual Meeting | 2019 |
| Section Editor, Public Health, <i>Western Journal of Emergency Medicine</i> | 2014 – 2017 |
| “Top 50 Reviewer” <i>Annals of Emergency Medicine</i> | 2015 |
| “Section Editor of the Year”, <i>Western Journal of Emergency Medicine</i> | 2016 – 2017 |

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| Abstract reviewer/presentation judge: Spivey Memorial Research Competition PACEP Annual Scientific Assembly | 2018 – 2021 |
| Abstract reviewer/presentation judge: Resident and Fellow Scholarship Day Geisinger Health System | 2018 – 2021 |
| Judge, CORD CPC Competition | 2018 – 2020 |

ABSTRACTS, LECTURES, PRESENTATIONS

Presentations and Panel Participation, National and International Conferences

Oral Presentation, "Reverse Triage: Criteria for Immediate Inpatient Disposition for Creation of Surge Capacity." Oral Research Forum. 14th World Congress of Disaster Medicine (WCDEM). Edinburgh, Scotland. May 2005.

Oral Presentation, "Twenty-years' experience with HIV testing among emergency department patients at the Johns Hopkins Hospital." *State-of-the-Art* Research Presentation. ACEP Scientific Assembly. Chicago, Illinois. October 2008.

Oral Presentation/Interactive Workshop, "Resident as Teacher." Council of Residency Directors in Emergency Medicine (CORD) Academic Assembly, Resident Track. Atlanta, Georgia. March 2012.

Small Group Facilitator, "Workforce Issues" Roundtable Discussion Resident and Young Physician Section at *ACEP Leadership and Advocacy Conference*, Washington, DC. May 2012.

Invited Panelist, "Top Ten Concerns: The Transition to Life as an Attending." OhioACEP Emergency Medicine Assembly, Columbus, Ohio. June 4, 2013.

Small Group Facilitator, Palliative Medicine in EM Conference New York City, New York University Department of Emergency Medicine. September 25, 2013.

Oral Presentation, "Gender Differences in Perceptions and Self-Reported Driving Behaviors Among Teenagers." Society for Academic Emergency Medicine (SAEM), Mid-Atlantic Regional Meeting, Philadelphia, Pennsylvania (Thomas Jefferson University). January 22, 2014.

Oral Presentation, "Gender Differences in Perceptions and Self-Reported Driving Behaviors Among Teenagers." Society for Academic Emergency Medicine (SAEM), National Meeting, Dallas, TX. May 17, 2014.

Oral Presentation, "Palliative Medicine Competency Education in Emergency Medicine: A Survey of Emergency Medicine Education Leaders." PACEP Spivey Research Competition. Harrisburg, PA. April 8, 2014

Oral Presentation, "Palliative Medicine Competency Education in Emergency Medicine: A Survey of Emergency Medicine Education Leaders." ACEP14 EMF Grant Showcase. Chicago, IL. October 28, 2014.

Co-Chair, Resident Track, Council of Residency Directors in Emergency Medicine (CORD) Academic Assembly - Atlanta, GA 2012; Denver, CO 2013; New Orleans, LA 2014

Faculty Panel Discussant (with Marna Greenberg, DO, MPH. Vicken Totten, MD. Bryan Kane, MD, Michael Menchine, MD). "Good, Better, Best: Approaches to the Resident Scholarly Activity Requirement." Society for Academic Emergency Medicine (SAEM) Annual Meeting, Orlando, Florida. May 19, 2017.

Invited Presenter. "State Legislative Update" presented to ACEP Chapter Executives. American College of Emergency Physicians 2018 Leadership and Advocacy Conference, Washington, DC. May 20, 2018.

Moderator, Emergency Medicine Residents' Association and ACEP Young Physicians Section Health Policy Primer, American College of Emergency Physicians 2018 Leadership and Advocacy Conference, Washington, DC. May 20, 2018

Moderator (Panelists: Steven Stack, MD; Jonathan Heidt, MD, MHA; Purva Grover, MD) "To the Defense of our Patients: State Level Responses to Insurer Attacks on the Prudent Layperson" American College of Emergency Physicians 2018 Leadership and Advocacy Conference, Washington, DC. May 21, 2018

Invited Presenter. "State Legislative Update" presented to ACEP Chapter Executives. American College of Emergency Physicians 2019 Leadership and Advocacy Conference, Washington, DC. May 5, 2019

Moderator, (Panelists: Nathan Schlicher, MD; Dan Morhaim, MD) "You say yes, I say no: what former state legislators have to say about effective and ineffective advocacy." American College of Emergency Physicians 2019 Leadership and Advocacy Conference, Washington, DC. May 6, 2019

Oral Presentation. **Kraus CK**, Melnychuk E, Hanson K. Hospitals as Disaster Victims. (Abstract 107-9) Xth Mediterranean Emergency Medicine Congress (MEMC19). Dubrovnik, Croatia. 23 September 2019.

Oral Presentation. Sullivan RA, **Kraus CK**. Stolen Ambulances Reported in the Media. SAEM Midwest Regional Meeting. 23 September 2020. (*Faculty Mentor for Medical Student)

Czaja MP, **Kraus CK**, Langdorf MI. "Nonfatal Injuries from Mass Shootings in the U.S., 2012-2019: Epidemiology, Outcomes, and Medical Resource Use". Featured Projects in Progress Presentation: Society for Academic Emergency Medicine (SAEM) 2021 Annual Meeting. From Bedside to Policy: Advancing Social Emergency Medicine and Population Health Through Research, Collaboration, and Education. May 11, 2021 Atlanta, GA. (Virtual due to COVID-19 precautions).

Didactic Session (panel). Ashurst JV, Greenberg MR, **Kraus CK**. Research in Every Environment. Society for Academic Emergency Medicine (SAEM) 2021 Annual Meeting. 12 May 2021. Atlanta, GA. (Virtual due to COVID-19 precautions).

Didactic Session. **Kraus CK**. Navigating Open Access Publishing. Society for Academic Emergency Medicine (SAEM) 2021 Annual Meeting. 14 May 2021. Atlanta, GA. (Virtual due to COVID-19 precautions).

Oral Presentation. Czaja MP, **Kraus CK**, Langdorf MI. "Nonfatal Injuries from Mass Shootings in the U.S., 2012-2019: Epidemiology, Outcomes, and Medical Resource Use". Society for Academic Emergency Medicine (SAEM) 2021 Annual Meeting. Featured Lightning Oral Abstract in Social Emergency Medicine, Social Media and Trauma. May 14, 2021.

Oral Presentation. Czaja, MP, **Kraus, CK**, Langdorf, MI. "Nonfatal Injuries from Mass Shootings in the U.S., 2012-2019: Epidemiology, Outcomes, and Medical Resource Use". International Conference on Emergency Medicine (ICEM21), Featured Abstract in Pediatrics and Trauma. Dubai, United Arab Emirates. June 11, 2021. (Virtual).

Oral Presentation. Czaja, MP, **Kraus, CK**, Langdorf, MI. "Nonfatal Injuries from Mass Shootings in the U.S., 2012-2019: Epidemiology, Outcomes, and Medical Resource Use". Population Health Research Competition. The American Academy of Emergency Medicine Resident and Student Association (AAEM/RSA) and The Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health (WestJEM). St. Louis, MO. June 21, 2021.

Invited presentation. **Kraus CK**. "Emergency Medicine Workforce and Population Health." Emergency Medicine Practice Management and Health Policy Section, American College of Emergency Physicians (ACEP) Annual Meeting. 25 October 2021. Westin Seaport. Boston, MA.

Kraus CK. Moderator. State-of-the-Art II: Palliative Care: “How” is not the right question. (Presenters David Wang, MD; Rebecaa Goett, MD) American College of Emergency Physicians (ACEP). Annual Meeting. 26 October 2021. Westin Seaport. Boston, MA.

Kraus CK. Moderator. Research Forum Session 24 (RF24) Administrative/Practice Management. Oral Presentations. American College of Emergency Physicians (ACEP) Annual Meeting. 26 October 2021. Westin Seaport. Boston, MA.

Barrett T, Cooper R, Greenberg M, **Kraus C**, Lagina A. (panel discussion) Editor’s Pears – Tips to Get Your Paper through Peer Review. American College of Emergency Physicians (ACEP) Annual Meeting. 27 October 2021. Westin Seaport. Boston, MA.

Goodloe J, **Kraus CK.** “Country Mouse, City Mouse” Discussion of practice patterns in rural and urban settings. American College of Emergency Physicians (ACEP)/Emergency Medicine Foundation (EMF) Corporate Council Roundtable. 8 February 2022. (Virtual due to COVID-19)

Didactic Session. **Kraus CK.** A Pain in the Neck: Neck Trauma – Pearls and Pitfalls. XIth Mediterranean Emergency Medicine Congress (MEMC). St. Julians, Malta. Breve Dulce VII (Trauma) #6. Intercontinental Hotel, Malta. 22 September 2022.

Oral Presentation. **Kraus CK**, Roberts S, Carlisle T. Fifth Metacarpal Injuries in the ED: A Descriptive Analysis. XIth Mediterranean Emergency Medicine Congress (MEMC). St. Julians, Malta. Oral Abstract Session O-N1. Intercontinental Hotel, Malta. 23 September 2022.

Oral Presentation. **Kraus CK**, Sullivan R. Stolen Ambulances: A Review of Media Reports, 1980-2020. XIth Mediterranean Emergency Medicine Congress (MEMC). St. Julians, Malta. Oral Abstract Session O-01. Intercontinental Hotel, Malta. 23 September 2022.

Didactic Session. **Kraus CK.** Open-Access Publishing: A Brave New World? XIth Mediterranean Emergency Medicine Congress (MEMC). St. Julians, Malta. Medical Education II: #4. Intercontinental Hotel, Malta. 23 September 2022.

Oral Presentation. Czaja M, **Kraus CK**, Langdorf M. Sullivan R. Non-fatal Injuries from Mass Shootings in the US, 2012-2019: Epidemiology, Outcomes, and Medical Resource Use. XIth Mediterranean Emergency Medicine Congress (MEMC). St. Julians, Malta. Oral Abstract Session O-J6. Intercontinental Hotel, Malta. 23 September 2022.

Presentations and Panel Participation, Local and Regional

“Reverse Triage: Criteria for Immediate Inpatient Disposition for Creation of Surge Capacity.” Johns Hopkins Department of Emergency Medicine Annual Research Day. Baltimore, Maryland. May 2005.

“Trends in HIV infection in the ED: a 16-year review.” Johns Hopkins Department of Emergency Medicine Annual Research Day. Baltimore, Maryland. May 2006.

“Vertebral Artery Dissection.” Clinical Pathological Conference (CPC). Lehigh Valley Health Network, Department of Emergency Medicine. Bethlehem, Pennsylvania. November 2011.

“DNR and POLST.” George E. Moerkirk Emergency Medicine Institute, EMS Continuing Education Lecture. Allentown, Pennsylvania. April 16, 2013.

“Crush Injuries: Out-of-hospital management and review of the Route 309 Tractor-Trailer Crash.” (Delivered to EMS providers, first responders, emergency medicine and trauma physicians and nurses). Lehigh Valley Health Network. Allentown, PA. March 20, 2014.

“Why research is important.” Geisinger Health System Medical Education Grand Rounds. October 11, 2018. Danville, PA.

“Practice changing articles of 2018.” Pennsylvania College of Emergency Physicians (PACEP) Annual Scientific Assembly. April 12, 2019. Crowne Plaza Hotel, King of Prussia, PA.

“Implementing a System-Wide Warm Hand-off Program” (invited speaker) Northcentral Pennsylvania Regional Summit. Warm Handoff for Opioid Overdose Survivors. April 16, 2019. Williamsport, PA. Hosted by: Pennsylvania Department of Drug and Alcohol Programs and Pennsylvania Department of Health.

“Ushering Out Stigma” (invited speaker) Pennsylvania Department of Health and Department of Drug and Alcohol Programs Medication Assisted Therapy (MAT) Northeast Regional Summit. Genetti Hotel. November 7, 2019. Williamsport, PA.

“Predatory Publishing in an Open-Access World” Geisinger Health System Osteopathic Grand Rounds. November 21, 2019. Danville, PA.

Session Moderator, Monroe H, Davis J, on behalf of the American College of Emergency Physicians. Webinar (first of multi-part series): “The Long and Winding Road of an Epidemic: Prescription Opioids, Heroin, and Beyond.” (Funded by SAMHSA’s *Opioid Response Network*, State Targeted Response Technical Assistance (STR-TA) grant program). 31 August 2020.

“Manuscript Publishing Pitfalls and Pearls.” SAEM Research Learning Series (RLS). Online presentation (live online) 10 November 2020.

Panelist (invited). Pennsylvania Psychostimulant Symposium. Breakout II, Session D “First-Hand Accounts from First Responders”. Wednesday, December 2, 2020 (Live online due to COVID-19)

Panelist (invited). EMRA Virtual Spring Medical Student Forum. MS-III Breakout Session: Osteopathic. Saturday, March 27, 2021. (Online due to COVID-19)

Panelist (invited). PACEP Young Physicians Section. “EM Practice Models/Environments”. Friday, April 9, 2021. (Online due to COVID-19)

“Practice Changing Articles.” 2021 Pennsylvania College of Emergency Physicians (PACEP) Annual Scientific Assembly, Friday April 9, 2021. (Online due to COVID-19)

EMTALA: On-call responsibilities. Presented to Geisinger Division of Gastroenterology. September 21, 2021.

“Practice Changing Literature 2021.” 2022 Pennsylvania College of Emergency Physicians (PACEP) Annual Scientific Assembly. Kalahari Resort and Convention Center. Pocono Manor, PA. (Lecture) April 1, 2022.

“PACEP President’s Update.” Pennsylvania College of Emergency Physicians (PACEP) Residents’ Days. Central (9/30/22, Geisinger Medical Center, Danville, PA ~150 attendees); Western (9/1/2022, University of Pittsburgh Medical Center, Pittsburgh, PA ~125 attendees); Eastern (9/14/2022, University of Pennsylvania/Children’s Hospital of Philadelphia, Philadelphia, PA ~225 attendees)

Kraus CK. Reale B, Ramsey E. “Physician Heal Thyself.” Discussion of physician mental health and suicide. *POMA DOes Podcast* (Pennsylvania Osteopathic Medical Association). 29 September 2022. Available online at: <https://www.poma.org/poma-does-podcast> [Last accessed October 5, 2022]

Kraus CK. American Medical Association (AMA), *Making the Rounds Podcast* “Meet Your Match: What to do after your residency interview.” Available online at: <https://podcasts.apple.com/us/podcast/making-the-rounds/id1434891498?mt=2> [Last accessed December 23, 2022]

Poster Presentations (electronic and oral posters included; presenter underlined)

1. “High Prevalence of Undiagnosed HIV Infection in Patients Who Were Not Offered Screening and Patients Who Declined Screening: Evaluation of a Rapid HIV Screening Program in a U.S. Urban Emergency Department.” Hsieh Y-H, Beck K, Kelen G, Shahan J, **Kraus C**, Laeyendecker O, Quinn T, Rothman R. STI & AIDS World Congress 2013, Vienna, Austria, July 14-17, 2013.
2. Barr GC, Kane KE, Barraco RD, Rayburg T, Dugan L, **Kraus CK**, Greenberg MR. Gender Differences in Perceptions and Self-reported Driving Behaviors among Teenagers. PaACEP14 Spivey Competition, Hilton Hotel, Harrisburg PA. April 8, 2014.
3. **Kraus CK**, Meyers M, Kane BG, Greenberg MR. Palliative medicine competency training in emergency medicine residency training: a preliminary report. 2014 Pennsylvania Osteopathic Medical Association (POMA) 106th Annual Clinical Assembly/Convention. Valley Forge Convention Center, King of Prussia, PA, May 1, 2014.
4. Carney D, Carlisle TE, **Kraus CK**. Emergency Medicine Physician Assistant (EMPA) Fellowships/Residencies: A Review of Training Curricula. Society for Emergency Medicine Physician Assistants (SEMPA) 360 Annual Conference. Sheraton Phoenix Downtown, Phoenix, AZ. April 9, 2017; also presented at Missouri Academy of Physician Assistants Annual Meeting, Branson, MO, June 25-27, 2017.
5. Stickles S, Carpenter C, Gekle R, **Kraus C**, Theodoro D, Scoville C, Ubinas G, Tran V, Raio C. The Diagnostic Accuracy of the Rapid Ultrasound in Shock (RUSH) Exam for Shock Etiology: A Systematic Review and Meta-Analysis. SAEM Annual Meeting, Indianapolis, IN. May 16, 2018 (1:10PM) Abstract 144.
6. Knorr AC, Ammerman BA, **Kraus C**, Nemoianu A, Strony R. Prospective prediction of suicide attempts among suicidal ideators following an emergency department visit. Oral presentation (Knorr) at: 52nd Annual Convention for the Association for Behavioral and Cognitive Therapies: November 2018, Washington, DC.
7. Knorr AC, Ammerman BA, **Kraus C**, Nemoianu A, Strony R. Suicide Attempts Among Suicidal Ideators After an Emergency Department Visit. Oral presentation (Knorr) 53rd Annual Convention for the Association for Behavioral and Cognitive Therapies: November 2019
8. Sullivan R. **Kraus CK**. Stolen Ambulances: US Media Reports, 1980-2020. PACEP Spivey Research Competition. (virtual due to COVID-19). April 9, 2021
9. Moore RC, Washabaugh C, Knorr A, **Kraus C**, Nemoianu A, Berger A, Unger K, Hoff N. Face-Off: Comparing Face-to-Face and Telephonic Psychiatric Consultations on ED Length of Stay and Disposition. PACEP Spivey Research Competition. (virtual due to COVID-19). April 9, 2021 ***AWARD: 2nd place e-poster**
10. Czaja MP, Landorf MI, **Kraus CK**. “Non-fatal injuries from Mass Shootings in the US, 2012-2019: Epidemiology, Outcomes, and Medical Resource Use.” American Academy of Emergency Medicine (AAEM)/Residents and Students Association (RSA) and *WestJEM* Competition at AAEM21, June 21, 2021
11. Czaja MP, Landorf MI, **Kraus CK**. “Non-fatal injuries from Mass Shootings in the US, 2012-2019: Epidemiology, Outcomes, and Medical Resource Use.” International Conference Emergency Medicine (ICEM21) (virtual due to COVID-19). Pediatrics and Trauma, June 11, 2021
12. Czaja MP, Landorf MI, **Kraus CK**. “Non-fatal injuries from Mass Shootings in the US, 2012-2019: Epidemiology, Outcomes, and Medical Resource Use.” Society for Academic Emergency Medicine (SAEM21) (virtual due to COVID-19). Abstracts: Lightning Oral Abstract- Social Emergency Medicine, Social Media and Trauma, May 14, 2021

13. Czaja MP, Landorf MI, **Kraus CK**. “Non-fatal injuries from Mass Shootings in the US, 2012-2019: Epidemiology, Outcomes, and Medical Resource Use.” Featured Projects in Progress Presentation: SAEM 2021 Consensus Conference: From Bedside to Policy: Advancing Social Emergency Medicine and Population Health Through Research, Collaboration, and Education. (virtual due to COVID-19) May 11, 2021.
14. Sullivan RA, **Kraus CK**. Stolen Ambulances: US Media Reports, 1980-2020. National Association of EMS Physicians (NAEMSP) Annual Meeting. San Diego, CA. Abstract 190. Stolen Ambulances. (Poster). Abstract 190. Published in *Prehosp Emerg Care*. January/February 2022. 26(1):158.
15. Melnychuk EM, **Kraus CK**. Characteristics and Outcomes of Traumatic Subarachnoid Hemorrhage in a Rural Trauma Center. Society for Academic Emergency Medicine (SAEM) 2022 Annual Meeting, New Orleans, LA. (e-Poster) May 11, 2022.

GRANTS AND CONTRACTS

Active support

| Period | Total Grant Award | Project Title | Role / % FTE effort | Funding Agency |
|------------------------|-------------------|--|--|--|
| 11/2022 – 10/2023 | \$3,624 | Institutional Accuracy of Dosing for Intubation Medication and its Relation to Failed First Attempts | Site PI | Geisinger Medicine Institute CRF |
| 7/1/2022 – 8/31/2023 | \$758,209 | Marijuana Reporting Among Geisinger Patients | Co-I 0.96 months for 2 years 8% FTE | Story of PA, CR |
| 2/1/2022 – 1/30/2023 | \$4,892 | Emergency Department (ED) Use Among Insured, Uninsured, and Medicaid Patients in PA | PI (Mentoring GCSOM medical student, Adam Klaus) 2.5% | Geisinger Commonwealth School of Medicine (GCSOM Institute) CRF 21-243 |
| 12/1/2021 – 11/30/2022 | \$4,939 | Pennsylvania Trauma Patient Mortality Rates Associated with Mode of Transportation, Proximity to Trauma Center, and Level of Referring Facility: An Examination of the PTOS Database | PI (Mentoring GCSOM medical student, Conner Johnson) 2.5% | Geisinger Commonwealth School of Medicine (GCSOM Institute) CRF 21-241 |

Previous Support**Clinical Trial of COVID-19 Convalescent Plasma of Outpatients (C3PO)**

NIH Award Number: 1OT2HL156812-01

ClinicalTrials.gov: NCT04355767

Role: Site Principal Investigator, Geisinger Medical Center

| Period | Amount | Project Title | Role | Funding Agency |
|-------------------|-------------|--|---|--|
| 08/2018 – 08/2020 | \$99,651 | A multimodal emergency department investigation: Improving prospective prediction of suicide risk and recidivism of psychiatric visits for patients in suicidal crisis | PI | Geisinger Clinic Research Fund |
| 07/2013 – 07/2014 | \$5,000 | Palliative medicine competency training in emergency medicine residency programs | PI | Emergency Medicine Foundation (EMF) and Emergency Medicine Residents' Association (EMRA) |
| 05/2013 – 05/2014 | \$2,500 | Palliative medicine competency training in emergency medicine residency programs | PI | PCOM MEDNet |
| 06/2012 – 07/2014 | \$25,000 | Palliative medicine competency training in emergency medicine residency programs | PI | Dorothy Rider Pool Health Care Trust |
| 06/2007 – 06/2008 | \$2,400 | HIV in the ED at the Johns Hopkins Hospital: A 20-year Review | PI (Faculty Mentor: Gabor D. Kelen, MD) | EMF and Society for Academic Emergency Medicine (SAEM) |
| 01/2004 – 10/2007 | \$911,199 | Discharge Criteria for the Creation of Hospital Surge Capacity | Project Manager (PI: Gabor D. Kelen, MD) | AHRQ (#1 U01 HS014353 01) |
| 06/2002 – 05/2003 | \$3,994,843 | Transmissibility of Gonorrhea (GC) and Chlamydia | Site Manger/Research Coordinator (Site PI: Richard E. Rothman, MD, PhD) | NIH (#1 RO1 HD39633-01 – SM Rogers, PhD, PI) |

PUBLICATIONS

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Google Scholar: <https://scholar.google.com/citations?user=KzzhmxgAAAAJ&hl=en>
h-index 17; l-10 index 30

PubMed: <https://pubmed.ncbi.nlm.nih.gov/?term=kraus+chadd>

Peer Reviewed Articles in Indexed Journals

1. Suarez TA, Baerwald JP, **Kraus C**. Central Venous Access: A study comparing internal jugular area across approach, position, and head rotation. *Anesthesia and Analgesia*. 2002;95(6):1519-1524. PMID:12456410
2. **Kraus CK**, Suarez TA. Is there a doctor in the House?...or the Senate? Physicians in U.S. Congress, 1960-2004. *JAMA*. 2004;292(17):2125-2129. PMID:15523073
3. Kelen GD, **Kraus CK**, McCarthy ML, Bass E, Hsu EB, Li G, Scheulen JJ, Shahan JB, Brill JD, Green GB. Inpatient disposition classification for the creation of hospital surge capacity: a multiphase study. *Lancet*. 2006;368(9551):1984-90. PMID:17141705
4. **Kraus CK**, Li G. Pilot alcohol violations reported in U.S. newspapers, 1990-2006. *Aviat Space Environ Med*. 2006;77;1288-1290. PMID:17183928
5. **Kraus CK**, Levy F, Kelen GD. Lifeboat Ethics: Considerations in the Discharge of Inpatients for the Creation of Hospital Surge Capacity. *Disaster Med Public Health Prep*. 2007;1(1):51-6. PMID:18388604.
6. Laeyendecker O, Rothman RE, Henson C, Horne BJ, Ketlogetswe KS, **Kraus CK**, Shahan J, Kelen GD, Quinn TC. The Effect of Viral Suppression on Cross Sectional Incidence Testing in the Johns Hopkins Hospital Emergency Department. *J Acquir Immune Defic Syndr*. 2008;48(2):211-5. PMID:18520680.
7. **Kraus CK**. Mortgaging our future, foreclosing our profession. *J Am Osteopath Assoc*. 2008 May;108(5):231-3. [Letter] PMID:18519831
8. Tang N, **Kraus CK**, Brill JD, Shahan JB, Ness C, Scheulen JJ. Hospital-Based Event Medical Support for the Baltimore Marathon, 2002-2005. *Prehosp Emerg Care*. 2008;12(3):320-26. PMID: 18584499
9. Kelen GD, McCarthy ML, **Kraus CK**, Ding R, Hsu EB, Li G, Shahan JB, Scheulen JJ, Green GB. Creation of surge capacity by early discharge of hospitalized patients at low risk for untoward events. *Disaster Med Public Health Prep*. 2009;3(2 Suppl):S10-16.
10. **Kraus CK**. A Teacher in Pain. *Fam Med*. 2010 Apr;42(4):243-4. PMID: 20373165
11. **Kraus CK**, Guth T, Richardson D, Kane BG, Marco CA. Ethical Considerations in Education Research in Emergency Medicine. *Acad Emerg Med*. 2012;19(12):1328-32. PMID: 23216740
11. Counselman FL, Borenstein MA, Chisholm CD, Epter ML, Khandelwal S, **Kraus CK**, Luber SD, Marco CA, Promes SB, Schmitz G. The 2013 Model of the Clinical Practice of Emergency Medicine. *Acad Emerg Med*. 2014;21(5):574-98. PMID: 24842511
12. Patel EU, Frank MA, Hsieh YH, Rothman RE, Baker AEO, **Kraus CK**, Shahan J, Gaydos C, Kelen GD, Quinn TC, Laeyendecker O. Prevalence and Factors Associated with Herpes Simplex Virus Type 2 Infection in Patients Attending a Baltimore City Emergency Department. *PLoS One*. 2014 Jul 18;9(7):e102422. doi: 10.1371/journal.pone.0102422. eCollection 2014. PMID:25036862

13. **Kraus CK**, Weaver KR. Traumatic Dislocation of the First Carpometacarpal Joint. *Am J Emerg Med*. 2014 Dec;32(12):1561.e1-2. doi: 10.1016/j.ajem.2014.05.048. PMID: 24993682
14. **Kraus CK**, Katz KD. Extensive facial hematoma following third molar removal. *Am J Emerg Med*. 2014 Sep;32(9):1153.e5-6. doi: 10.1016/j.ajem.2014.02.031. Epub 2014 Feb 26. PMID: 24685402
15. Barr GC Jr, Kane KE, Barraco RD, Rayburg T, Demers L, **Kraus CK**, Greenberg MR, Rupp VA, Hamilton KM, Kane BG. Gender Differences in Perceptions and Self-reported Driving Behaviors Among Teenagers. *J Emerg Med*. 2015 Mar;48(3):366-70.e3. doi: 10.1016/j.jemermed.2014.09.055. PMID: 25497842
16. Hsieh Y-H, Kelen GD, Laeyendecker OB, **Kraus CK**, Quinn TC, Rothman RE. HIV Care Continuum for HIV-Infected Emergency Department Patients in an Inner-City Academic ED. *Ann Emerg Med*. 2015;Jul;66(1):69-78. PMID: 25720801
17. **Kraus CK**. Transformative Leadership: Emergency Physicians Lead AOA and AMA. *West J Emerg Med*. 2015;16(7):1086-87. PMID: 26759660
18. Hsieh Y-H, Kelen GD, Beck KJ, **Kraus CK**, Shahan JB, Laeyendecker OB, Quinn TC, Rothman RE. Evaluation of Hidden HIV Infections in an Urban ED with a Rapid HIV Screening Program. *Am J Emerg Med*. 2016;34(2):180-4. PMID: 26589466
19. **Kraus CK**, Ray DE, Greenberg MR, Dy SM. Palliative Care Education in Emergency Medicine Residency Training: A Survey of Program Directors, Associate Program Directors, and Assistant Program Directors. *J Pain Symptom Manage*. 2016;51(5):898-906. PMID: 26988848
20. Marco CA, Venkat A, Baker EF, Jesus JE, Geiderman JM, for the **ACEP Ethics Committee***. Prescription Drug Monitoring Programs: Ethical Issues in the Emergency Department. *Ann Emerg Med*. 2016;68(5):589-98. (*member of Committee as Collaborating Author)
21. **Kraus CK**, Marco CA. Shared Decision-Making in the Emergency Department: Ethical Considerations. *Am J Emerg Med*. 2016;34:1668-72. PMID: 27260552
22. EuDaly M, **Kraus CK**. Frontal mucocele following previous facial trauma with hardware reconstruction. *Case Reports in Emergency Medicine*. 2016;2016:4236421. PMID: 28003917
23. Applegren N, **Kraus CK**. Lyme Disease: Emergency Department Considerations. *J Emerg Med*. 2017;52(6):815-24. PMID: 28291638
24. Mohebbi MR, **Kraus CK**. Paratracheal cysts. *Clin Pract Cases Emerg Med*. 2017;1(3):253-55. PMID: 29849340.
25. Marco CA, Brenner JM, **Kraus CK**, McGrath N, Derse AR, ACEP Ethics Committee. Refusal of Emergency Medical Treatment: Case Studies and Ethical Foundations. *Ann Emerg Med*. 2017;70(5):696-703. PMID: 28559033.
26. Simon JR, **Kraus C**, Rosenberg M, Wang DH, Clayborne EP, Derse AR. "Futile Care" - An Emergency Medicine Approach: Ethical and Legal Considerations. *Ann Emerg Med*. 2017;70(5):707-13. PMID: 28754353.
27. Lam H, Katyal N, Parker C, Natteru P, Nattanamai P, Newey CR, **Kraus CK**. Thromboelastography With Platelet Mapping is Not an Effective Measure of Platelet Inhibition in Patients With Spontaneous Intracerebral Hemorrhage on Antiplatelet Therapy. *Cureus*. 2018;10(4):e2515. doi:10.7759/cureus.2515 PMID: 29942718.
28. Ritter J, **Kraus CK**. Blunt traumatic cervical vascular injury without any Modified Denver Criteria: Case

- Report and Review of the Literature. *Clin Pract Cases Emerg Med*. 2018;2(3):200-202. PMID: 30083632.
29. Langabeer J, Gottlieb M, **Kraus CK**, Lotfipour S, Murphy LS, Langdorf MI. Scholarship in Emergency Medicine: A Primer for Junior Academics: Part II: Promoting Your Career and Achieving Your Goals. *West J Emerg Med*. 2018;19(4):741-45. PMID 30013714.
 30. **Kraus CK**, Carlisle TE, Carney DM. Emergency Medicine Physician Assistant (EMPA) Post-Graduate Training Programs: Program Characteristics and Training Curricula. *West J Emerg Med*. 2018;(19)5:803-07. PMID 30202490.
 31. Jesus JE, Marshall K, **Kraus CK**, Derse A, Baker E, McGreevy, on behalf of the American College of Emergency Physicians (ACEP) Ethics Committee. Should Emergency Department Patients with end-of-life documents be admitted to the ICU? *J Emerg Med*. 2018;55(3):435-440. PMID 30054156.
 32. Gottlieb M, Lotfipour S, Murphy L, **Kraus CK**, Langabeer J, Langdorf MI. Scholarship in Emergency Medicine: A Primer for Junior Academics Part I: Writing and Publishing. *West J Emerg Med*. 2018;19(6):996-1002. PMID: 30429932.
 33. Nibley PD, **Kraus CK**. Rib Osteomyelitis in a Pediatric Patient: A Case Report and Review of the Literature. *WestJEM: Clin Pract Cases Emerg Med*. 2018;2(4):294-96. PMID: 30443609.
 35. Baker EF, **Kraus CK**, et al. Open Access Medical Journals: Promise, Perils, and Pitfalls. *Acad Med*. 2019;94(5):634-39. PMID: 30570493.
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 37. Kane BG, Totten VY, **Kraus CK**, Allswede M, Diercks DB, Garg N, Ling L, McDonald EN, Rosenau A, Wilk M, Holmes A, Hemminger A, Greenberg MR. Creating Consensus: Revisiting the Emergency Medicine Resident Scholarly Activity Requirement. *West J Emerg Med*. 2019;20(2):269-75. PMID 30881559.
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 39. **Kraus C**, Carlisle TE, Carney DM. Response to: "Letter to the Editor: Emergency Medicine Physician Assistant Postgraduate Training Programs: Characteristics and Training Curricula." *West J Emerg Med*. 2019;20(3):495-6. PMID: 31123551.
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 41. Halupa AJ, Strony RS, Bulbin DH, **Kraus CK**. Pseudogout Diagnosed by Point-of-care Ultrasound. *Clin Pract Cases Emerg Med*. 2019;4(4):425-27. PMID: 31763605.
 42. Davis R, Reed E, **Kraus CK**. Arm pain and swelling in a college swimmer: A case of Page-Schroetter." *J Amer Osteopath Assoc*. 2020 Jan 13. PMID: 31930395.
 43. **Kraus CK**. Moskop J. Marshall KD. Bookman K. ACEP Ethics Committee. Ethical Issues in Access to and Delivery of Emergency Department (ED) Care in an Era of Changing Reimbursement and Novel Payment Models. *J Am Coll Emerg Physicians Open*. 2020;1(3):276-80. PMID: 33000043.
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47. **Kraus CK**. The ED Waiting Room: A barometer of hospital throughput and capacity? (invited editorial) *J Am Coll Emerg Physicians Open*. 2020;1(5):1060-1061. PMID: 33145558.
48. Laam LA, Wary AA, Strony RS, Fitzpatrick MH, **Kraus CK**. Quantifying the impact of patient boarding on Emergency Department length of stay: All admitted patients are negatively affected by boarding. *J Am Coll Emerg Physicians Open*. 2021;2(2):e12401. PMID: 337118931.
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50. **Kraus CK**, Langdorf MI. Firearms Injury Prevention, Emergency Medicine, and the Public's Health: A Call for Unity of Purpose. *West J Emerg Med*. 2021;22(3):457-58. PMID: 34125013.
51. Olaf MF, **Kraus CK**. Igniting Inquiry: Development and Implementation of a Novel Journal Club Curriculum in an Emergency Medicine Residency. *J Emerg Med*. Online ahead of print. PMID: 34481687.
52. Korley FK, Durkalski-Mauldin V, Yeatts SD, [et, al], for the **SIREN-C3PO Investigators* (Author list as Geisinger Site PI)**. Early Convalescent Plasma for High-Risk Outpatients with COVID-19. *N Engl J Med*. 2021;385(21):1951-1960. PMID: 34407339.
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54. Melnychuk EM, Sallade, TD, **Kraus CK**. Hospitals as Disaster Victims: Lessons not Learned? *J Am Coll Emerg Physicians Open*. 2022;3(1):e12632. PMID: 350336993
55. Stoltzfus GT, **Kraus CK**. The forgotten disease. *J Am Coll Emerg Physicians Open*. 2022;3(2):e12715. PMID: 35387324
56. Isenberg DL, Henry KA, Sigal A, Deaner T, Nomura JT, Murphy KA, Cooney D, Wojcik, Brandler ES, Kuc A, Carroll G, **Kraus C**, Shahan JH, Herres J, Ackerman D, Gentile NT. Optimizing Prehospital Stroke Systems of Care – Reacting to Changing Paradigms (OPUS-REACH): a pragmatic registry of large vessel occlusion stroke patients to create evidence-based stroke systems of care and eliminate disparities in access to stroke care. *BMC Neurol*. 2022;22(1):132. PMID: 35392840.
57. Czaja MP, **Kraus CK**, Phyo S, et al. Non-fatal Injuries from Mass Shootings in the United States, 2012-2019: Epidemiology, Outcomes, and Resource Use. *JAMA Netw Open*. 2022;5(5):e2213737. PMID: 35622366
58. Stickles S, Shipley Kane D, **Kraus CK**, Strony RJ, Ablordeppey EA, Doering MM, Theodoro D, Lee JS, Carpenter CS. Adverse events related to ultrasound-guided regional anesthesia performed by Emergency Physicians: systematic review protocol. *PLoS One* 2022;17(6):e0269697. PMID: 35749370.
59. Katsilometes J, Galuska M, **Kraus CK**, Levitin HW, Leuchten S, Daugherty-Luck J, Lata J, Brannan G, Santarelli A, Ashurst J, FOEM Research Network. Multisite assessment of emergency medicine resident knowledge of evidence-based medicine measured by the Fresno Test of Evidence-Based Medicine. *J Osteopath Med*. 2022;122(10):509-515. PMID: 35704661

60. Brenner JM, **Kraus C**, Dilip M, Goett R, Clayborne EP, Kluenser N. Emergency Physician Professionalism versus Wellness: A Conceptual Model. *J Am Coll Emerg Physicians Open* (Accepted, in press Aug 2022)
61. Isenberg D, **Kraus CK**, Henry KA, Ackerman D, Cooney DR, Brandler E, Kuc A, Nomura JT, Herres J, Sigal A, Simon K, Mylin J, Gentile NT. Evolution of Endovascular Stroke Centers and Disparities in Access to Stroke Care in Four Northeastern States: 2015-2019. *J Stroke Cerebrovasc Dis*. 32(1): January 2023
62. Isenberg D, Isenberg R, Henry K, **Kraus CK**, Ackerman D, Sigal A, Herres J, Brandler E, Kuc A, Nomura A. Assessing Disparities in Access to Advanced Stroke Care in Four Northeastern States Using the Social Vulnerability Index. *J Stroke Cerebrovasc Dis*. ACCEPTED December 2022

Book Chapters

1. **Kraus CK**. Small Group Learning. In: Guth TA (ed). *Resident as Educator*. 1st Edition. Emergency Medicine Residents' Association (EMRA): Irving, TX; 2013:19-22.
2. **Kraus CK**, Ventura E. Physician Shortages and Workforce Issues. In: Schlicher NR, Haddock A (eds). *Emergency Medicine Advocacy Handbook, 3rd Edition*. Emergency Medicine Residents' Association (EMRA): Irving, TX; 2013:85-90.
3. PaACEP EM Board Review Question and Answer Book, 4th Edition Editor JB Leiser, WA Schradling. 2014. (Question review and revision)
4. Cohen R, Ren, RK. **Kraus CK**. Chapter 22: Palliative and End-of-Life Care. In: Schlicher NR, Haddock A (eds). *Emergency Medicine Advocacy Handbook, 4th Edition*. Emergency Medicine Residents' Association (EMRA): Irving, TX; 2016:123-28. **senior author mentoring resident authors**
5. Bowman J, **Kraus CK**. Chapter 23: Palliative and End-of-Life Care in the Emergency Department. In Schlicher N, Haddock A (eds). *Emergency Medicine Advocacy Handbook. 5th Edition*. Emergency Medicine Residents' Association (EMRA): Irving, TX;2019:145-50. **senior author mentoring resident authors**
6. **Kraus CK**. Chapter 17: "12/10" Abdominal Pain. In: Baker EF, ed. *Legal and Ethical Issues in Emergency Medicine*. New York, NY: Oxford University Press; 2020:121-125. ISBN: 978-0-19-006642-0
7. **Kraus CK**. Chapter 19: Everyday J. In: Baker EF, ed. *Legal and Ethical Issues in Emergency Medicine*. New York, NY: Oxford University Press; 2020:131-135. ISBN: 978-0-19-006642-0
8. **Kraus CK**. Chapter 24: An Industrial Accident. In: Baker EF, ed. *Legal and Ethical Issues in Emergency Medicine*. New York, NY: Oxford University Press;2020:163-166. ISBN: 978-0-19-006642-0
9. Paxton JH (Editor). **Kraus CK**, Wilkerson RG, Gaddis GM, Cairns CB (Section Editors). *Resident Research and Scholarly Activity: A Primer*. American College of Emergency Physicians. Dallas, Texas. 2021. Full text available online at: <https://www.acep.org/globalassets/sites/acep/media/sections-documents/research/acepresearchprimer.pdf>
10. **Kraus CK**. Chapter 2: We Need Labs and an EKG. In: Baker EF, ed. *What Do I Do Now?: Emergency Medicine Psychiatric Emergencies*. New York, NY: Oxford University Press;2022:11-15. ISBN: 978-0-19-75446-4
11. **Kraus CK** Chapter 21: Everything Hurts and I'm Weak, Doc. In: Baker EF, ed. *What Do I Do Now?: Emergency Medicine Psychiatric Emergencies*. New York, NY: Oxford University Press;2022:145-148. ISBN: 978-0-19-75446-4

12. **Kraus CK** Chapter 25: You're Staying, Whether You Like It or Not. In: Baker EF, ed. *What Do I Do Now?: Emergency Medicine Psychiatric Emergencies*. New York, NY: Oxford University Press;2022:173-179. ISBN: 978-0-19-75446-4
13. **Kraus CK** Chapter 26: Sick From Waiting. In: Baker EF, ed. *What Do I Do Now?: Emergency Medicine Psychiatric Emergencies*. New York, NY: Oxford University Press;2022:181-185. ISBN: 978-0-19-75446-4

Peer-Reviewed Published Abstracts

1. Henson C, Laeyendecker O, **Kraus C**, Horne BJ, Rothman RE, Shahan JB, Kelen GD, Quinn TC. A Fifteen Year Retrospective in Trends in Incidence, Prevalence, and Risk Factors for HIV Infection Among Inner-City Patients Attending The Johns Hopkins Emergency Department from 1988-2003. 11th International Conference on Retrovirus and Opportunistic Infections (CROI). Paper #89, Session 18. (San Francisco, California. February 11-14, 2004). Available online at: <http://www.retroconference.org/2004/cd/Abstract/89.htm>.
2. Kelen GD, **Kraus CK**, Brill JD, the CEPAR Research Group. Creation of Hospital Surge Capacity by the Early Discharge of Inpatients *Acad Emerg Med* 2005;12:23a
3. Brill JD, **Kraus CK**, Tang N. Going the Distance: Epidemiology of Participant Injuries and Description of On-Site Medical Services during the Baltimore Marathon, 2002-2004. *Ann Emerg Med* 2005;46(3):S31.
4. Suarez TA, **Kraus CK**. Ascending Aortic Dissection (Type A) with Hemodynamically Significant Cardiac Tamponade in a Previously Hypertensive Pregnant Woman after Acute Cocaine Use: A Case Report and Discussion. In Abstracts of Posters Presented at the International Anesthesia Research Society (IARS) 80th Clinical and Scientific Congress. San Francisco, California, March 24-28, 2006. Supplement to *Anesthesia and Analgesia*. ISSN 0003-2999;102(25) Feb 2006;S48.
5. Kelen GD, **Kraus CK**, and CEPAR Research Group. Creation of Health System Surge Capacity by the Immediate Discharge of Inpatients. *Acad Emerg Med*. 2006;13(5):S94
6. **Kraus CK**, Rothman RE, Shahan JB, Quinn T, Kelen GD. Trends in HIV infection in the ED: a 16 year review. *Acad Emerg Med*. 2006;13(5):S22
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8. **Kraus CK**, Shahan JB, Rothman RE, Hsieh Y, Laeyendecker O, Oliver A, Gamiel J, Quinn TC, Kelen GD. Seroprevalence of HSV-2 infection among an urban emergency department population. *Ann Emerg Med*. 2008;52(4):S54.
9. **Kraus CK**, Shahan JB, Rothman RE, Hsieh Y, Laeyendecker O, Oliver A, Gamiel J, Quinn TC, Kelen GD. Twenty-years experience with HIV testing among emergency department patients at the Johns Hopkins Hospital. *Proceedings of the 2008 National Summit on HIV Diagnosis, Prevention, and Access to Care*. Hyatt Regency Crystal City (Arlington, Virginia, November 18-21, 2008).
10. Oliver A, Layendecker O, **Kraus C**, Hairston H, Gamiel G, Neal J, Moore R, Rothman R, Shahan J, Kelen G, Quinn T. Trends in HIV Prevalence and Incidence in the Johns Hopkins Hospital Emergency Department. *The Johns Hopkins Urban Health Institute, Baltimore Research Day Program and Abstract Booklet*. May 9, 2008; Poster #19, page 59.
11. **Kraus CK**, Ray DE, Greenberg MR, Dy SM. Palliative Medicine Competency Education in Emergency Medicine Residency Training: A Survey of Emergency Medicine Education Leaders. *Ann Emerg Med*. 2014;64(45):S143.

12. Knorr AC, Ammerman BA, Hileman B, **Kraus C**, Nemoianu A, Strony R. (October, 2018). Influential predictors of suicide attempt among suicidal ideators following an emergency department visit. [Abstract 50]. *Ann Emerg Med.* 2018;72(4):S23
13. Melnychuk E, **Kraus C**, Cocciolone AJ. Outcomes of patient presenting to the emergency department with traumatic subarachnoid hemorrhage. [Abstract 392] *Ann Emerg Med.* 2021;78(48):S158
14. Melnychuk E, Berger A, **Kraus C**. Coagulopathies and Mortality in Patients with Traumatic Subarachnoid Hemorrhage. [Abstract 315] *Ann Emerg Med.* 2022;80(4):S134-135

Other Publications (including clinical policies)

1. Rothman RE, **Kraus CK**. Emergency Medicine on the Front Lines of Homeland Security. Society for Academic Emergency Medicine (SAEM) Newsletter. November/December 2002.
2. **Kraus CK**. Be Aware of Student Loan Flux. *EM Resident.* August/September 2008;35(4):18-19.
3. **Kraus CK**. Clinical Pearl: Abdominal Pain in the Elderly Patient. *EM Resident.* October/November 2008;35(5):16-17.
4. **Kraus CK**. Palliative Medicine: A New Frontier in Emergency Medicine. *EM Resident.* February/March 2012. 39(1): 12.
5. **Kraus CK**. Assassins and Saboteurs: The Low-Risk Chest Pain Patient. *EM Resident.* 39(2): April/May 2012: 38-39.
6. **Kraus CK**. The 2012 CORD Academic Assembly: Advancing collaboration in emergency medicine. *EM Resident.* 39(3): June/July 2012: 25.
7. **Kraus CK**. Pulseless...and talking (LVADs in the ED). *EM Resident.* 39(4): Aug/Sept 2012: 28-29.
8. **Kraus CK**. Bitten: A snake envenomation primer. *EM Resident.* 39(5): Oct/Nov 2012: 28-29.
9. **Kraus CK**. EMRA Update. *Council of Emergency Medicine Residency Directors' (CORD) Newsletter.* Winter 2012.p6.
10. **Kraus CK**. Time to get involved in EMRA's educational activities. *EM Resident.* Dec 2012/Jan 2013;39(6): 24.
11. **Kraus CK**. Going viral (or not): Intussusception Case Report. *EM Resident.* Feb/Mar 2013;40(1):24-25.
12. **Kraus CK**. Case Study: Meet the PRES (Posterior-Reversible Encephalopathy Syndrome Case Report). *EM Resident.* April/May. 2013;40(2):14-15.
13. **Kraus CK**. When Warming is a Warning: Infant and Neonatal Fever. *EM Resident.* Aug/Sept. 2013;40(4):35-36.
14. **Kraus CK**. Excellence Defined: A Tribute to Ron Krome, MD. *EM Resident.* Oct/Nov. 2013;40(5):14-15.
15. Marco CA, **Kraus C**. Shared Decision Making in Emergency Medicine: Choosing Wisely with your patients, not for your patients. *ACEPNow.* May 2014: 9-10.

16. **Kraus CK**, Heidt J, on behalf of the Emergency Medicine Residents' Association. Resolution 22(13), "Graduate Medical Education Funding and the Match Process." Revised and Adopted by the 2013 ACEP Council.
17. ED Back-pain Observation Protocol (Revision). Lehigh Valley Health Network, Department of Emergency Medicine. May 2014.
18. Carlisle TE, Seithel M, **Kraus C**. PAs in the ED: What Do Residents Need to Know? *EM Resident*. Apr/May 2016;43(2):20-21.
19. **Kraus CK**. EM Physician Assistant Terry Carlisle Recalls Long Career, Discusses Future of Specialty. *ACEPNow*. September 20, 2017.
20. Monroe H, **Kraus CK**. "State of the States" (legislative update). ACEP Medical Directors' Section Newsletter (Inaugural Edition), March 2018.
21. Kraus CK. Emergency services face drug shortage. [Letter to Editor]. Lancaster Online. June 7, 2018. Available online at: https://lancasteronline.com/opinion/letters_to_editor/emergency-services-face-drug-shortage/article_c74d170-69a6-11e8-95f2-a36ae23ec1f6.html.
22. **Kraus CK**, Aberger K, Brenner J, Marco C, Schears RM, Simon J. How Does ACEP's Code of Ethics Apply to Me? *ACEPNow*. September 11, 2018. Available online at: https://www.acepnow.com/article/how-does-aceps-code-of-ethics-apply-to-me/?elq_mid=30316&elq_cid=10114521. Last Accessed: 9/17/18
23. **Kraus CK**. 50 Years of EM: Happy 50th Birthday, ACEP! *PACEP News*. Fall 2018. 13.
24. **Kraus CK**. Social Determinants of Health – A 'Healthy Opportunity' for Emergency Medicine. *PACEP News*. Winter 2019. 3-4.
25. Hanson K, **Kraus C**. Rare Occurrence of Lemierre's Syndrome: A Case Report. *EM Resident*. April/May 2019.
26. **Kraus CK**. Jack and Jill of all Trades (and Master of Most): Practice Environments for Emergency Physicians. ACEP Young Physicians Newsletter. May 2019. Available online at: <https://www.acep.org/how-we-serve/sections/young-physicians/news/may-2019/practice-environments-for-em-physicians/>
27. **Kraus CK**, McGrath NA, Brenner JM, Vearrier L, Larkin GL. Emergency Physicians' Rights and Responsibilities During the COVID-19 Pandemic. *ACEPNow*. July 15, 2020. Available online at: <https://www.acepnow.com/article/emergency-physicians-rights-and-responsibilities-during-the-covid-19-pandemic/>. Last Accessed: 7/17/20
28. Simon JR, Kraus CK, Basford JB, Clayborne EP, Kluesner N, Bookman K. ACEP Ethics Committee. The Impact of Boarding Psychiatric Patients on the Emergency Department: Scope, Impact, and Proposed Solutions: An Information Paper. (Approved by ACEP Board of Directors, November 2019). Available online at: <https://www.acep.org/globalassets/new-pdfs/information-and-resource-papers/the-impact-of-psychiatric-boarders-on-the-emergency-department.pdf> (Last accessed 3/1/2021)
29. Cassone M, **Kraus C**, Ebrom P, Fisher M, Howard M, Mathur H. Is the Grass Always Greener? Perspectives from EM Residents taht Switched from Other Specialties. *EM Resident*. 10/9/2020. Available online at: <https://www.emra.org/emresident/article/switching-to-em>. Last Accessed: 5/5/2021
30. Cassone MA, Appel MA, Walton MB, **Kraus C**. "Brews and News" An Innovative, Resident-Driven Model for Wellness and Topical Discussions in an Emergency Medicine Residency. *EM Resident*. 10/9/2020. Available online at: <https://www.emra.org/emresident/article/brews-and-news/>. Last Accessed: 5/5/2021

31. **Kraus CK.** PACEP at 50 – Celebrating our past, forging our future. *PACEP News*. Spring 2021. pp: 12-13.
32. **Kraus CK.** “A Summer Celebration...and Time to Get Involved” *PACEP News*. Summer 2021. Page 17
33. **Kraus CK.** Executive Privilege (President’s Message). *PACEP News*. Spring 2022. pp: 1,3.
34. Calderon Y, Barton M, Tyler L, Livingston C, **Kraus CK.** The American Board Of Emergency Medicine (ABEM) Haley Academy: Bridging The Gap Of Diversity, Equity, And Inclusion By Engaging Underrepresented Medical Students *ACEPNow*. October 26, 2022. Available online at: <https://www.acepnow.com/article/the-american-board-of-emergency-medicine-abem-haley-academy-bridging-the-gap-of-diversity-equity-and-inclusion-by-engaging-underrepresented-medical-students/>. Last Accessed: 11/1/22

Online Publications

1. **Kraus CK.** “The interview.” Medical Student Pearl. Emergency Medicine Residents’ Association (EMRA). Available online at: http://www.emra.org/emra_articles.aspx?id=29588 (Member access)
2. **Kraus CK.** “Hot Topics in Emergency Medicine: Issues to know for your interview.” Medical Student Pearl. Emergency Medicine Residents’ Association (EMRA). Available online at: http://www.emra.org/emra_articles.aspx?id=29518 (Member access)
3. **Kraus CK.** “What’s Up in Emergency Medicine.” Various topics discussed in monthly e-newsletter distributed to approximately 8,000 members of the Emergency Medicine Residents’ Association (EMRA), June 2008 – June 2010
4. **Kraus CK.** “Heatstroke: When “I’ll be just a minute” is too long.” ACEP Emergency Care For You. Available online at: <http://www.emergencycareforyou.org/Health-Tips/Doc-Blog/Heatstroke--When-“I’ll-just-be-a-minute”-is-too-long/>
5. **Kraus CK.** “Lyme disease: More than a tick and bulls’-eye rash.” ACEP Emergency Care for You. Available online at: <http://www.emergencycareforyou.org/Health-Tips/Doc-Blog/Lyme-disease--More-than-a-tick-and-bulls'-eye-rash/> [Last accessed 9/8/15]
6. **Kraus CK.** “Chair’s Corner” ACEP Young Physicians Section Newsletter. December 2017. Available online at: <https://www.acep.org/how-we-serve/sections/young-physicians/news/december-2017/chairs-corner/#sm.0001s1426g4aoff2pxf237r8y21z8> [Last accessed 2/1/18]
7. **Kraus CK.** “Young Physicians Section Update” ACEP Young Physicians Section Newsletter. March 2018. Available online at: <https://www.acep.org/how-we-serve/sections/young-physicians/news/march-2018/young-physicians-section-update/#sm.0001s1426g4aoff2pxf237r8y21z8>. [Last accessed 6/10/18]
8. **Kraus CK.** “LAC Highlights Upcoming YPS Events” ACEP Young Physicians Section Newsletter. May 2018. Available online at: <http://www.multibriefs.com/briefs/acep-yps/kraus-april2018.pdf>. [Last accessed 9/12/18]
9. **Kraus CK.** “Celebrate ACEP’s 50th Anniversary with YPS in San Diego this October.” ACEP Young Physicians Section Newsletter. September 2018. Available online at: http://www.multibriefs.com/briefs/acep-yps/sep2018_chair_letter.pdf [Last accessed 11/10/18]
10. **Kraus CK.** “Wrap-up and Look Ahead from the 2018 Midterm Elections. ACEP Young Physicians Section Newsletter. December 2018. Available online at: <https://www.acep.org/how-we-serve/sections/young-physicians/news/december-2018/yps-midterm-election-recap/#sm.0001s1426g4aoff2pxf237r8y21z8> [Last accessed 12/9/18]

Acknowledgements for Contributions to Peer-Reviewed Publications

1. Rogers SM, Miller WC, Turner CF, et al. Concordance of Chlamydia trachomatis infections within sexual partnerships. *Sex Transm Infect.* 2008;84(1):23-28. (Acknowledged for oversight of enrollment of subjects and interviews at the Johns Hopkins Adult Emergency Department)
2. Lyons MS, Lindsell CJ, Haukoos JS, et al. on behalf of the National Emergency Department HIV Testing Consortium. Nomenclature and Definitions for Emergency Department Human Immunodeficiency Virus (HIV) Testing: Report from the 2007 Conference of the National Emergency Department HIV Testing Consortium. *Acad Emerg Med.* 2009;16(2):168-77. (Acknowledged as a scribe for the discussion sections and assisting with compilation of comments provided by Consortium participants)

MEDIA ENGAGEMENTS

Featured in American College of Emergency Physicians (ACEP) Leadership and Advocacy Conference Promotional Video. January-May 2013.

Invited Guest - NPR affiliate, KCSN (Northridge, California) to discuss "Physicians in Congress. November 4, 2004.

Invited Guest - National Public Radio's (NPR) "Talk of the Nation: Science Friday with Ira Flatow" (live broadcast to 240 NPR-member stations across the United States) to discuss "Physicians in Congress." November 5, 2004.

Invited Expert - RadioMD: Stay Well®: The Dr. Leigh Vinocur Show (ER101). "Osteoporosis: Why Are Men Rarely Screened?" Available online at: <http://radiomd.com/show/er-101/item/24267-osteoporosis-why-are-men-rarely-screened?> Air Date: November 7, 2014.

Featured interviewee - Money on Your Mind: "How student debt can influence physicians' career choices" by Rose Raymond in *The DO* Available online at: <http://thedo.osteopathic.org/2015/08/how-student-debt-can-influence-physicians-career-choices/> August 12, 2015.

Invited Expert - RadioMD: Stay Well®: The Dr. Leigh Vinocur Show (ER 101). "Importance of Immunizations." Available online at: <http://radiomd.com/show/er-101/item/28798-importance-of-immunizations>. Air Date: August 14, 2015.

Invited Expert - RadioMD: Stay Well®: The Dr. Leigh Vinocur Show (ER 101). "Celebrating this Season? Preventing Holiday Heart." Available online at: <http://radiomd.com/show/er-101/item/29993-celebrating-prevent-holiday-heart-syndrome>. Air Date: November 20, 2015.

Invited Expert - RadioMD: Stay Well®: The Dr. Leigh Vinocur Show (ER 101). "Heart Health: Men vs. Women." Available online at: <http://radiomd.com/show/er-101/item/30804-heart-health-men-vs-women>. Air Date: February 12, 2016.

Invited Expert. ABC 17 KMIZ (Columbia, MO), Special Report: Prescription for Overdose (discussion of opioid overdose epidemic) Air Date: April 28, 2016. Available online at: <http://www.abc17news.com/news/prescription-for-overdose/39127516>

Invited Expert. KMOS (PBS public television affiliate) / KBIA (NPR radio affiliate) (Columbia, MO), Fall Prevention. on "Radio Friends with Paul Pepper" Air Date: May 10, 2016. Available online at: <http://kbia.org/post/paul-pepper-fall-injury-awareness-and-prevention-meet-new-second-chance-executive-director>

Invited Expert. ABC 17 KMIZ (Columbia, MO), "Bill passes legislature letting people buy heroin overdose treatment." Air Date: May 11, 2016. Available online at: <http://www.abc17news.com/news/bill-passes-legislature-letting-people-buy-heroin-overdose-treatment/39479250>

Invited Expert. KBIA (Columbia, MO, NPR-member station), "Annual Mosquito Spraying Program Begins in Columbia." (by Emily McCarter) Air Date: June 2, 2016. Available online at: <http://kbia.org/post/annual-mosquito-spraying-program-begins-columbia>

Invited Expert. ABC 17 KMIZ (Columbia, MO), "Cutting electric costs during the summer heat." Air Date: June 14, 2016. Available online at: <http://www.abc17news.com/news/cutting-electric-costs-during-the-summer-heat/40055316>

Invited Expert. ABC 17 KMIZ (Columbia, MO), "University Hospital Reports It's Seen 6 Patients for Heat-Related Illnesses This Week." Air Date: June 15, 2016. Available online at: <http://www.abc17news.com/news/record-breaking-temperatures-bring-heat-illnesses/40069712>
Quoted Expert. Boone County Journal. "Take Heat Precautions." Published: June 15, 2016. Available online at: <http://bocojo.com/news/take-heat-precautions/>

Invited Expert. KFRU-AM 1400AM, "Columbia Morning with David Lile" discussing heat-related health precautions. Airdate: June 16, 2016. Available online at: <http://www.kfru.com/shows/columbia-morning-with-david-lile/>

Quoted Expert. Columbia Daily Tribune (Columbia, MO) "Heat advisory issued for Thursday in Central Missouri; Wednesday high sets record." Published: June 16, 2016. Available online at: http://www.columbiatribune.com/news/local/heat-advisory-issued-for-thursday-in-central-missouri-wednesday-high/article_70cd0797-0987-5e2e-b303-1aa743ac5a80.html

Invited Expert. MissouriNet Radio (Missouri Statewide News Service), discussing heat-related health precautions. Interview Date: June 17, 2016. Available online at: www.missourinet.com

Invited Expert. NBC KOMU 8 (Columbia, MO), "MU Health Care physicians offer tips on keeping your family safe this summer." Airdate: June 19, 2016. Available online at: <http://www.komu.com/news/mu-health-care-physicians-offer-tips-on-keeping-your-family-safe-this-summer>

Quoted Expert. KTTS 94.7FM (Springfield, MO), "MU Emergency Physician Urges Safety During Hot Weather." Posted: June 21, 2016. Available online at: <http://www.ktts.com/news/mu-emergency-physician-urges-safety-during-hot-weather>

Invited Expert. ABC 17 KMIZ (Columbia, MO), "Turning off air conditioning to cut costs could increase possibility of heat stroke." Air Date: June 22, 2016. Available online at: <http://www.abc17news.com/news/turning-off-air-conditioning-to-cut-costs-could-have-negative-health-effects/40180146>

Quoted Expert. Sikeston Standard Democrat (Sikeston, MO), "Beating the heat: Ways to avoid illnesses during outdoor sports." Published: June 25, 2016. Available online at: <http://www.standard-democrat.com/story/2316731.html>

Invited Expert, ABC 17 KMIZ (Columbia, MO), "Columbia to test water for lead" (Lead Story) Air Date: June 29, 2016. Video available upon request.

Invited Expert, ABC 17 KMIZ (Columbia, MO), "Heat medically connected to crime increase: Doctors say heat has a psychological effect on people." Air Date: June 30, 2016. Available online at: <http://www.abc17news.com/sports/heat-medically-connected-to-crime-increase/40302216>

Invited Expert, ABC 17 KMIZ (Columbia, MO), "What not to eat in the heat." Air Date: July 20, 2016. Available online at: <http://www.abc17news.com/weather/what-not-to-eat-in-the-heat/40806230>

Invited Expert, Delaware Online: The News Journal. "10 facts about heat you're your health in Delaware." (Author Jen Rini, The News Journal), August 2, 2016 Available online at: <http://www.delawareonline.com/story/news/health/2016/08/01/10-facts-heat-and-your-health-delaware/87448294/>

Invited Expert, ABC 17 KMIZ (Columbia, MO), "Dangerous Synthetic Drug Appears in Taney County, Missouri." Air Date: August 26, 2016. Available online at: <http://www.abc17news.com/news/crime/dangerous-synthetic-drug-appears-in-taney-county-missouri/80497386>

Invited Expert, Delaware Online: The News Journal. "Lead paint removal a slow, expensive process for Delaware." (Author Adam Duvernay, The News Journal), August 16, 2016 Available online at: <http://www.delawareonline.com/story/news/2016/08/16/lead-paint-removal-slow-expensive-process-delaware/88531498/>

Featured in American College of Emergency Physicians (ACEP) Video, "FACEP: It Means More" Available online at: <https://www.acep.org/fellow/#sm.00014jvknkt5fafsfn1jnvsk1nrv>

Actor, InnovatED at ACEP19, Denver Colorado. Behavioral Health Emergencies.

Invited expert. "Palliative Care Integrated into Critical Care Settings, Including EDs." *Medical Ethics Advisor*. Vol. 37, No. 4; 37-48. April 2021

Invited expert, Fox43 (Harrisburg, PA). Discussion of UnitedHealthcare reimbursement policy. "Group of emergency physicians condemns healthcare policy they say could put patients on hook to pay up for ER visits." Air Date: June 10, 2021. Available online at: <https://www.fox43.com/article/news/local/emergency-room-healthcare-costs-physicians-united-patients-pay-hospital-bills/521-59fdcae8-66ff-4de3-9592-4a38ada9b766>. [Last accessed October 1, 2021]

Invited Expert. "Program directors list 4 red flags for residency applicants to avoid." American Medical Association (AMA). Available online at: <https://www.ama-assn.org/residents-students/residency/program-directors-list-4-red-flags-residency-applicants-avoid>. September 15, 2021. [Last accessed October 1, 2021]

Invited Expert. ABC16 WNEP (Scranton, PA). "Geisinger COVID-19 update: Boosters, cases, and testing: Doctors at Geisinger Medical Center near Danville are seeing a rise in COVID-19 cases across the region." Air Date: September 27, 2021. Available online at: <https://www.wnep.com/article/news/local/montour-county/geisinger-covid-19-update-boosters-cases-and-testing/523-478d747a-a1a7-4021-a24f-69b0e2e72c79>. [Last accessed October 1, 2021]

Invited expert. "Notify Patient if Initial Radiology Read is Incorrect." *ED Management*. Vol. 33, No. 11; 145-147. November 2021.

Invited expert. "Patients' Involvement in Decision-Making Linked to Lower Malpractice Risks." *ED Management*. Vol. 34, No. 1; 12. January 2022.

Invited expert. "Older Adults with Abdominal Pain Risk Mistrriage, Inadequate Diagnostic Tests." *ED Management*. Vol. 34, No. 2; 27-28. February 2022.

Invited expert. "Detailed Charting on Handoffs Stops Legal Finger-Pointing." *ED Management*. Vol. 34, No. 5; 74-76. May 2022.

Invited expert. "Obligations for EDs if Clinicians Suspect Human Trafficking." *ED Management*. Vol. 34, No. 10; 155-56. October 2022.

Quoted expert. Boyle P. "The cost of surviving gun violence: Who pays?" AAMC News. October 18, 2022.

Documentary Films

Production Advisor, *24/7/365: The Evolution of Emergency Medicine* (released October 2013)
 *A documentary film of the history of Emergency Medicine as told by the founders and leaders in the specialty. Awards include: Gold Circle Award, 2014 American Society of Association Executives (ASAE); Bronze Winner, The 35th Annual Telly Awards; Official Selection, St. Louis International Film Festival; Best Documentary (“New England Emmy”), Boston/New England Chapter National Academy of Television Arts & Sciences.

Director and Executive Producer, “Missing Square to Shining Star” 2018 – 2022
 PACEP Documentary Film of History of Emergency Medicine in Pennsylvania

TEACHING AND MENTORING ACTIVITIESNational Teaching

Instructor, Advanced Trauma Life Support (ATLS) 461470 2016 – present
 Faculty, Emergency Medicine Oral Board Review Course, Illinois College of
 Emergency Physicians (ICEP), Chicago, IL 2015 – 2019

Medical School/Medical Students

Ambulatory Care Experience (ACE) Mentor 02/2016 – 10/2016
 University of Missouri-Columbia School of Medicine
 Provide clinical mentoring / introduction for MS-I/II medical students interested in EM

Summer Research Fellowship Mentor 05/2016 – 10/2016
 University of Missouri-Columbia School of Medicine
 Provide SOM-funded clinical research experience for MS-I/II medical students

- Helena Lam: Awarded 2nd place, Category I (Clinical) University of Missouri School of Medicine Health Sciences Research Day 11/17/16
- Nathan Applegren, MS

Advice Support and Career (ASC) Preclinical Advising Program Mentor 07/2016 – 10/2016
 University of Missouri-Columbia School of Medicine
 Provide guidance, support, mentoring to MS-I and MS-II medical students

Mock Residency Interview Program, Philadelphia College of Osteopathic Medicine (PCOM)
 2019 – 2020

SAEM Medical Student Mentor 2020 – present

GCSOM Medical Research Honors Program (MRHP) Mentor 2020 – present
 Niraj Vyas (Class of 2024)
 Conner Johnson (Class of 2024)
 Adam Klaus (Class of 2024)

Invited Faculty Panelist, American Medical Association: “Preparing for the 2022 Match for AMA Members: Finalizing your ERAS Application” (>600 registrants) 8/18/2021

Residency/Residents

Faculty Journal Club Director 01/2016 – 10/2016
 Emergency Medicine Residency
 University of Missouri-Columbia

Faculty Co-Director, Evidence-Based Medicine (EBM) Rotation 07/2016 – 10/2016
Emergency Medicine Residency
University of Missouri-Columbia

Clinical Competency Committee (CCC) 07/2016 – 10/2016
Emergency Medicine Residency
University of Missouri-Columbia

Group Facilitator, Geisinger Bioethics Symposium 03/26/2019
“Professionalism: Eliciting and Respecting Patients’ Goals and Values”
Geisinger Health System

Graduate Students 03/2016 – 10/2016

PhD Committee Member, Benjamin Coe, RN
Sinclair School of Nursing, University of Missouri-Columbia

Classroom Instruction

Faculty, Central Line Course for new residents and fellows 07/2011, 06/2013
Lehigh Valley Health Network (LVHN), Division of Education, Allentown, PA

Faculty, “Introduction to Clerkship” for 3rd Year Medical Students from 5/8-9/2014
University of South Florida/LVHN SELECT program (Scholarly Excellence, Leadership
Experiences, Collaborative Training)

Head Graduate Teaching Assistant (TA) and Course Coordinator MPH Graduate Program, Johns Hopkins
Bloomberg School of Public Health, Baltimore, MD
Environmental & Occupational Health Law & Policy (180.628) 01/2010 – 05/2010
Alcohol & Health (301.657) 01/2006 – 05/2006
Problem Solving in Public Health (550.608) 01/2006 – 01/2008
(supervision of approximately 15 TAs per term)

Residency Lectures (Grand Rounds and Didactic Conferences)

“Diseases of the Premature Infant.” Lehigh Valley Health Network, Department of Emergency Medicine.
Bethlehem, Pennsylvania. March 28, 2013.

“Resident as teacher.” (co-presenter with Amy Smith, PhD) Grand Rounds, Lehigh Valley Health Network,
Department of Emergency Medicine June 27, 2013.

“Community-Acquired Pneumonia for the Emergency Physician.” Lehigh Valley Health Network,
Department of Emergency Medicine. Bethlehem, PA. March 13, 2014.

“It’s Not a Stroke: Non-Stroke Neurology” University of Pittsburgh, Emergency Medicine Residency,
Pittsburgh, PA. February 12, 2015.

“Community-Acquired Pneumonia” University of Missouri-Columbia, Emergency Medicine Residency,
Columbia, MO. November 12, 2015.

“Papers that changed my practice” (Contributor) University of Missouri-Columbia, Emergency Medicine
Residency, Columbia, MO. December 3, 2015.

Simulation Day, “Stroke,” University of Missouri-Columbia Emergency Medicine, Columbia, MO. December
17, 2015.

“Cognitive Errors” University of Missouri-Columbia, Emergency Medicine Residency, Columbia, MO.
January 7, 2016.

“Visual Diagnosis” University of Missouri-Columbia, Emergency Medicine Residency, Columbia, MO. February 18, 2016.

“Research Ethics 101” University of Missouri-Columbia, Emergency Medicine Residency, Columbia, MO. March 3, 2016.

Oral Board Review Mock Cases, University of Missouri-Columbia, Emergency Medicine Residency, Columbia, MO. March 24, 2016.

“Research Study Designs” University of Missouri-Columbia, Emergency Medicine Residency, Columbia, MO. March 31, 2016.

“Errors in Research” University of Missouri-Columbia, Emergency Medicine Residency, Columbia, MO. April 7, 2016.

“Understanding and Translating Risk” University of Missouri-Columbia, Emergency Medicine Residency, Columbia, MO. May 5, 2016.

“Cognitive Errors” University of Missouri-Columbia, Emergency Medicine Residency (PGY-I “Boot Camp” Orientation), Columbia, MO. July 22, 2016

“HIV Testing in the ED” Wellspan York Hospital, Emergency Medicine Residency, Grand Rounds Invited Guest Lecturer, York, PA. September 27, 2016.

“Shared decision-making in the ED” Wellspan York Hospital, Emergency Medicine Residency, Grand Rounds Invited Guest Lecturer, York, PA. September 27, 2016.

“Presentations and Publications” University of Missouri-Columbia, Emergency Medicine Residency, Columbia, MO. July 21, 2016; Geisinger Emergency Medicine Residency. September 18, 2017

“Endocarditis” Oral Board based review. Geisinger Emergency Medicine Residency. Danville, PA. October 3, 2017.

Simulation Day, “Emergency Cardiac Pacing in Lyme Disease,” Geisinger Emergency Medicine Residency. Danville, PA. October 17, 2017.

“Endocrine Emergencies: Thyroid Storm and Myxedema Coma” Oral Board based review. Geisinger Emergency Medicine Residency. Danville, PA. October 24, 2017.

“Oncologic Emergencies” Geisinger Emergency Medicine Residency. Danville, PA. December 12, 2017.

“Sexually Transmitted Infections: Emergency Department Perspectives” Geisinger Emergency Medicine Residency. Danville, PA. March 6, 2018; July 9, 2019; January 12, 2021; August 2, 2022

“Tick-Borne Illnesses” Geisinger Emergency Medicine Residency. Danville, PA. March 6, 2018; February 6, 2021; August 9, 2022.

“Initial Approach to Trauma” Geisinger Emergency Medicine Residency. Danville, PA. April 10, 2018.

“Basic Approach to Wound Management” PGY-1 Orientation, Geisinger Emergency Medicine Residency. Danville, PA. July 6, 2018.

“Approach to Abdominal Pain” PGY-1 Orientation, Geisinger Emergency Medicine Residency. Danville, PA. July 6, 2018.

“Shared decision-making” Kingman Regional Medical Center Emergency Medicine Residency. Kingman, AZ. September 27, 2018.

“Sexually Transmitted Infections: Emergency Medicine Perspective” Kingman Regional Medical Center Emergency Medicine Residency. Kingman, AZ. September 27, 2018.

“Introduction to ACEP and Professional Advocacy” Kingman Regional Medical Center Emergency Medicine Residency. Kingman, AZ. September 27, 2018.

“Why Research is Important” Fundamentals of Research Course: Geisinger Graduate Medical Education: 2018-19 Academic Year Curriculum and Faculty Development. October 11, 2018.

“Practice changing articles of 2018.” Geisinger Emergency Medicine Residency. Danville, PA. April 30, 2019.

“LVADs.” Geisinger Emergency Medicine Residency. Danville, PA. July 2, 2019.

“Sexually Transmitted Infections.” Geisinger Emergency Medicine Residency. Danville, PA. July 9, 2019.

“Cultural Competency.” Geisinger Emergency Medicine Residency. Danville, PA. July 16, 2019; August 2, 2022.

“Acid-base disturbances.” Geisinger Emergency Medicine Residency. Danville, PA. July 23, 2019; August 2, 2022.

“Pain Management in the ED.” (PGY-I orientation lecture) Geisinger Emergency Medicine Residency. Danville, PA July 25, 2019.

“Local anesthetics.” Geisinger Emergency Medicine Residency. Danville, PA. August 13, 2019; February 9, 2021; August 9, 2022.

“Advocacy through professional organizations.” Geisinger Emergency Medicine Residency. Danville, PA. October 8, 2019; March 16, 2021; September 6, 2022.

“Biological Warfare Agents.” Geisinger Emergency Medicine Residency. Danville, PA. November 5, 2019; May 4, 2021; October 25, 2022.

“HIV: An Emergency Medicine Perspective.” Geisinger Emergency Medicine Residency. Danville, PA. December 10, 2019; July 6, 2021; December 20, 2022

“Breaking Bad News/Crucial Conversations.” Geisinger Emergency Medicine Residency. Danville, PA. December 17, 2019.

“Diseases of the Mouth.” Geisinger Emergency Medicine Residency. Danville, PA. January 14, 2020; August 17, 2021.

“Ethics in Emergency Medicine.” Geisinger Emergency Medicine Residency. Danville, PA. January 14, 2020; July 20, 2021

“Interpersonal violence and abuse.” Geisinger Emergency Medicine Residency. Danville, PA. January 14, 2020; July 6, 2021; December 20, 2022.

“Thermal burns.” Geisinger Emergency Medicine Residency. Danville, PA. January 14, 2020; August 3, 2021.

"Post-surgical Complications: Bariatric surgery and Ostomies." Geisinger Emergency Medicine Residency. Danville, PA. January 28, 2020; August 17, 2021.

"EMTALA." Geisinger Emergency Medicine Residency. Danville, PA. February 12, 2020; August 17, 2021.

"Evolving Trends in Healthcare Delivery." Geisinger Emergency Medicine Residency. Danville, PA. February 12, 2020; August 17, 2021.

"Evolving Trends in Healthcare Delivery." Lehigh Valley Health Network, Emergency Medicine Residency. Bethlehem, PA. March 5, 2020.

"Spinal Cord Injury." Geisinger Emergency Medicine Residency. Danville, PA. February 18, 2020; February 8, 2022.

"Nerve Agents." Geisinger Emergency Medicine Residency. Danville, PA. February 18, 2020; February 8, 2022.

"Clinical Practice Guidelines." Geisinger Emergency Medicine Residency. Danville, PA. March 3, 2020, September 21, 2021.

"Translating Risk." Geisinger Emergency Medicine Residency. Danville, PA. March 3, 2020, September 21, 2021.

"EMTALA." Lehigh Valley Health Network, Emergency Medicine Residency. Bethlehem, PA. March 5, 2020.

"Neck Trauma." Geisinger Emergency Medicine Residency. Danville, PA. March 24, 2020; October 12, 2021.

"Approach to Abdominal Pain." Geisinger Emergency Medicine Residency. Danville, PA. March 24, 2020; October 12, 2021.

"Medication-Induced Immunosuppression." Geisinger Emergency Medicine Residency. Danville, PA. April 7, 2020.

"Complications of Renal Dialysis." Geisinger Emergency Medicine Residency. Danville, PA. April 21, 2020; November 23, 2021.

"Anticoagulants and Antithrombotic Agents." Geisinger Emergency Medicine Residency. Danville, PA. May 5, 2020; December 7, 2021.

"Contracts and Practice Models." Geisinger Emergency Medicine Residency. Danville, PA. May 5, 2020; December 7, 2021.

"Dementia." Geisinger Emergency Medicine Residency. Danville, PA. June 2, 2020; January 11, 2022.

"Arboviruses." Geisinger Emergency Medicine Residency. Danville, PA. July 7, 2020; February 1, 2022.

"Structural disorders of the GI Tract." Geisinger Emergency Medicine Residency. Danville, PA. July 7, 2020; January 11, 2022.

"Pain Management in the ED." Geisinger Emergency Medicine Residency. Danville, PA. July 10, 2020.

"Oropharynx/Throat Infections." Geisinger Emergency Medicine Residency. Danville, PA. July 28, 2020.

“Privacy and Confidentiality.” Geisinger Emergency Medicine Residency. Danville, PA. August 11, 2020; May 17, 2022.

“Inflammatory and Infectious Disorders of Anus and Rectum.” Geisinger Emergency Medicine Residency. Danville, PA. August 18, 2020; April 26, 2022.

“Oncologic Emergencies.” Geisinger Emergency Medicine Residency. Danville, PA. August 25, 2020; April 26, 2022.

“Synthetic Cannabinoids.” Geisinger Emergency Medicine Residency. Danville, PA. October 13, 2020; May 17, 2022.

“CNS Tumors.” Geisinger Emergency Medicine Residency. Danville, PA. October 13, 2020; April 26, 2022.

“Hydrocephalus.” Geisinger Emergency Medicine Residency. Danville, PA. October 20, 2020, March 22, 2022.

“HTN.” Geisinger Emergency Medicine Residency. Danville, PA. October 20, 2020; May 31, 2022.

“Liver Tumors.” Geisinger Emergency Medicine Residency. Danville, PA. November 3, 2020; February 1, 2022.

“Ophthalmologic Trauma” Geisinger Emergency Medicine Residency. Danville, PA. November 10, 2020; July 20, 2021.

“Emerging Infections and Pandemics” Geisinger Emergency Medicine Residency. Danville, PA. December 1, 2020.

“Lithium” Geisinger Emergency Medicine Residency. Danville, PA. December 8, 2020; May 31, 2022.

“Reimbursement Issues in Emergency Medicine” Geisinger Emergency Medicine Residency. Danville, PA. April 20, 2021; October 11, 2022.

“Practice Changing Articles, 2020” Geisinger Emergency Medicine Residency. Danville, PA. May 4, 2021.

“Practice Changing Articles, 2021” Geisinger Emergency Medicine Residency. Danville, PA. October 25, 2022.

“Social Determinants of Health” Geisinger Emergency Medicine Residency. Danville, PA. May 18, 2021; November 1, 2022.

“Gender Identity and Sexual Orientation” Geisinger Emergency Medicine Residency. Danville, PA. May 18, 2021; November 1, 2022.

“External Quality Metrics” Geisinger Emergency Medicine Residency. Danville, PA. May 25, 2021; November 8, 2022.

Clinical Instruction/Bedside Teaching

Attending Physician in Emergency Department (Clarion Hospital, Clarion, PA) 11/2014 – 05/2015
Bedside instruction to medical students, family medicine residents (Lake Erie COM)

Attending Physician in Emergency Department (University of Missouri-Columbia) 01/2016 – 11/2016
Bedside instruction to medical students, emergency medicine, orthopedic, family medicine, internal medicine, and pediatric residents and emergency medicine physician assistant fellows

Faculty Preceptor, Ambulatory Care Experience (University of Missouri-Columbia) 01/2016 – 10/2016
Mentor 1st year medical students in clinical introduction to emergency medicine

OTHER CLINICAL POSITIONS AND EMPLOYMENT

Emergency Medicine Staff Privileges

| | |
|---|-------------------|
| Geisinger Health System | 08/2017 – present |
| Geisinger Medical Center, Danville, PA (Level 1 trauma, regional referral center with EM Residency) | |
| Geisinger Wyoming Valley, Plains Township, PA (Level 2 trauma center) | |
| Geisinger Shamokin Area Community Hospital, Coal Township, PA | |
| Geisinger Bloomsburg Community Hospital, Bloomsburg, PA | |
| System Triage Officer, Patient Placement/Transfer Center | 06/2019 – present |
| (Includes telehealth and mobile community paramedic command physician) | |
| University Medical Center (UMC) (Lubbock, TX) | 09/2016 – present |
| Teaching Hospital for Texas Tech University SOM | (prn staff) |
| 412 bed, urban (county-operated) Level 1 trauma and burn center for West Texas, Eastern New Mexico, ~85,000 ED visits | |
| Geisinger Holy Spirit (Camp Hill, PA) | 08/2017 – 11/2020 |
| (now Penn State Health, Holy Spirit Med Ctr), Level 2 Trauma center ~50,000 ED visits | |
| Wellspan Health, York Hospital (York, PA) | 04/2017 – 01/2019 |
| 550 bed, suburban Level 1 trauma center with EM residency, ~70,000 ED visits | |
| ERNow Freestanding Emergency Center (Amarillo, TX) | 12/2016 – 09/2017 |
| Panhandle Emergency Physicians | |
| ExcelER Freestanding Emergency Center (Odessa, TX) | 08/2016 – 02/2017 |
| Staff Care, Inc. | |
| University of Missouri-Columbia (Columbia, MO) | 01/2016 – 10/2016 |
| Teaching Hospital for University of Missouri-Columbia SOM | |
| Level 1 trauma center with regional referral and burn center with EM residency, ~45,000 ED visits | |
| Women's and Children's Hospital, Specialty pediatric and women's hospital | |
| Medical Leave of Absence from clinical activities | 05/2015 – 12/2015 |
| Clarion Hospital (Clarion, PA) | |
| Emergency Resource Management, Inc. | 11/2014 – 05/2015 |
| (ERMI was affiliate of University of Pittsburgh Medical Center) | |
| 80 bed, rural hospital ~18,000 ED visits | |
| Elk Regional Health System (now Penn Highlands – Elk) (St. Marys, PA) | |
| Hospital-employed | 06/2013 – 02/2014 |
| Schumacher Group employed | 02/2014 – 09/2014 |
| 80 bed, rural hospital; 18,000 ED visits | |
| Sacred Heart Hospital (Allentown, PA) | 08/2013 – 03/2015 |
| 215-bed urban hospital, ~32,000 ED visits | |

| | |
|---|-------------------|
| Blue Mountain Health System (Lehigh, PA) 110-bed rural hospital, ~19,000 ED visits | 09/2013 – 09/2014 |
| Lehigh Valley Health Network (LVHN) LVHN-Cedar Crest (Allentown, PA) 800-bed Level I trauma and burn center, ~70,000 ED visits LVHN-Muhlenberg (Bethlehem, PA) 180-bed suburban hospital, ~60,000 ED visits | 10/2013 – 06/2014 |
| Chief Medical Officer (hospital level) Penn Highlands Healthcare System – Elk Campus Saint Marys, PA 15857 (Position eliminated by health system) | 07/2014 – 09/2014 |
| Tuberculosis Physician Pennsylvania Department of Health Bureau of Community Health Systems, Northwest District Office (Saint Marys, PA) | 08/2014 – 08/2015 |
| Resident EMS Medical Director Multiple EMS Agencies Lehigh Valley International Airport EMS (Lehigh County, PA) Trappe Fire and EMS (Montgomery County, PA) Upper Perkiomen Valley Ambulance (Montgomery County, PA) Bally EMS (Berks County, PA) | 06/2012 – 06/2014 |
| Research Coordinator/Program Manager Department of Emergency Medicine Johns Hopkins University Baltimore, MD Work in all phases of research projects, supervise research assistants | 2002 – 2007 |

HONORS AND AWARDS

| | |
|---|------------------|
| Teacher of the Year, Geisinger Emergency Medicine Residency | 2019 |
| Service Award (for Advancing Patient Care in West Texas), Lubbock, Crosby, Garza County Medical Society | 2017 |
| Outstanding Resident Research Award, Lehigh Valley Health Network, Department of Emergency Medicine | 2014 |
| John C. Hume Doctoral Award (\$2,900), Johns Hopkins School of Public Health (awarded to Health Policy and Management student who shows great potential in the field of public health) | 2010 – 2011 |
| Featured as Alumni Success Story: <i>Successful Young Professionals Who Use Writing in Their Careers</i> (Saint Marys, PA Catholic School System) | 09/2010 |
| Polyprobe Scholarship (\$4,000) Philadelphia College of Osteopathic Medicine (awarded to one medical student for research excellence) | 2008 – 2009 |
| Medal of Excellence, Top Graduate in Political Science, Loyola College | 05/2001 |
| Invocation Speaker, 149 th Commencement Ceremonies, Loyola College | 05/2001 |
| Distinguished Essay Award, Loyola College Catholic Studies Program | 11/2000 |
| Pi Sigma Alpha, Political Science Honor Society | selected 05/1999 |
| Eta Sigma Pi, Honor Society in Latin and Greek | selected 05/1999 |
| Distinguished Essay Award, Loyola College History Department | 11/1999 |
| Men's Varsity Basketball Letterwinner, Case Western Reserve University (NCAA Division III) 1996 – 1998 | |

INSTITUTIONAL ADMINISTRATIVE APPOINTMENTS AND ACTIVITIES

| | |
|---|-------------------|
| Geisinger Health System / Geisinger Medical Center / Geisinger College of Health Sciences Institute of Medicine, Clinic Research Fund Advisory Group | 07/2022 – present |
|---|-------------------|

| | |
|---|-------------------|
| Chair, Geisinger Emergency Medicine Research Committee | 08/2017 – present |
| Physician Champion, Geisinger Medical Center emPATH (Emergency Psychiatric Assessment, Treatment, Healing) unit | 05/2022 – present |
| Physician Champion, Geisinger Emergency Medicine HIV Program | 08/2021 – present |
| Geisinger Graduate Medical Education (GME) Research Steering Committee | 01/2022 – present |
| ProvenCare Pneumonia Clinical Policy workgroup Transitions of Care Subgroup | 01/2021 – present |
| Internal Clinical Advisor, Steele Institute, Behavioral Insights Team | 01/2020 – present |
| Asthma Steering Committee | 06/2021 – present |
| Institutional Review Board (IRB) | 07/2019 – present |
| Scientific Review Committee (SRC) | 07/2019 – present |
| Academic Promotion and Tenure Committee | 07/2022 – present |
| Medical Officer of the Day (MOD): physician resource officer | 07/2018 – 07/2020 |
| Opioid Workgroup | 04/2018 – 12/2019 |
| Hospital Ethics Committee, Geisinger Medical Center | 03/2019 – 09/2021 |
| COVID-19 Research Oversight Committee | 04/2020 – 03/2022 |
| University of Missouri – Columbia | |
| Hospital Anticoagulation Task Force | 01/2016 – 10/2016 |
| Lehigh Valley Health Network | |
| Resident Representative, ACGME CLER (Clinical Learning Environment Review) site visit to LVHN | 02/18/2014 |
| Drexel School of Public Health | 09/2003 |
| Member, Council on Education for Public Health (CEPH) Accreditation Self-Study Committee, Drexel School of Public Health (Appointed by Dean Marla Gold, MD) | |
| Philadelphia College of Osteopathic Medicine | |
| Member, Medical School Admissions Committee | 08/2008 – 05/2010 |
| Emergency Department Administrative Appointments | |
| Department of Emergency Medicine, University of Missouri-Columbia | |
| Peer-Review/Quality Improvement Committee | 12/2015 – 10/2016 |
| Chair, Research Committee | 12/2015 – 10/2016 |
| Pain Policy Task Force (wrote pain management guidelines) | 02/2016 – 10/2016 |
| Alpha Sigma Nu (National Jesuit Honor Society), Milwaukee, WI | 1999 – present |
| Vice President, Board of Directors | 10/2006 – 10/2009 |
| Director, Board of Directors | 10/2000 – 10/2009 |
| Member, Bylaws Committee, Alpha Sigma Nu Board of Directors | 10/2006 – 10/2009 |
| Chairman, Nominations Committee, Alpha Sigma Nu Board of Directors | 10/2003 – 10/2009 |
| Founding President, Baltimore, MD Alumni Club | |

COMMUNITY SERVICE

| | |
|---|-------------|
| Volunteer Head Youth Basketball Coach. Lewisburg, PA | 2019 – 2022 |
| Volunteer Head and Assistant Little League Coach. Lewisburg, PA | 2018 – 2021 |
| First Aid Presentation, Boy Scouts of America, Pack 3538, Lewisburg, PA | 11/5/19 |
| Counselor for Medicine Merit Badge University Boy Scouts of America, Great Rivers Council (Missouri) | 2016 |

2023 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Abhi Mehrotra, MD, MBA, FACEP

Question #1: How can ACEP optimize its financial resources to ensure future stability?

To optimize its financial resources and ensure future stability, ACEP can implement several strategies:

- **Diversify Revenue Streams:** ACEP should explore and develop multiple sources of revenue beyond membership dues and meetings. This can include partnerships with industry stakeholders, sponsorships, and grants. Further expansion of the accreditation business line should be prioritized. By diversifying revenue streams, ACEP can reduce its reliance on a single source and enhance its financial stability.
- **Improve Membership Retention and Recruitment:** ACEP should continue to prioritize efforts to retain existing members and attract new ones. This can be achieved through work already underway (reimagining meeting structure and content) as well as new initiatives (EMDI). By continuously demonstrating the value of membership, ACEP can maintain a strong and engaged membership base, which in turn supports financial stability.
- **Embrace Technology and Digital Transformation:** Leveraging technology can enhance efficiency and cost-effectiveness for ACEP. Investing in digital platforms for communication, education, and event management can reduce operational costs and expand reach.
- **Foster Collaborations and Partnerships:** ACEP should actively seek collaborations and partnerships with other organizations, both within and outside of the healthcare sector. The development of EMDI facilitates these collaborative opportunities.
- **Invest in Professional Development and Leadership:** ACEP should prioritize investments in the professional development of its staff and leaders. By providing training, mentorship, and resources, ACEP can build a strong team capable of effective financial management and strategic decision-making.

By implementing these strategies, ACEP can optimize its financial resources, diversify revenue streams, and enhance its long-term stability. These efforts will enable ACEP to continue its mission of advocating for emergency physicians and supporting the advancement of emergency medicine.

Question #2: Describe how your election to the Board of Directors would enhance ACEP's ability to speak for and represent all emergency physicians.

As a member of the Board, I would bring a diverse range of experiences, perspectives, and insights that would ensure our organization truly represents the entirety of the emergency medicine community.

First and foremost, I am clinically active and understand the challenges and realities faced by emergency physicians on a day-to-day basis. Through my years of practice and engagement with the hospital and healthcare system, I have witnessed firsthand the unique issues and concerns that arise in our practice. This firsthand knowledge will enable me to advocate effectively for the interests and needs of emergency physicians across different practice settings and demographics.

Furthermore, I have a deep commitment to fostering inclusivity and diversity within our specialty. I recognize that emergency medicine is comprised of professionals from diverse backgrounds, with varying levels of experience, and with unique perspectives on the specialty. If elected, I would actively seek out and promote opportunities for underrepresented groups within our specialty to ensure that their voices are heard and their needs are addressed. By actively working to include all emergency physicians in our decision-making processes, we can create a more robust and representative organization.

Collaboration is also one of my core strengths. I firmly believe in the power of teamwork and effective communication to achieve our collective goals. If elected, I would actively engage with emergency physicians from all regions and practice settings, ensuring that their concerns and viewpoints are brought to the forefront. By actively listening and facilitating

constructive dialogue, I would strive to create a sense of unity and cohesion within our organization and specialty. This collaborative approach would enable ACEP to speak with a stronger and more unified voice on behalf of all emergency physicians.

In conclusion, my election to the Board of Directors would significantly enhance ACEP's ability to speak for and represent all emergency physicians. With my understanding of the challenges faced by emergency physicians, my commitment to inclusivity and diversity, and my collaborative approach, I am confident in my ability to contribute to ACEP's mission of advocating for the entire emergency medicine community and appreciate your vote to serve in this role.

Question #3: From your perspective, what would you do to ensure that emergency medicine remains an attractive specialty?

To ensure that emergency medicine remains an attractive specialty, several strategies can be implemented. First, it is important that we acknowledge and address the current challenges faced by our specialty. These include factors like the No Surprises Act, workforce shortages, hospital capacity concerns, and scope of practice. By recognizing these issues, we can work towards finding solutions that improve our practice environment and make emergency medicine more appealing.

One way to refocus on the joy of medicine is by emphasizing the sanctity of the physician-patient relationship. This core aspect of EM can bring fulfillment to emergency physicians and remind us of the meaningful impact we have on patients' lives. By nurturing this relationship, we can reignite the passion and sense of purpose of why we chose this specialty.

Advocacy efforts should continue to address issues like the No Surprises Act (NSA) and other regulatory barriers that affect emergency medicine, ensuring that we continue to highlight workplace violence, boarding, and behavioral health resource constraints. By actively engaging in advocacy, we can influence policy decisions that positively impact our specialty and create a more favorable working environment.

While projecting the future workforce is important, it is crucial that we acknowledge the uncertainties associated with such predictions. It is essential to adapt recommendations to the current situation, considering factors such as changing demographics, covid effects, technological advancements, and evolving healthcare delivery models. By remaining flexible and open to change, we can better address the needs of our colleagues and patients, and ensure the specialty remains attractive.

The ACEP should rededicate itself to the well-being and development of emergency physicians. This can be achieved through expanding the ongoing efforts, such as consultation services and providing support at each career stage – residency, early practice, mid-career, and exploring retirement. By offering guidance and resources, ACEP can help emergency physicians navigate our professional journeys, enhancing job satisfaction and retention.

As healthcare delivery evolves, it is important to emphasize the core of emergency medicine, which is acute and unscheduled care. No one else does this better than we do! Collaborating with thought leaders in areas such as telehealth, clinical decision support, and emergency preparedness can provide new opportunities for emergency physicians. By actively participating in these emerging fields, emergency medicine can continue to grow and remain relevant in the changing healthcare landscape.

Ultimately, our focus should be on what is best for both emergency physicians and the specialty itself. ACEP should prioritize initiatives that support the well-being and satisfaction of emergency physicians and physician-led teams. Students and residents need to see the enthusiasm and enjoyment within the specialty, which can help attract the next generation of emergency physicians. By showcasing the rewards and fulfillment of emergency medicine, we can ensure its attractiveness as a specialty for years to come.

CANDIDATE DATA SHEET

Abhi Mehrotra, MD, MBA, FACEP

Contact Information

117 Sagerview Way
Durham, NC. 27713

Phone: 919-672-0396

E-Mail: Abhi@med.unc.edu

Current and Past Professional Position(s)

| | | |
|------------------------------|--|----------------|
| University of North Carolina | Assistant Prof. of Emergency Medicine | 2003 – 2013 |
| University of North Carolina | Assistant Residency Director | 2005 – 2007 |
| University of North Carolina | Associate Residency Director | 2007 – 2010 |
| University of North Carolina | Assistant Medical Director | 2004 – 2020 |
| University of North Carolina | Associate Prof. of Emergency Medicine | 2013 – 2019 |
| University of North Carolina | Medical Director, Hillsborough Campus | 2015 – 2020 |
| University of North Carolina | Dept. of EM, Vice Chair - Operations | 2015 – Present |
| University of North Carolina | System Emergency Service Co-lead | 2018 – Present |
| University of North Carolina | Professor of Emergency Medicine | 2019 – Present |
| University of North Carolina | Adjunct Professor, Kenan Flagler Business School | 2021 – Present |

Education (include internships and residency information)

| | | |
|------------------------------|------------------------------|-------------|
| M.B.A. | University of North Carolina | 2014 – 2015 |
| Emergency Medicine Residency | University of North Carolina | 2000 – 2003 |
| M.D. | The Ohio State University | 1996 – 2000 |
| B.A. (Chemistry) | The Ohio State University | 1992 – 1996 |

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

Diplomate, American Board of Emergency Medicine – 2004, Renewal 2014

Professional Societies

American College of Emergency Physicians
North Carolina College of Emergency Physicians
Society for Academic Emergency Medicine
Emergency Medicine Residents' Association
American Medical Association
North Carolina Medical Society

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Abhi Mehrotra, MD, MBA, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: University of North Carolina at Chapel Hill

Address: 103 South Building, Campus Box 9100

Chapel Hill, NC 27599

Position Held: Attending Physician

Type of Organization: University

Employer: MedScribes, Inc.

Address: 6409 Fayetteville Rd., Suite 120-346

Durham, NC 27713

Position Held: CEO

Type of Organization: Medical scribe services

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: North Carolina College of Emergency Physicians

Address: PO Box 1038

Wake Forest, NC 27588

Type of Organization: State Chapter of ACEP

Leadership Position: Board of Directors

Term of Service: 2010 – 2016

Organization: Emergency Medicine Residents Association (EMRA)

Address: 4950 W. Royal Lane

Irving, TX. 75063

Type of Organization: Not-for-profit organization representing Emergency Medicine Residents and Medical Students with a career interest in Emergency Medicine

Leadership Position: Board of Directors

Term of Service: 2000 - 2002

Organization: University of North Carolina Faculty Physicians

Address: 145 Medical Drive, Suite 400

Chapel Hill, NC 27599

Type of Organization: Faculty group practice plan

Leadership Position: Board of Directors

Term of Service: 2017 – 2020

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: Co-founder and CEO of a medical scribe company

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.

Abhishek Mehrotra

Date

June 20, 2023



August 15, 2023

ACEP Council

Re: Endorsement of Abhi Mehrotra, MD, MBA, FACEP

Dear ACEP Council:

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.ncecp.org>

A chapter of the



American College of
Emergency Physicians

It is with great enthusiasm and conviction that we endorse Abhi Mehrotra, MD, MBA, FACEP as a candidate for the ACEP Board of Directors. His unwavering dedication to advancing emergency medicine and his exceptional leadership qualities make him a standout candidate who will undoubtedly contribute significantly to ACEP's mission.

Dr. Mehrotra's exceptional track record of leadership and service within the North Carolina College of Emergency Physicians (NCCEP) is a testament to his passion for our specialty. As a pivotal figure in our chapter, he has consistently demonstrated a keen understanding of the challenges and opportunities that emergency physicians encounter. His commitment to nurturing a collaborative environment and fostering innovation has left a lasting impact on our community.

Beyond his local involvement, Dr. Mehrotra's engagement on the national level exemplifies his commitment to enhancing emergency medicine. His active participation in ACEP committees, his contribution to educational initiatives, and his dedication to advocacy underscore his comprehensive approach to advancing our field. His unique ability to bridge local and national perspectives equips him to effectively represent the diverse interests of emergency physicians.

Dr. Mehrotra's professional accomplishments highlight his dedication to innovation and patient care. His work at the intersection of emergency medicine and informatics showcases his forward-thinking approach to healthcare. As an advocate for evidence-based practice, he has actively contributed to advancements that benefit both patients and practitioners. His expertise in technology and his commitment to staying at the forefront of healthcare trends are valuable assets that ACEP can leverage for the betterment of our specialty.

Moreover, Dr. Mehrotra's commitment to inclusivity and diversity is evident in his professional activities. His involvement in initiatives promoting equity in healthcare delivery reflects his dedication to addressing disparities within our specialty. By prioritizing inclusivity, Dr. Mehrotra not only embodies the values that ACEP stands for but also ensures that all voices within emergency medicine are heard and represented.

Abhi Mehrotra, MD, MBA, FACEP

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In conclusion, Dr. Abhi Mehrotra's exceptional leadership, profound dedication to our specialty, and commitment to innovation make him an outstanding candidate for the ACEP Board of Directors. His ability to inspire collaboration, advocate for evidence-based practice, and champion diversity and inclusivity are precisely the attributes that our organization needs to thrive in an ever-evolving healthcare landscape.

We are honored to extend our heartfelt endorsement for Dr. Abhi Mehrotra for the national ACEP Board of Directors. His vision and capabilities align seamlessly with ACEP's mission to represent and advocate for all emergency physicians, ensuring a prosperous future for our specialty.

Sincerely,

A handwritten signature in black ink, appearing to read "Jill Benson", with a stylized flourish at the end.

Jill Benson, MD, FACEP

President, North Carolina College of Emergency Physicians

Abhi Mehrotra, MD, MBA, FACEP

Dear Esteemed Councillors and ACEP Family,

As a passionate advocate for emergency medicine, I write to humbly request your support and vote for my candidacy for the ACEP Board of Directors. My vision is rooted in the future stability of our specialty and ensuring that every emergency physician's voice is represented within our organization.

The landscape of emergency medicine is littered with challenges. Regulatory burdens, workforce shortages, hospital capacity shortfalls, and scope of practice intrusions are among the complex issues we confront. If elected to the Board of Directors, I am committed to addressing these challenges head-on. By working together, we can collaboratively find innovative and effective solutions to enhance our practice environment and make emergency medicine a more attractive specialty.

I firmly believe that the joy of practicing medicine is a key aspect of attracting and retaining emergency physicians. The sanctity of the physician-patient relationship is at the core of our profession and brings immense fulfillment to our work. I am dedicated to nurturing this special relationship, reigniting our passion, and reinforcing the sense of purpose that inspired us to choose emergency medicine as our calling.

Advocacy efforts are a cornerstone of ACEP's mission. Tackling challenges such as the No Surprises Act and other regulatory barriers requires an informed and united voice. I am committed to ensuring that ACEP continues to advocate tirelessly for individual emergency physicians and the issues that matter to us most.

In projecting the future of our workforce, I am cognizant of the uncertainties that lie ahead. Changing demographics, enduring effects of the COVID-19 pandemic, technological advancements, and evolving healthcare delivery models demand an adaptive approach. If elected, I will champion solutions that are both responsive to our current situation and also forward-looking. By remaining flexible and open to change, we can effectively address the ever-evolving needs of our colleagues and patients.

The American College of Emergency Physicians is our collective voice, and I am dedicated to enhancing its efforts to promote the well-being of emergency physicians. Expanding consultation services and offering support at every career stage will empower us to navigate the complex, exciting, yet too often distressing journey of our chosen specialty. By providing guidance and resources, ACEP will enhance job satisfaction and retention, ensuring a brighter future for emergency physicians and the specialty as a whole.

Ultimately, my focus is on what is best for both emergency physicians and our specialty. By prioritizing initiatives that support our well-being, satisfaction, and representation, we can inspire the next generation of emergency physicians. Students and residents need to witness our enthusiasm and joy within the specialty to be drawn to its rewards and fulfillment.

I am honored to have your consideration and, if elected, I pledge to dedicate myself wholeheartedly to the advancement of ACEP's mission and the betterment of emergency physicians everywhere.

Thank you for your time, consideration, and leadership in our specialty. I humbly ask for your vote for ACEP Board of Directors.

Sincerely,

Abhi Mehrotra, MD, MBA, FACEP

Abhi Mehrotra, MD, MBA, FACEP

Endorsed by the North Carolina College of Emergency Physicians

Candidate, ACEP Board of Directors

National Leadership

- ✦ YPS Section Chair
- ✦ EMP & HP Section Chair
- ✦ CEDR Committee Chair
- ✦ Finance Committee
- ✦ HIT Committee
- ✦ EM Practice Committee
- ✦ ED Categorization TF
- ✦ Diversity & Inclusion TF
- ✦ EMRA Board of Directors

Council Service & Awards

- ✦ Steering Committee, 2000
- ✦ Steering Committee, 2008
- ✦ Reference Committees
- Chair, 2010, 2021, 2022
- ✦ Councillor 2010 - Present
- ✦ EMRA 45 Under 45
- ✦ Council Horizon Award
- ✦ Hero of Emergency
Medicine Award

Chapter Leadership

- ✦ President
- ✦ Secretary-Treasurer
- ✦ Board Member
- ✦ Councillor
- ✦ Education Committee Chair

Experience

- ✦ Vice Chair, Operations
- ✦ EM System Co-lead
- ✦ Medical Director
- ✦ Admin Fellowship Director
- ✦ Co-founder & CEO

VOTE



Abhi Mehrotra, MD, MBA, FACEP

Candidate for ACEP Board of Directors

**ABHISHEK MEHROTRA, MD, MBA, FACEP
CURRICULUM VITAE**

OFFICE ADDRESS: 170 Manning Drive, CB# 7594
Chapel Hill, NC 27599-7594
Tel (919) 843-8896
Fax (919) 966-3049
Email: Abhi@med.unc.edu

HOME ADDRESS: 117 Sagerview Way
Durham, NC 27713
Tel (919) 493-1538

CURRENT POSITION: Clinical Professor
Vice Chair, Strategic Initiatives & Operations
Department of Emergency Medicine
University of North Carolina

EDUCATION:

Professional Development

| | | |
|--|---|------------------|
| Professional Development Foundation Series | University of North Carolina SOM Chapel Hill, NC | 2018 |
| Chair Development Program | Association of Academic Chairs of Emergency Medicine | 2017 |
| Six Sigma Blue Belt | University of North Carolina Hospitals Chapel Hill, NC | 2010 |
| Six Sigma Yellow Belt | University of North Carolina Hospitals Chapel Hill, NC | 2009 |
| Team STEPPS Coach | University of North Carolina Hospitals Chapel Hill, NC | 2009 |
| ACEP Medical Director's Academy Phase I, II, III | American College of Emergency Physicians Dallas, TX | 2005, 2007, 2008 |
| EMF/ACEP Research Skills Course | American College of Emergency Physicians Dallas, TX | 2007 |

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|---------------------------------|--|------|
| EMF/ACEP Teaching Fellowship | American College of Emergency Physicians Dallas, TX | 2005 |
|---------------------------------|--|------|

Postgraduate

| | | |
|---------------------------------|---|-------------|
| Emergency Medicine Residency | University of North Carolina Hospitals Chapel Hill, NC | 2000 – 2003 |
|---------------------------------|---|-------------|

Graduate

| | | |
|--------|--|-------------|
| M.B.A. | The University of North Carolina Kenan-Flagler Business School Chapel Hill, NC | 2014 – 2015 |
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|------|--|-------------|
| M.D. | The Ohio State University College of Medicine and Public Health Columbus, OH | 1996 – 2000 |
|------|--|-------------|

Undergraduate

| | | |
|--|---|-------------|
| B.A. (Chemistry) Honors in the Liberal Arts | The Ohio State University Columbus, OH | 1992 – 1996 |
|--|---|-------------|

MEDICAL LICENSURE: North Carolina #2003-00383

BOARD CERTIFICATION: Diplomate, American Board of Emergency Medicine
2004, Renewal 2014

ACADEMIC & RESEARCH POSITIONS:

| | |
|--|----------------|
| Adjunct Professor, Kenan-Flagler Business School University of North Carolina Chapel Hill, NC | 2021 – Present |
| Clinical Professor, Department of Emergency Medicine University of North Carolina Chapel Hill, NC | 2019 – Present |
| Clinical Associate Professor, Department of Emergency Medicine University of North Carolina Chapel Hill, NC | 2013 – 2019 |
| Vice Chair, Strategic Operations, Dept. of Emergency Medicine University of North Carolina Chapel Hill, NC | 2015 – Present |
| Medical Director, Hillsborough Campus, Dept. of Emergency Medicine University of North Carolina Chapel Hill, NC | 2015 – 2020 |
| Assistant Medical Director, Medical Center, Dept. of Emergency Medicine University of North Carolina Chapel Hill, NC | 2004 – 2020 |
| Chief, Division of Quality & Performance, Dept. of Emergency Medicine University of North Carolina Chapel Hill, NC | 2010 – 2015 |
| Associate Residency Director, Department of Emergency Medicine University of North Carolina Chapel Hill, NC | 2007 – 2010 |
| Assistant Residency Director, Department of Emergency Medicine University of North Carolina Chapel Hill, NC | 2005 – 2007 |
| Clinical Assistant Professor, Department of Emergency Medicine University of North Carolina Chapel Hill, NC | 2003 – 2013 |
| Chief Resident, Department of Emergency Medicine University of North Carolina, Chapel Hill, NC | 2002 – 2003 |

| | |
|---|------------------|
| Research Assistant, Quality & Operations Improvement Department The Ohio State University Medical Center Columbus, OH | 1999 – 2000 |
| Research Assistant, NHLBI National Institutes of Health, NHLBI Bethesda, MD | 1994, 1995, 1997 |

HONORS AND AWARDS:

| | |
|---|----------------|
| Emergency Medicine Resident’s Association 45 Under 45 Awarded to recognize influencers in the field of Emergency Medicine | 2019 |
| UNC School of Medicine Academy of Educators Fellow Awarded in recognition of excellence in teaching | 2017 – Present |
| UNC School of Medicine ACCLAIM Fellow Leadership development program | 2015 – 2016 |
| Beta Gamma Sigma International Honor Society for Collegiate Schools of Business | 2015 |
| Poets & Quants for Executives Class of 2015 – The Best Executive MBAs Awarded by Poets & Quants based upon nominations from across the country | 2015 |
| Council Horizon Award American College of Emergency Physicians (ACEP) Awarded by the ACEP Council to a member who displays leadership potential | 2010 |
| Hero of Emergency Medicine ACEP Awarded by ACEP in recognition of contribution to the specialty | 2009 |
| Renaissance Award UNC Department of Emergency Medicine Awarded by the EM Residents to an attending exemplifying balance of professional & personal life | 2006, 2008 |
| Fellow, American College of Emergency Physicians ACEP | 2006 |
| Distinguished Fellow, EMF / ACEP Teaching Fellowship ACEP | 2004 |

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|--|------|
| Robert J. Doherty EMF / ACEP Teaching Fellowship Scholarship ACEP | 2004 |
| Most Helpful Resident Award UNC Hospitals' Nursing Staff | 2003 |
| Chief Resident UNC Department of Emergency Medicine | 2002 |
| Sphinx Senior Class Honorary The Ohio State University | 1995 |
| Bucket & Dipper Junior Class Honorary The Ohio State University | 1994 |

PUBLICATIONS:

A) Book Chapters

- 1) Mehrotra A. Behavioral Health in Emergency Care, in Strauss R, Mayer T (editors), ED Management, 2nd Edition, (American College of Emergency Physicians) 50, 2021.
- 2) Glickman S, **Mehrotra A.** Using Data on Patient Experience to Improve Clinical Care, in Wiler J, Pines J, Ward M (editors), Value and Quality Innovations in Acute and Emergency Care, (Cambridge University Press) 178, 2017.
- 3) Goodman G, **Mehrotra A.** Ethical / Legal Issues, in Blok B, Cheung D, Platts-Mills T (editors), First Aid for the Emergency Medicine Boards, (McGraw Hill) 1059, 2016.
- 4) Waller N, **Mehrotra A.** Pericarditis, Myocarditis, and Endocarditis, in Mattu A, et al. (editors), Cardiovascular Emergencies, (American College of Emergency Physicians), 2014.
- 5) **Mehrotra A**, Hobgood C. Disclosure of Medical Error and Truth Telling, in Jesus J, et al. (editors), Ethical Problems in Emergency Medicine: A Discussion Based Review, (Wiley-Blackwell), 27, 2012.
- 6) **Mehrotra A.** Hematologic Emergencies, in Rivers CS (editor), Preparing for the Written Board Exam in Emergency Medicine (5th edition) (EMEE) 2006.
- 7) **Mehrotra A**, Harmondy M. Headache, in Schaidler J, et al. (editors), Rosen and Barkin's 5 Minute Emergency Medicine Consult (2nd edition) (Philadelphia; Lippincott Williams & Wilkins) 468, 2003.

B) Peer-Reviewed Manuscripts

- 1) Lin P, Argon NT, Cheng Q, Evans C, Linthicum B, Liu Yufeng, Mehrotra A, Patel M, Ziya S. Disparities in Emergency Department Prioritization and Rooming of Patients with Similar Triage Acuity Score. *Academic Emergency Medicine*, 29:11, pp 1320-1328, 2022.
- 2) Chen W, Argon NT, Borhmann T, Linthicum B, Lopiano K, **Mehrotra A**, Travers D, Ziya S. Using Hospital Admission Predictions at Triage for Improving Length-of-Stay in Emergency Departments. *Operations Research*. In Press. 2022.
- 3) Gettel CJ, Han CR, Granovsky MA, Berdahl CT, Kocher KE, **Mehrotra A**, Schuur JD, Aldeen AZ, Griffey RT, Venkatesh AK. Emergency clinician participation and performance in the CMS Merit-based Incentive Payment System. *Academic Emergency Medicine*, 29:1, pp 64-72, 2022.
- 4) Peacock WF, Baumann BM, Rivers EJ, Davis TE, Handy B, Jones C W, Hollander JE, Limkakeng AT, **Mehrotra A**, Than M, Cullen L, Ziegler A, & Dinkel-Keuthage C. Using Sex-specific Cutoffs for High-sensitivity Cardiac Troponin T to Diagnose Acute Myocardial Infarction. *Academic Emergency Medicine*, 28:4, pp 463-466, 2021.
- 5) Chen, W, Linthicum B, Argon NT, Bohrman T, Lopiano K, **Mehrotra A**, Travers D, Ziya S. The Effects of Emergency Department Crowding on Triage and Hospital Admission Decisions. *The American Journal of Emergency Medicine*. 38(4): 774-779, 2020.
- 6) Ahalt V, Argon NT, Ziya S, Strickler J, **Mehrotra A**. Comparison of Emergency Department Crowding Scores: A Discrete-Event Simulation Approach. *Health Care Management Science*. 21(1), pp. 144–155, 2018.
- 7) Peacock WF, Baumann BM, Bruton D, Davis TE, Handy B, Jones CW, Hollander JE, Limkakeng AT, **Mehrotra A**, Than M, Ziegler A, Dinkel C. Efficacy of High-Sensitivity Troponin T in Identifying Very-Low-Risk Patients With Possible Acute Coronary Syndrome. *JAMA Cardiology*. 2017.
- 8) Peacock WF, Baumann BM, Davis TE, Handy B, Jones CW, Hollander JE, Limkakeng AT, **Mehrotra A**, Than M, Dinkel C, Ziegler A. High-Sensitivity Troponin T Identifies Patients at Very Low Risk of Adverse Events. *Annals of Emergency Medicine*. Elsevier, 70(4), p. S5, 2017.

- 9) Limkakeng, AT, Carr C, **Mehrotra A**, et al. Chest Pain Care Patterns Across the Carolinas: Determining the Readiness for Widespread HEART Pathway Dissemination. *Annals of Emergency Medicine*. 70(4), p. S1, 2017.
- 10) Rebecca Bollinger Parker, Steven J. Stack, Sandra M. Schneider, Steven H. Bowman, Kerryann B. Broderick, N. Adam Brown, C. Savoy Brummer, Michelle Byers, Vidya Eswaran, Katherine L. Heilpern, Sanford H. Herman, Sheryl L. Heron, Hamad Husainy, Tiffany D. Jackson, Jay Kaplan, Dara Kass, Kevin Klauer, Linda L. Lawrence, Michael Lozano Jr., **Abhi Mehrotra**, Sonja Montgomery, Aasim I. Padela, Rebecca Parker, Sanjay Pattani, Julie A. Rispoli, Hala Sabry, Cynthia Singh, Java Tunson, Dean Wilkerson, Carole Wollard. Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians' Future Success. *Annals of Emergency Medicine*, 69:6:714-717, 2017.
- 11) Glickman SW, **Mehrotra A**, Shea CM, et al. A patient reported approach to identify medical errors and improve patient safety in the emergency department. *J Patient Saf*. 2016.
- 12) Kalich BA, Maguire JM, Campbell-Bright SL, **Mehrotra A**, Caffey T, Tulu Z, Lin FC, Carson SS. Impact of an Antibiotic-specific Sepsis Bundle on Appropriate and Timely Antibiotic Administration for Severe Sepsis in the Emergency Department. *J Emerg Med*; 50(1):79-88.e1, 2016.
- 13) Jones CW, Culbreath KD, **Mehrotra A**, Gilligan PH. Reflex Urine Culture Cancellation in the Emergency Department. *J Emerg Med*; 46(1):71-6, 2014.
- 14) Diercks DB, **Mehrotra A**, Nazarian DJ, Promes SB, Decker WW, Fesmire FM. American College of Emergency Physicians. Clinical policy: Critical Issues in the Evaluation of Adult Patients Presenting to the Emergency Department with Acute Blunt Abdominal Trauma. *Annals of Emergency Medicine*. 57:387-404, 2011.
- 15) **Mehrotra A**, Sklar DP, Tayal VS, Kocher KE, Handel DA, Riner RM. Important Historical Efforts at Emergency Department Categorization in the United States and Implications for Regionalization. *Academic Emergency Medicine*. 17:12:e154-60, 2010.
- 16) Kocher KE, Sklar DP, **Mehrotra A**, Tayal VS, Gausche-Hill M, Riner RM. Categorization, designation, and regionalization of emergency care: definitions, a conceptual framework, and future challenges. *Academic Emergency Medicine*. 17:12:1306-1311, 2010.
- 17) Wiler J, Gentle C, Halfpenny J, Heins A, **Mehrotra A**, Mikhail M, Fite D. Optimizing Emergency Department Front End Operations. *Annals of Emergency Medicine*. 55:142-160, 2010.
- 18) Broder J, **Mehrotra A**, Tintinalli J. Injuries from the 2002 North Carolina Ice Storm and Strategies for Prevention. *Injury*. 36:1:21-26, 2005.

C) Non Peer-Reviewed Articles

- 1) **Mehrotra A**, Buff TD, Hatfield LM, Kessler CS. Oral anticoagulation reversal. *Emergency Medicine Reports*. 37: 197-208, 2016.

D) Abstracts

- 1) Mendoza C, Lucke A, Barletson P, **Mehrotra A**, Bohrmann T, Patel M, Seaman C. Implementation of an Influenza Vaccination Program is a Feasible and Effective Public Health Tool in the Emergency Department. *Annals of Emergency Medicine*; 78 (4), p. S125; 2021.
- 2) Myers JG, Sackmann R, Cai A, Meyer M, **Mehrotra A**. Eliminating Routine Use of Oral Contrast in Diagnostic Abdominopelvic Computed Tomography Imaging: Implications for Patient Care and Efficiency in the Emergency Department. *Academic Emergency Medicine*, 25 (S1), p. S234, 2018.
- 3) Limkakeng AT, Carr C, **Mehrotra A**, Smith L, Pajewski N, Burke GL, Wells BJ, Mahler S. Chest Pain Care Patterns Across the Carolinas: Determining the Readiness for Widespread HEART Pathway Dissemination. *Annals of Emergency Medicine*; 70(4), p. S1; 2017.
- 4) **Mehrotra A**, Travers D, Chen W, Lopiano K, Bohrmann T, Argon N, Ziya S, Strickler J, Ring J, Linthicum B. Starting with a Clear Endpoint: Development of a Tool to Predict Admissions at Triage. *Academic Emergency Medicine*. 24:S1:S13-4, 2017.
- 5) Heaton HA, Matthews SM, Cummings AG, Forbach CR, **Mehrotra A**. Financial Impact of Scribes in an Academic Emergency Department. *Annals of Emergency Medicine*. 64:4:S3, 2014.
- 6) Heaton HA, Matthews SM, Cummings AG, Forbach CR, **Mehrotra A**. Impact of Scribes on Patient Throughput in an Academic Emergency Department. *Annals of Emergency Medicine*. 64:4:S75, 2014.
- 7) Jones C, Culbreath K, **Mehrotra A**, Gilligan P, Shofer S. Urinalysis Reflex Testing in the Emergency Department. *Academic Emergency Medicine*. 18:4:S197-8, 2011.
- 8) **Mehrotra A**, Glickman S, Torell M, Cairns C. Discrepancies in Reporting and Payment in the CMS EM PQRI Program in an Academic Medical Center. *Academic Emergency Medicine*. 16:4:S258, 2009.
- 9) Biese K, **Mehrotra A**, Page B, Cook J, Merck L. ED Crowding Increases Acquisition Time of Brain CT and ECG. *Academic Emergency Medicine*. 15:5:S199-200, 2008.

TEACHING RECORD:

COURSE DIRECTOR

Emergency Medicine Administration and Leadership Fellowship
UNC Department of Emergency Medicine
Ongoing Audience: 2
Chapel Hill, NC

Administration Rotation
UNC Emergency Medicine Residency Curriculum
Ongoing Audience: 12
Chapel Hill, NC

LECTURES / GRAND ROUNDS

“Operational Challenges in Managing an ED”
MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
December 2022 Audience: 40
Chapel Hill, NC

“Operational Challenges in Managing an ED”
MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
August 2022 Audience: 40
Chapel Hill, NC

“Entrepreneurship Lessons”
MBA 956 – New Ventures – Discovery; UNC Kenan-Flagler Business School
March 2022 Audience: 50
Chapel Hill, NC

“Boarding – Solutions?”
North Carolina College of Emergency Physicians’ Medical Director’s Summit
March 2022 Audience: 60
Greensboro, NC

“Quality Measures in the ED”
Topics in Emergency Medicine
September 2021 Audience: 40
Las Vegas, NV

“Alternatives to Opioids”
Topics in Emergency Medicine
September 2021 Audience: 40
Las Vegas, NV

“Anticoagulation Reversal”
 Topics in Emergency Medicine
 September 2021 Audience: 40
 Las Vegas, NV

“Stroke Update”
 Topics in Emergency Medicine
 September 2021 Audience: 40
 Las Vegas, NV

“Psychiatric Boarding Solutions”
 Topics in Emergency Medicine
 September 2021 Audience: 40
 Las Vegas, NV

“Novel Agents for Sedation”
 Topics in Emergency Medicine
 September 2021 Audience: 40
 Las Vegas, NV

“GI Foreign Bodies”
 Topics in Emergency Medicine
 September 2021 Audience: 40
 Las Vegas, NV

“Operational Challenges in Managing an ED”
 MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
 July 2021 Audience: 40
 Chapel Hill, NC

“Operational Challenges in Managing an ED”
 MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
 January 2021 Audience: 40
 Chapel Hill, NC

“Quality Measures in the ED”
 Topics in Emergency Medicine
 December 2020 Audience: 80
 Virtual

“Alternatives to Opioids”
 Topics in Emergency Medicine
 December 2020 Audience: 80
 Virtual

“Anticoagulation Reversal”

Topics in Emergency Medicine
 December 2020 Audience: 80
 Virtual

“Stroke Update”
 Topics in Emergency Medicine
 December 2020 Audience: 80
 Virtual

“Psychiatric Boarding Solutions”
 Topics in Emergency Medicine
 December 2020 Audience: 80
 Virtual

“Sepsis Quality Measures Update”
 Topics in Emergency Medicine
 December 2020 Audience: 80
 Virtual

“Design and Delivery of Healthcare Systems”
 MBA 898 – UNC Kenan-Flagler Business School – Healthcare Operations
 July 2020 Audience: 40
 Chapel Hill, NC

“Metrics in Managing the ED”
 North Carolina College of Emergency Physicians’ Medical Director’s Summit
 March 2020 Audience: 60
 Greensboro, NC

“GI Foreign Bodies”
 Topics in Emergency Medicine
 November 2019 Audience: 130
 Key West, FL

“Anticoagulation Reversal”
 Topics in Emergency Medicine
 November 2019 Audience: 130
 Key West, FL

“Novel Agents for Sedation”
 Topics in Emergency Medicine
 November 2019 Audience: 130
 Key West, FL

“Quality Measures in the ED”
 Topics in Emergency Medicine

November 2019 Audience: 130
Key West, FL

“What’s New With Sepsis?”
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

“ED Quality in the Eyes of the Patient: Does the Internet Lie?”
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

“Psychiatric Boarding Solutions”
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

“ED Quality in the Eyes of the Patient: Does the Internet Lie?”
American College of Emergency Physicians Scientific Assembly
October 2019 Audience: 110
Denver, CO

“ACEP Connect: Split Flow Success – Avoiding Pitfalls and Getting Up to Speed”
American College of Emergency Physicians Scientific Assembly
October 2019 Audience: 200
Denver, CO

“How to Sleep Soundly After Discharging Suicidal Patients From Your ED”
American College of Emergency Physicians Scientific Assembly
October 2019 Audience: 200
Denver, CO

“Sepsis Core Measures – Where Are We Now?”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
October 2019 Audience: 70
Asheville, NC

“Approach to Low Risk Chest Pain”
UNC Department of Medicine Grand Rounds
September 2019 Audience: 200
Chapel Hill, NC

“ACS Risk Stratification”
UNC Department of Emergency Medicine Residency Conference

August 2019
Chapel Hill, NC

Audience: 40

“Operational Challenges in Managing an ED”
MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
July 2019
Chapel Hill, NC

Audience: 40

“Shark Tank”
PUBH 755 – Translating Evidence into Practice for Population Health; UNC School of Public Health
April 2019
Chapel Hill, NC

Audience: 35

“Chest Pain Pathway”
UNC Department of Emergency Medicine Faculty Education Session
April 2019
Chapel Hill, NC

Audience: 25

“Entrepreneurship Lessons”
MBA 956 – New Ventures – Discovery; UNC Kenan-Flagler Business School
March 2019
Chapel Hill, NC

Audience: 90

“Case Study – MedScribes”
MBA 835 – Introduction to Entrepreneurship; UNC Kenan-Flagler Business School
March 2019
Chapel Hill, NC

Audience: 60

“Metrics in Managing the ED”
North Carolina College of Emergency Physicians’ Medical Director’s Summit
March 2019
Greensboro, NC

Audience: 60

“Physician Executives in the Hospital Environment”
HPM 713 – Hospital Operations; UNC School of Public Health
January 2019
Chapel Hill, NC

Audience: 35

“Sepsis Core Measures – Where Are We Now?”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2018
Asheville, NC

Audience: 70

“Thrombolysis or No Thrombolysis – Update in Acute Stroke Care”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care

November 2018
Asheville, NC

Audience: 70

“ED Quality in the Eyes of the Patient: Does the Internet Lie?”
American College of Emergency Physicians Scientific Assembly
October 2018
San Diego, CA

Audience: 110

“ACEP Connect: Split Flow Success – Avoiding Pitfalls and Getting Up to Speed”
American College of Emergency Physicians Scientific Assembly
October 2018
San Diego, CA

Audience: 200

“Working with a Scribe: Tips and Tricks for Success!”
UNC Emergency Medicine Resident Conference
July 2018
Chapel Hill, NC

Audience: 25

“Operational Challenges in Managing an ED”
UNC Kenan-Flagler MBA Class – Healthcare Operations
July 2018
Chapel Hill, NC

Audience: 40

“One Organization’s Journey Through the Psychpocalypse”
EDPMA Solutions Summit
April 2018
Ft. Lauderdale, FL

Audience: 130

“GI Foreign Bodies”
Topics in Emergency Medicine
April 2018
Singer Island, FL

Audience: 70

“Anticoagulation Reversal”
Topics in Emergency Medicine
April 2018
Singer Island, FL

Audience: 70

“Novel Agents for Sedation”
Topics in Emergency Medicine
April 2018
Singer Island, FL

Audience: 70

“Quality Measures in the ED”
Topics in Emergency Medicine

April 2018
Singer Island, FL

Audience: 70

“Thrombolysis or No Thrombolysis: Update on Stroke Management”

Topics in Emergency Medicine

April 2018

Audience: 70

Singer Island, FL

“Case Study – MedScribes”

MBA 835 – Introduction to Entrepreneurship; UNC Kenan-Flagler Business School

March 2018

Audience: 60

Chapel Hill, NC

“Optimizing Psychiatric Care – Beyond Boarding”

North Carolina College of Emergency Physicians Medical Director Summit

March 2018

Audience: 45

Greensboro, NC

“Operational Challenges in Managing an ED”

UNC Kenan-Flagler MBA Class – Healthcare Operations

February 2018

Audience: 40

Chapel Hill, NC

“Innovations in the Healthcare Arena”

UNC Kenan-Flagler MBA Class – Health Economics

February 2018

Audience: 40

Chapel Hill, NC

“Physician Executives in the Hospital Environment”

HPM 713 – Hospital Operations; UNC School of Public Health

January 2018

Audience: 35

Chapel Hill, NC

“This Boarding is Crazy: What To Do With Mental Health Boarders in Your Department”

American College of Emergency Physicians Scientific Assembly

October 2017

Audience: 220

Washington, D.C.

“ED Quality in the Eyes of the Patient: Does the Internet Lie?”

American College of Emergency Physicians Scientific Assembly

October 2017

Audience: 150

Washington, D.C.

“ACEP Connect: Mental Health Patients in Your Department”

American College of Emergency Physicians Scientific Assembly

October 2017
Washington, D.C.

Audience: 300

“Sepsis Core Measures – Where Are We Now?”

Excellence in Emergency Medicine: Update in Emergency and Trauma Care

October 2017

Audience: 70

Asheville, NC

“Novel Agents for Sedation”

Excellence in Emergency Medicine: Update in Emergency and Trauma Care

October 2017

Audience: 70

Asheville, NC

“VTE – A Critical Unmet Need”

Portola Preceptorship

August 2017

Audience: 35

Chapel Hill, NC

“Managing Major Bleeds on NOACs”

Portola Preceptorship

August 2017

Audience: 35

Chapel Hill, NC

“Anticoagulation Reversal”

Hot Topics in Emergency Care 2017

June 2017

Audience: 75

Porto, Portugal

“Operational Challenges in Managing an ED”

UNC Kenan-Flagler MBA Class – Healthcare Operations

April 2017

Audience: 35

Chapel Hill, NC

“GI Foreign Bodies”

Emergency Medicine Update

March 2017

Audience: 120

Kauai, HI

“Anticoagulation Reversal”

Emergency Medicine Update

March 2017

Audience: 120

Kauai, HI

“Novel Agents for Sedation”

Emergency Medicine Update

March 2017 Audience: 120
Kauai, HI

“Quality Measures in the ED”
Emergency Medicine Update
March 2017 Audience: 120
Kauai, HI

“Panel Discussion: Moving Forward as an Emergency Care Community”
Turn the Tide NC – A US Surgeon General Initiative
March 2017 Audience: 110
Durham, NC

“Behavioral Health Challenges – An Update for North Carolina”
North Carolina Medical Director’s Summit
March 2017 Audience: 65
Greensboro, NC

“Physician Executives in the Hospital Environment”
HPM 713 – Hospital Operations; UNC School of Public Health
January 2017 Audience: 35
Chapel Hill, NC

“LLSA Literature Review”
Coastal Emergency Medicine Conference
June 2016 Audience: 45
Kiawah Island, SC

“Focused Reassessment of Where We Stand: Sepsis Core Measures are Here”
Coastal Emergency Medicine Conference
June 2016 Audience: 90
Kiawah Island, SC

“Reversing the Irreversible (NOACs and Their Reversal Agents)”
Coastal Emergency Medicine Conference
June 2016 Audience: 90
Kiawah Island, SC

“Leading Transformational Change: The Physician-Executive Partnership”
5th Annual Triangle Healthcare Executive Forum Leadership Summit
June 2016 Audience: 120
Cary, NC

“GI Foreign Bodies”
Emergency Medicine Update

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|---|--------------|
| May 2016 Destin, FL | Audience: 75 |
| “Anticoagulation Reversal” Emergency Medicine Update May 2016 Destin, FL | Audience: 75 |
| “Novel Agents for Sedation” Emergency Medicine Update May 2016 Destin, FL | Audience: 75 |
| “Quality Measures in the ED” Emergency Medicine Update May 2016 Destin, FL | Audience: 75 |
| “Operational Challenges in Managing an ED” UNC Kenan-Flagler MBA Class – Healthcare Operations April 2016 Chapel Hill, NC | Audience: 35 |
| “Physician Executives in the Hospital Environment” HPM 713 – Hospital Operations; UNC School of Public Health January 2016 Chapel Hill, NC | Audience: 35 |
| “LLSA Literature Review” Excellence in Emergency Medicine: Update in Emergency and Trauma Care November 2015 Asheville, NC | Audience: 40 |
| “Anticoagulation Reversal” Excellence in Emergency Medicine: Update in Emergency and Trauma Care November 2015 Asheville, NC | Audience: 40 |
| “Psychiatric Boarding: Three State Perspective on a National Problem” American College of Emergency Physicians Scientific Assembly October 2015 Boston, MA | Audience: 60 |
| “Emergency Physician Career Transitions” American College of Emergency Physicians Scientific Assembly | |

October 2015 Audience: 100
Boston, MA

“Maintaining Your ACEM Certification: Review of 2015 LLSA Articles: Part 1”
American College of Emergency Physicians Scientific Assembly
October 2015 Audience: 250
Boston, MA

“Maintaining Your ACEM Certification: Review of 2015 LLSA Articles: Part 2”
American College of Emergency Physicians Scientific Assembly
October 2015 Audience: 250
Boston, MA

“LLSA Literature Review”
Coastal Emergency Medicine Conference
June 2015 Audience: 45
Kiawah Island, SC

“Anticoagulation Reversal”
Emergency Medicine Update
March 2015 Audience: 50
Punta Cana, Dominican Republic

“GI Foreign Bodies”
Emergency Medicine Update
March 2015 Audience: 50
Punta Cana, Dominican Republic

“Quality & Performance Measures”
Emergency Medicine Update
March 2015 Audience: 50
Punta Cana, Dominican Republic

“LLSA Literature Review”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2014 Audience: 40
Asheville, NC

“Quality and Performance Measures – Why You Should Care”
Risk Management Emergency Medicine Seminar 2014
October 2014 Audience: 30
Jekyll Island, GA

“High Risk Coagulation Problems – Anticoagulation Reversal”
Risk Management Emergency Medicine Seminar 2014

October 2014 Audience: 30
Jekyll Island, GA

“Quality Measures”
APS Orientation
September 2014 Audience: 25
Chapel Hill, NC

“LLSA Literature Review”
Coastal Emergency Medicine Conference
June 2014 Audience: 45
Kiawah Island, SC

“Quality Measures in EM – Why You Should Care”
University of California, San Francisco Residency in Emergency Medicine Grand Rounds
March 2014 Audience: 70
San Francisco, CA

“LLSA Literature Review”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2013 Audience: 35
Asheville, NC

“Innovations and Best Practices – Patient Satisfaction at UNC”
ACEP and Urgent Matters Present: Emergency Care Quality Improvement in the Era of Public
Accountability
October 2013 Audience: 150
Seattle, WA

“LLSA Literature Review”
Coastal Emergency Medicine Conference
June 2013 Audience: 45
Kiawah Island, SC

“Anticoagulation Reversal”
24th Annual May Day Trauma Conference
May 2013 Audience: 20
Chapel Hill, NC

“Innovative Transfer Center Strategies and Successful ED Patient Flow Management”
Patient Flow Management Congress
January 2013 Audience: 60
Las Vegas, NV

“LLSA Literature Review”

Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2012 Audience: 20
Asheville, NC

“Quality Measures Update”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2012 Audience: 30
Asheville, NC

“Quality Measures Update”
University of California, Davis Residency in Emergency Medicine
Grand Rounds, August 2012 Audience: 60
Sacramento, CA

“LLSA Literature Review”
North Carolina College of Emergency Physicians
June 2012 Audience: 25
Myrtle Beach, SC

“Complications of Conscious Sedation”
University of North Carolina Department of Internal Medicine
Grand Rounds, January 2012 Audience: 100
Chapel Hill, NC

“Quality Measures in EM – Why You Should Care”
University of California, Davis Residency in Emergency Medicine
Grand Rounds, November 2011 Audience: 60
Sacramento, CA

“Quality Assessment in Emergency Medicine”
7th Annual Indo-US Emergency Medicine Summit; INDUS-EM
September 2011 Audience: 150
New Delhi, India

“Quality Measures in EM – Why You Should Care”
University of North Carolina Residency in Emergency Medicine
Grand Rounds, July 2010 Audience: 40
Chapel Hill, NC

“Quality Measures in EM – Why You Should Care”
East Carolina University Residency in Emergency Medicine
Grand Rounds, July 2010 Audience: 50
Greenville, NC

“Quality Measures in EM – Why You Should Care”
Carillion Clinic Residency in Emergency Medicine

Grand Rounds, May 2010 Audience: 50
Roanoke, VA

“Quality Measures in EM – Why You Should Care”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2010 Audience: 40
Asheville, NC

“Update on Acute Stroke Management”
North Carolina College of Emergency Physicians
June 2009 Audience: 50
Myrtle Beach, SC

“EM Gastrointestinal Foreign Body Management”
Resident Lecture Series, 2009 Audience: 30
UNC Residency in Emergency Medicine
Chapel Hill, NC

“Financial Planning for EM Physicians”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
September 2008 Audience: 25
Asheville, NC

“LLSA Literature Review”
North Carolina College of Emergency Physicians
June 2007 Audience: 25
Myrtle Beach, SC

“Dog Days of Summer”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
September 2006 Audience: 30
Asheville, NC

“Clinical Decision Rules”
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
September 2006 Audience: 30
Asheville, NC

“Overview of the 2005 AHA ECC Guidelines”
Resident Lecture Series, 2006 Audience: 25
UNC Residency in Emergency Medicine
Chapel Hill, NC

“Basic Airway Instruction”
Intern Orientation Lecture Series, 2005 – 2011

UNC Residency in Emergency Medicine
Chapel Hill, NC Audience: 15

“Basic Laryngoscopy”
Intern Orientation Lecture Series, 2005 – 2011
UNC Residency in Emergency Medicine
Chapel Hill, NC Audience: 15

“Introduction to Wound Management”
Resident Lecture Series, 2005 - 2011
UNC Residency in Emergency Medicine
Chapel Hill, NC Audience: 15

“Suturing Techniques for Primary Care Physicians”
North Carolina State University Student Health Service
April 2004 Audience: 15
Raleigh, NC

“Fiberoptic Scope – Airway Management”
American College of Emergency Physicians Scientific Assembly
October 2002 Audience: 30
Seattle, WA

“Introduction to Pediatric Wound Management”
Resident Lecture Series, 2002, 2003, 2008
UNC Residency in Pediatrics Audience: 25
Chapel Hill, NC

RESEARCH GRANTS:

Carolinas Collaborative Mehrotra (Site PI) 2016 – 2017
The HEART Pathway” a learning health system project, translating evidence to practice across the Carolinas.
Role: Site PI (0% Effort – NC TRACS Grant)

UNC Innovations Center Mehrotra, Travers (Co-PI) 2015 – 2016
Improving Throughput Time for High Complexity Patients in the Emergency Department
Role: Co-PI

| | | |
|--|----------------------------------|-----------------|
| Roche | Mehrotra (Site PI) | 2014 – 2016 |
| Clinical Performance of Elecsys Troponin T Gen 5 in Subjects with Symptoms of Acute Coronary Syndrome (ACS): ACS Collection Study for Serum Claim. | | |
| Role: Site PI | (0% Effort – Industry Sponsored) | |
| BTG International, Inc. | Quackenbush (Site PI) | 2014 – 2015 |
| A Randomized, Double-Blind, Placebo-Controlled Study comparing CroFab® versus Placebo with Rescue Treatment for Copperhead Snake Envenomation | | |
| Role: Site Sub-Investigator | | |
| Roche | Mehrotra (Site PI) | 2011 – Jan 2013 |
| Clinical Performance of Elecsys High Sensitive Troponin T in Subjects with Symptoms Suggestive of Acute Coronary Syndrome (ACS) Study # CIM RD001088 | | |
| Role: Site PI | (0% Effort – Industry Sponsored) | |
| Bayer | Sen (Site PI) | 2003 – 2004 |
| A Randomized, Double-Blind, Placebo-Controlled Trial to Evaluate the Efficacy, Safety, Tolerability, and Pharmacokinetic/Pharmacodynamic Effects of a Targeted Exposure of Intravenous Repinotan HCL in Patients with Acute Ischemic Stroke (Modified RECT) | | |
| Role: Site Sub-Investigator | | |
| Concentric Medical | Solander (Site PI) | 2003 – 2004 |
| Mechanical Embolus Removal in Cerebral Ischemia Trial to Study Safety and Efficacy of the MERCI Retriever in the Treatment of Thrombotic Occlusion Originating in the Internal Carotid, Middle Cerebral (M1 & M2 segments), Basilar or Vertebral Arteries | | |
| Role: Site Sub-Investigator | | |
| Ono Pharma | Sen (Site PI) | 2003 – 2005 |
| A Randomized, Double-blind, Placebo-controlled, Multi Center Study of the Effects of ONO-2506 Intravenous Infusion on the Amelioration of Neurological Damage and Improvement of Stroke Assessment Scale Scores in Patients with Acute Ischemic Stroke” (RREACT Study) | | |
| Role: Site Sub-Investigator | | |
| Centers for Disease Control | Roseman (Site PI) | 2003 – 2010 |
| The North Carolina Collaborative Stroke Registry | | |
| Role: Site Sub-Investigator | | |
| Genentech | Sen (Site PI) | 2004 – 2007 |
| IV vs. IA tPA (Activase) in Acute Ischemic Stroke with CTA Evidence of Major Vessel Occlusion | | |
| Role: Site Sub-Investigator | | |
| Astrazeneca | Felix (Site PI) | 2004 – 2006 |

A double-blind, randomized, placebo-controlled, parallel-group, multicenter, phase IIb/III study to assess the efficacy and safety of intravenous NXY-059 in acute ischemic stroke (SA-NXY-0007)

Role: Site Sub-Investigator

CoAxia Sen (Site PI) 2005 – 2010

SENTIS Stroke Trial: Safety and Efficacy of NeuroFlo Technology in Ischemic Stroke with SCION: A Study of Care Intensity and outcomes of NeuroFlo

Role: Site Sub-Investigator

National Institutes of Health Sen (Site PI) 2005 – 2010

IMS-III: Interventional Management of Stroke (IMS-III) Trial” (randomized, open-label multi-center study examining whether a combined intravenous (IV) and intra-arterial (IA) approach to recanalization is superior to standard IV t-PA)

Role: Site Sub-Investigator

Taisho Pharmaceutical Sen (Site PI) 2005 – 2007

A Multi-Center, Randomized, Double-Blind, Placebo-controlled, Ascending-Dose Study of the Safety, Pharmacokinetics, and Pharmacodynamics of a Single, 1-Hour Infusion of TS-011 in Acute Ischemic Stroke (AIS) Patients

Role: Site Sub-Investigator

NovoNordisk Huang (Site PI) 2005 – 2006

Randomised, Double-Blind, Placebo Controlled, Multi-Centre, Parallel Groups Confirmatory Efficacy and Safety Trial of Activated Recombinant Factor VII (NovoSeven ®/Niasase®) in Acute Intracerebral Haemorrhage

Role: Site Sub-Investigator

NINDS U01 NS40406-04 National Institutes of Health Sen (Site PI) 2006 – 2010

Albumin in Acute Stroke (ALIAS) Trial: A Phase III Randomized Multi-center Clinical Trial of High-Dose Human Albumin Therapy for Neuroprotection in Acute Ischemic Stroke

Role: Site Sub-Investigator

University Research Council Mehrotra, Biese (Co-PI) 2007

ED Overcrowding affecting time to diagnostic studies

Role: Co-PI

PhotoThera, Inc. Huang (Site PI) 2007 – 2008

NeuroThera® Effectiveness and Safety Trial - 2 (NEST-2) A double blind, randomized, controlled, parallel group, multicenter, pivotal study to assess the safety and effectiveness of the treatment of acute ischemic stroke with the NeuroThera® Laser System within 24 hours from stroke onset

Role: Site Sub-Investigator

CoAxia Sen (Site PI) 2007 – 2008
Safety and Efficacy of NeuroFlo in 8-24 Hour Stroke Patients (FIO 24)
Role: Site Sub-Investigator

NATIONAL COMMITTEE SERVICE:

American College of Emergency Physicians (ACEP):

| | |
|--|---------------------------------|
| Finance Committee | 2022 – Present |
| Representative to American Society of Hematology TEP | 2022 – Present |
| <i>Implementing Clinical Pretest Probability Tools into Practice</i> | |
| Data Registry Source Selection Task Force | 2020 – 2021 |
| Health Innovation Technology Committee | 2019 – Present |
| Clinical Resources Review Committee | 2019 – Present |
| Clinical Data Registry Committee | 2017 – Present |
| <i>Chair</i> | <i>2018 – 2020</i> |
| ACEP Councillor | 2010 – Present |
| Quality and Performance Committee | 2010 – 2021 |
| Quality Improvement and Patient Safety Section | 2008 – Present |
| EM Practice Management and Health Policy Section | 2007 – Present |
| <i>Chair</i> | <i>2012 – 2014</i> |
| <i>Chair-Elect</i> | <i>2010 – 2012</i> |
| <i>Secretary</i> | <i>2008 – 2010</i> |
| Young Physicians Section | 2005 – Present |
| <i>Immediate Past Chair, Chair, Chair-Elect</i> | <i>2006 – 2009</i> |
| Diversity and Inclusion Task Force | 2016 – 2018 |
| Council Steering Committee | 2008 – 2010 |
| <i>Annual Meeting & Communications Subcommittee</i> | <i>2008 – 2009</i> |
| <i>Chair</i> | <i>2009 – 2010</i> |
| <i>Election Reform Subcommittee</i> | <i>2008 – 2009</i> |
| <i>Strategic Issues Forum</i> | <i>2009</i> |
| Transitions of Care Task Force | 2011 – 2012 |
| ED Categorization Task Force | 2008 – 2010 |
| <i>Chair</i> | <i>2008 – 2010</i> |
| Integration Model Task Force | 2009 – 2010 |
| ACEP Alternate Councillor | 2008 – 2010 |
| ACEP Council Reference Committee | 2001, 2008, 2010, 2021, 2022 |
| <i>Chair</i> | <i>2010, 2021, 2022</i> |
| Clinical Policies Committee – Blunt Abdominal Trauma Subcommittee Member | 2007 – 2011 |
| Emergency Medicine Practice Committee – Subcommittee Chair | 2004 – 2009 |
| Finance Committee | 2002 – 2003 |
| Council Steering Committee | 2000 – 2002 |

Society for Academic Emergency Medicine (SAEM):

| | |
|------------------------------------|----------------|
| Finance Committee | 2016 – 2020 |
| Membership Committee | 2016 – 2020 |
| Clinical Director’s Interest Group | 2008 – Present |
| Faculty Development Committee | 2016 – 2017 |
| Regionalization Task Force | 2009 – 2010 |

American Board of Emergency Medicine (ABEM):

| | |
|---------------|----------------|
| Item Writer | 2015 – Present |
| Oral Examiner | 2012 – Present |

National Quality Forum:

| | |
|---|-------------|
| Chief Complaint-Based Quality of Emergency Care Committee | 2018 – 2020 |
|---|-------------|

Emergency Medicine Residents’ Association (EMRA):

| | |
|------------------------|-------------|
| Program Committee | 2001 – 2003 |
| <i>Chair</i> | 2001 – 2002 |
| ACEP Board Liaison | 2000 – 2002 |
| Program Representative | 2000 – 2002 |

American Medical Association (AMA):

| | |
|---|-------------|
| Medical Student Section (MSS) Reference Committee | 1998 – 1999 |
| <i>Chair</i> | 1999 |
| Committee on Recruitment | 1998 – 1999 |
| Computer Projects Committee | 1997 – 1998 |

REGIONAL COMMITTEE SERVICE:

North Carolina Department of Health & Human Services:

| | |
|---|----------------|
| Behavioral Health Crisis Referral System Advisory Committee | 2017 – Present |
|---|----------------|

North Carolina Division of Health Service Regulation:

| | |
|----------------------------------|------|
| Trauma Designation Site Reviewer | 2009 |
|----------------------------------|------|

North Carolina College of Emergency Physicians (NCCEP):

| | |
|--------------------------------------|----------------|
| Immediate Past President | 2015 – 2016 |
| President | 2014 – 2015 |
| President-Elect | 2013 – 2014 |
| Secretary-Treasurer | 2012 – 2013 |
| Board Member | 2010 – 2016 |
| Councillor to ACEP Council | 2010 – Present |
| Alternate Councillor to ACEP Council | 2008 – 2010 |

| | |
|-----------------------|-------------|
| Educational Committee | 2006 – 2008 |
| <i>Chair</i> | 2007 |

Ohio State Medical Association (OSMA):

| | |
|--|-------------|
| Committee on Emergency and Disaster Medical Care | 1998 – 1999 |
| Reference Committee | 1998 |
| Medical Student Section | 1996 – 2000 |
| <i>Chair</i> | 1999 – 2000 |
| <i>Vice-Chair</i> | 1998 – 1999 |

LOCAL COMMITTEE SERVICE:

UNC Healthcare System:

| | |
|--|----------------|
| System Emergency Services Committee | 2018 – Present |
| <i>Co-Chair</i> | 2018 – Present |
| System Pharmacy & Therapeutics Committee | 2016 – Present |
| <i>Chair</i> | 2016 – Present |

UNC Faculty Physicians:

| | |
|-----------------------------|-------------|
| Board Member | 2017 – 2020 |
| <i>Benefits Committee</i> | 2018 – 2020 |
| <i>Exceptions Committee</i> | 2018 – 2020 |

UNC School of Medicine:

| | |
|---|-------------|
| Representative to University Faculty Council | 2021 – 2024 |
| Fixed Term Faculty Promotions Committee | 2017 – 2020 |
| Physician Service Line Leader | 2009 – 2021 |
| Chair Review Committee | 2017 |
| Member, Department of Ophthalmology Review | |
| Physician’s Performance Improvement Leadership Group | 2005 – 2008 |
| Problem Based Learning curriculum development committee | 2003 – 2004 |

UNC Hospitals:

| | |
|--|----------------|
| Patient Flow & Transitions of Care Committee | 2020 – Present |
| Hillsborough Campus Executive Steering Committee | 2017 – 2020 |
| Outpatient Care Services Executive Council | 2013 – 2019 |
| UNC Medical Center Improvement Council | 2013 – Present |
| Standing Orders Committee | 2013 – 2020 |
| Utilization Management Committee | 2012 – Present |
| Credentials Committee | 2011 – Present |
| Acute Myocardial Infarction Process Improvement Team | 2005 – Present |
| Pharmacy & Therapeutics Committee | 2004 – Present |
| <i>Chair</i> | 2010 – 2018 |
| Adult Sedation Committee | 2008 – 2011 |
| <i>Chair</i> | 2008 – 2010 |
| Transfusion Committee | 2007 – 2017 |

| | |
|---|-------------|
| Medical Staff Executive Committee | 2005 – 2007 |
| Quality Council | 2005 – 2013 |
| Pneumonia Clinical Process Improvement Team | 2004 – 2005 |

UNC Department of Emergency Medicine:

| | |
|--|----------------|
| Finance Committee | 2017 – Present |
| Leadership Council | 2015 – Present |
| Peer Review Committee | 2013 – Present |
| <i>Chair</i> | 2013 – 2016 |
| Clinical Operations Group | 2004 – Present |
| <i>Co-Chair</i> | 2004 – Present |
| Throughput Committee | 2008 – 2013 |
| <i>Chair</i> | 2008 – 2013 |
| Residency Selection Committee | 2005 – 2010 |
| Residency Education Steering Committee | 2002 – 2003 |
| | 2005 – 2010 |
| Patient Safety Board | 2004 – 2006 |
| <i>Chair</i> | 2004 – 2005 |
| Electronic T-System Implementation Committee | 2003 – 2004 |

OSU College of Medicine & Public Health:

| | |
|---|-------------|
| Pre-Clinical Task Force | 1999 – 2000 |
| Medical Student Council | 1997 – 2000 |
| <i>Vice-President</i> | 1998 – 1999 |
| Problem Based Learning Program Evaluation Committee | 1997 – 1998 |
| Problem Based Learning Program Computer Resources Committee | 1997 – 1998 |

Columbus Medical Association:

| | |
|---------------------------------|-------------|
| Governing Council | 1997 – 1998 |
| Education and Program Committee | 1997 – 1998 |

PROFESSIONAL SOCIETIES:

| | |
|--|----------------|
| American College of Healthcare Executives | 2016 – Present |
| American College of Emergency Physicians | 2000 – Present |
| Society for Academic Emergency Medicine | 2000 – Present |
| North Carolina College of Emergency Physicians | 2000 – Present |
| Emergency Medicine Resident's Association | 2000 – Present |
| American Medical Association | 1996 – Present |
| North Carolina Medical Society | 2000 – 2007 |
| Ohio State Medical Association | 1996 – 2000 |

MODERATOR / REVIEWER SERVICES:

Moderator, Careers with Impact Forum 2021
UNC Kenan Flagler Business School, Reimaging Healthcare
Chapel Hill, NC

Reviewer, ACEP17 Research Forum 2017
ACEP17 Annual Meeting
Washington, D.C.

Moderator, Small & Medium Chapter Breakfast Discussion 2016
ACEP Leadership & Advocacy Meeting
Washington, D.C.

Moderator, Strategic Issues Forum 2009
ACEP Annual Council
Boston, Massachusetts

BOARD SERVICE:

Advisory Board 2020 – Present
Excelerate Health Ventures
Durham, NC

Board Member 2017 – 2020
UNC Faculty Physicians Practice
Chapel Hill, NC

Board Member 2015 – Present
MedScribes, Inc.
Durham, NC

Board Member 2010 – 2016
North Carolina College of Emergency Physicians
Raleigh, NC

Advisory Board 2008
King Pharmaceuticals
Philadelphia, PA

Board Member 2000 – 2002
Emergency Medicine Resident's Association
Dallas, TX

EDITORIAL SERVICE:

Manuscript Consultant / Reviewer
Journal of Emergency Medicine

2007 – Present

2023 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Henry Z. Pitzele, MD, FACEP

Question #1: How can ACEP optimize its financial resources to ensure future stability?

The most important thing for the future stability of the College is membership. The world has moved on from the era when lifetime ACEP membership was an expected thing for all ER docs, a code which instilled in us to varying degrees during our (very distant) residency days. Now, the cost of membership is viewed as a luxury expense, one which must be continuously justified with clear, concrete benefits of membership. And those benefits exist! We need to work even harder on conveying these fundamental benefits—both the carrot (obvious positive pressure on compensation, a welcoming community, excellent practice resources) and the stick (fighting encroachment from payors, government, corporations, non-physicians),

Further along this continuum, we need to evolve the College away from the business model of selling CME. What used to be a lucrative and reliable pillar of ACEP's financial tripod is dwindling away, as learners choose different ways to stay current. This fact has also synergized with our difficulties in membership, as those who chose membership are highly re-targeted with ads for educational products, and if their main contacts with the College are ads for products they no longer use, it is ever more difficult to make the value proposition of continued membership. Instead of CME, the College needs to refocus on more sustainable business models, which fit in no less integrally with our organizational goals than education—the most promising two models right now are grants/research, and the data structures and processes enabled by ACEP's Emergency Medicine Data Institute.

Unfortunately, resource management is only going to get us part way to our goal; the contraction of the entire association industry suggests that our future stability is going to involve contraction of our organization as well, with the cutting out of products and services from College operations. It will not only be painful to our members who have grown accustomed to the many things that ACEP comprises, but even more painful to the leaders who must decide to part with members of the staff who many consider extended family, and who literally make this College run. ACEP will survive—it must—but the stability of its next phase of life will rest partially in its smaller footprint.

Question #2: Describe how your election to the Board of Directors would enhance ACEP's ability to speak for and represent all emergency physicians.

I am a working clinical ER doc—until this year, when my VA asked me to take on some Informatics duties before our planned national switch of EMR's, I was working 100% clinically since giving up my position as Chief of Emergency in 2014. I still work 50% of my time at the VA clinically as a nocturnist (night shift is the best shift), and I moonlight in other institutions to keep my breadth of clinical practice wide. I am not a boss of ER docs, nor an officer of an EM company or group, nor the head of an academic institution. I say these things because I think that it is important that the voice of the frontline EM physician be heard loudly in the boardroom, and ACEP's leadership positions are often taken by people who are organizational leaders in their work life—this is natural! We *should* be leveraging the work of people who are such talented leaders that they have risen to the top of their organizations. But I also think the boardroom should have some strong voices of working pit docs. Our strategic plan has realigned the organization to overtly represent those voices, and having Board representation with docs who are primarily clinical is a strong signal to members (and potential members) that the improvement of their working lives is our true North.

I also want to spend significant time and effort on honing our College's communications apparatus directly, so we can get our message across to our audience of EP's—especially younger ones. The tremendous and important work we do, and the immense value the College provides to the specialty is a message that isn't getting across to early career physicians, who the statistics suggest aren't seeing the value proposition of membership. I think that there are discrete steps we can take which will help to convey our value and dedication to the well-being of this highly important group (they are literally our future!)—we can spend more resources in our online presence, have an app that provides utility, and use personal, boutique messaging from faces they know (rather than impersonal/corporate communiques). Our presence in social media can not be an afterthought, but must be a primary source of information and communication. And we cannot dismiss younger physicians' concerns about Workforce as alarmist; there *is* cause for concern, the future is *not* clear, and messaging that suggests that everything is fine makes it even more difficult to convey the important message—that the College is here, and taking Workforce very seriously, and that we will

continue to monitor, research, plan, legislate, and litigate to make sure that working in EM continues to not only be a great and fulfilling job, but a legitimate career option as well.

Lastly, I want to concentrate some more of the College's efforts on Chapter relations. I feel that the large amount of variance in the ways that Chapters operate, as well as the variance in the levels of how tightly they are unified, communicate, and act in concert with the national organization allow for some room for improvement, especially within the leadership pipeline. I think that for a lot of EP's, their most frequent contact with the College is through their Chapter—easy to access, providing local events and service, and most of all, a chance to see people they know and respect taking part in organized EM. I think that if we want College leadership to speak for all and represent all ER docs, we need access to the hearts and minds of all ER docs, and that starts locally, at the Chapter level. If we don't have unity of thought and action with the Chapters, then EP's have less of a chance of seeing people who look like them, who talk like them, from the same place as them, actively participating in College activities and making the specialty a better place, and we lose all of that potential talent long before they even consider running for ACEP leadership. Chapter work is where my journey started, and I was lucky to have a strong and active Chapter—we need to extend that to everyone.

Question #3: From your perspective, what would you do to ensure that emergency medicine remains an attractive specialty?

There are some elements of EM which have always made our specialty attractive—our ability to truly care for people in their time of need, to take care of anything and anyone, any time, in any place, and the freedom to do so in discrete and prescheduled shifts. The attractive elements have not changed, and will not—but the last two Matches show that the outlook on the future of EM *has* changed, and ACEP can and must focus our most fundamental organs—those of advocacy and communication—towards even stronger defenses of Workforce, autonomy, compensation, and community.

Our efforts on Workforce are ongoing, but we can do even more—we have engaged the greater EM community and the ACGME, but exploring other partnerships (such as ABEM) can help us further demonstrate the value of EP's. More resources for PR, and increased support for definitive, original research could further bolster the greater public acceptance of the obvious good of physician-led teams. But where we excel, and where we can really create change is in DC; it is time to commit to legislation regarding GME funding, which will help us not only with supply-side Workforce increases, but also with distributive imbalances (urban vs rural). Workforce cannot be an afterthought for the College.

While on the topic of legislative advocacy, it is time to legitimately explore legislation to end the Medicare funding cycle. ACEP is the only EM organization who has (and who can) step up and fight for our compensation from CMS, but every year at LAC, I sit in congressional offices describing our ever-decreasing compensation, and hear the same refrain from lawmakers: "This isn't a good year to talk about this." Well, given the state of EM recruiting, this *must* be the year we talk about permanent legislation for Medicare increases.

We must also continue (and amplify) our fight against consolidation. Our March letter to the FTC decrying noncompetes and our April letter to CMS about ownership disclosures were just an opening salvo—our attractiveness as a specialty will continue to plummet if the front-line EP's sense of autonomy continues to erode, and EM consolidation is a direct cause of this erosion. We need to not only work against consolidation through our governmental interfaces, but in our own business practices as well.

Finally, the college needs to put more resources into our core function of providing community. Not only must we do a better job of communicating the immense value we provide to the frontline doc, but in showing all of the work we do, and the fights we fight on their behalf, we will help to show students choosing a specialty that we do, still, work in the best corner of the house of medicine. And when we leverage our deep resources to foster that sense of community, we improve not only our own sense of well-being, but foster a pipeline of new leaders who will be the ones setting the landscape for the next chapter of EM.

CANDIDATE DATA SHEET

Henry Z. Pitzele, MD, FACEP

Contact Information

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Chicago, IL 60607
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E-Mail: pitzele@gmail.com

Current and Past Professional Position(s)

Attending Physician (full time), Jesse Brown VA Medical Center, Chicago (2007-present)
Deputy Section Chief of Emergency Medicine 2007-2012
Section Chief of Emergency Medicine 2012-2015
Chief Health Informatics Officer 2023-present
Attending Physician (part time) Advocate Illinois Masonic Medical Center, Chicago (2010-present)
Attending Physician (part time) Mesa View Regional Medical Center, Mesquite NV (2011-present)
Attending Physician, Mercy Hospital, Chicago (full time 2003-2007, part time 2007-2010)

Education (include internships and residency information)

Univ. of Illinois at Chicago, Emergency Medicine residency 2000-2003
Univ. of Illinois at Chicago College of Medicine:
MD 2000

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

ABEM 2004, 2014
Clinical Informatics 2022

Professional Societies

ACEP, AAEM, ICEP (Illinois Chapter)

National ACEP Activities – List your most significant accomplishments

State Legislative/Regulatory Committee 2021-23—led several subcommittees in designing roundtable webinar discussions on scope of practice and leveraging strength in small/medium chapters, and in creating a dashboard to display state advocacy work on a number of common issues.
Communications Committee 2022-23—worked on a rapid-action response team for social media issues
ACEP Partner Collaborative Summit 2023

ACEP Chapter Activities – List your most significant accomplishments

ICEP president 2020-21
ICEP Board of Directors 2015-2022
ICEP EMBRi Written Board Review Course, course and committee chair 2012-2019

Practice Profile

Total hours devoted to emergency medicine practice per year: 2200 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 55 % Research % Teaching % Administration 5 %

Other: Health Informatics 40 %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Full time in tertiary VA teaching hospital, split 50/50 clinical EM (nocturnist) and Chief of Informatics. Moonlighting 1-2 times per month at an urban Level I trauma center (also an EM residency program site), as well as at a rural CAH in Nevada.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Chief of Health Informatics since March 2023

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases Plaintiff Expert 0 Cases

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Henry Z. Pitzele, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: US Dept of Veterans Affairs—Jesse Brown VAMC

Address: 820 S. Damen

Chicago, IL 60612

Position Held: Attending Physician, Chief Health Informatics Officer, former Section Chief

Type of Organization: VA Hospital

Employer: Advocate Medical Group—Advocate Illinois Masonic Hospital

Address: 836 W. Wellington

Chicago, IL 60657

Position Held: Attending Physician—part-time/moonlighting

Type of Organization: Regional medical group

Employer: American Physician Partners (Mesa View Regional Hospital)

Address: 5121 Maryland Way #300

Brentwood, TN 37027

Position Held: Attending Physician—part-time/moonlighting

Type of Organization: National CMG

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Illinois College of Emergency Physicians

Address: 2001 Butterfield Rd, Esplanade 1, Suite 320

Downer's Grove, IL 60515

Type of Organization: State Chapter of ACEP

Leadership Position: Board member, various officer positions including president

Term of Service: 7 years (2015-2022)

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than \$100.

NONE

If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

NONE

If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

NONE

If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

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.

Henry Pitzele

Date

6/4/2023



Illinois College of Emergency Physicians

ADVANCING EMERGENCY CARE  ICEP.org

2001 Butterfield Road, Esplanade I, Suite 320, Downers Grove, IL 60515

phone: 630.495.6400 toll-free: 888.495.ICEP

The Illinois College of Emergency Physicians proudly endorses Dr. Henry Pitzele for election to the board of directors of the American College of Emergency Physicians.

Dr. Pitzele has been a vital and active member of the Illinois College for two decades. His service began as an educator lecturing in our oral board review course. His dynamic speaking style and conceptualization of the learning process rapidly moved him up to the position of course director and chairman of that committee. He led the course for seven years, curating and managing speakers, supervising the modernization of marketing efforts, and engaging leadership development to assure the continued excellence of the course.

Dr. Pitzele moved into leadership of the Chapter, starting on the Board of Directors in 2015, just in time to face significant challenges to the financial health of the organization. With an eye on the long-term health of the College, but without fear of significant changes to the organization’s structure and physical presence, Dr. Pitzele and the leadership team heralded ICEP through those times to the strong fiscal foundation on which it now rests.

Dr. Pitzele served as ICEP president from 2020-21, which certainly provided a different set of challenges. In concert with the courageous and tireless efforts of ICEP staff, Henry was able to lead the organization through that tumultuous year, pivoting to an online position for most activities, bringing in new engagement with Social EM, and setting up important EM legislation in Springfield. Most importantly, he was able to stand up for individual EM physicians in Illinois who, as independent contractors, were not given COVID protections by their hospital systems.

We at ICEP have been proud to see Henry continue that focus on the front-line physician as he turned his efforts to the national organization. Through the past three years of campaigning, though his efforts on the State Legislative Committee, and even more with the Communications Committee, Dr. Pitzele has been one of the leaders who has begun to re-center ACEP as an organization with the central goal of representing the working interests of the working Emergency Physician. And we know that the clear voice he has used in the boardroom, online, and in person to keep those interests sacrosanct in the face of challenges from government, corporations, and payors will allow the College to continue to prosper, even in times of significant financial peril.

Dr. Pitzele is the leader we need right now, and we hope you join us in bringing him to the table.

Sincerely,

Howie K. Mell, MD, MPH, CPE, FACEP
President, Illinois College of Emergency Physicians

BOARD OF DIRECTORS

| | | | | |
|---|--|---|--|--|
| Howie Mell, MD, MPH, CPE, FACEP <i>President</i> | Willard W. Sharp, MD, PhD, FACEP <i>President-Elect</i> | Amit Arwindekar, MD, MBA, FACEP <i>Secretary-Treasurer</i> | Kim Stanford, MD, MPH, FACEP <i>Member-at-Large</i> | Jason Kegg, MD, CHSE, FACEP <i>Past President</i> |
|---|--|---|--|--|

| | |
|-----------------------------------|--------------------------------|
| Kristen Donaldson, MD, MPH, FACEP | Adnan Hussain, MD, FACEP |
| Katarzyna (Kasia) Gore, MD, FACEP | Joseph Palter, MD |
| Scott Heinrich, MD, FACEP | Monika Pitzele, MD, PhD, FACEP |

| |
|--|
| Robert Tennill, MD, CHSE, FACEP |
| Trenika Williams, MD <i>Resident Member</i> |

EXECUTIVE DIRECTOR
Bailey A. McMurray, IOM, MAOL

Henry Z. Pitzele, MD, FACEP

I wish I could say that it's not going to get worse before it gets better, but it will, a bit.

Our work itself is more difficult than ever before—boarding is intolerable, government and payors are steadily decreasing our compensation, and our patients are frustrated and helpless, and taking it out on us. Moreover, we work for an ever-decreasing number of entities, most with shaky business foundations that have already started to fail—we ourselves feel frustrated and helpless. This feeling is visible to everyone, especially med students choosing a specialty, and our Match results are proof.

This has led us to an unprecedented period in the College's history—one where we are actually contracting. We are bleeding membership—not just from lack of growth among young physicians, but many of the mid- to late-career members we thought would be lifetime members are not renewing, and our collective power is waning with the decreasing membership.

Never has ACEP been in such dire straits. But never has ACEP been more important to the specialty.

To successfully lead Emergency Medicine through this crisis, the College must do two things—contract in a controlled manner, concentrating on the core functions that we do best (Advocacy and Community, functions that no one else can do), and shore up our own business model with fundamentals that will grow and flourish in the next decade.

We need to concentrate on Advocacy. Our members count on us to represent their interests when interfacing with the monoliths of government and insurance, and that's something we do extremely well. We must shift a larger portion of our resources towards Public Affairs, so that our already audible voice in DC (the *only* voice of EM in DC) is heard even louder. We must be heard in Congress, but also in the executive branch, where CMS and DOJ are deciding our financial fate (and the fates of our increasingly consolidated employers). And most of all, we need to double down resources on our state legislative coordination—so much of our everyday, working lives are dictated by state law, and our members deserve a highly coordinated, country-wide effort to manage EM legislation at the statehouse level.

We need to concentrate on Community. Never has EM more needed the sense that we are all in this together—many of us work by ourselves, single coverage and non-academic, and it's easy to forget that we all face the same problems. ACEP can and should be the net that binds us together—it should be the place we turn when we need practice help and guidelines, in times of turbulence and eroded trust in information (like a pandemic), and when we need to hear our elected leaders tell us how things are going inside the College, in DC, and most of all, in all of the *other* ED's across the globe, where our brothers and sisters are fighting the same fights. We need to invest in the communications platforms, devices, and strategies that really bind us together now (digital ones), which have traditionally been an afterthought.

And it is through those communication channels that we will better demonstrate our value to our members. We do so much to improve the working lives for frontline EM—we *will* do a better job of communicating that to EP's. We must. Because even as we refocus our business towards more sustainable models (EMDI, grants/partnership) and away from others (CME), the next few years will bring many difficult decisions. It is only with a clear vision of a strong future College that we will achieve a successful transformation.



we can get through this

the College is facing an unprecedented era of decreasing membership and revenue, at a time when EM needs **leadership** more than ever

we must concentrate ACEP on our strongest core principles and functions: **advocacy** and **communication/community**

we must never stop fighting collectively on behalf of the **frontline EP**

together, we will pilot the College through crisis, and establish strong fundamentals for ACEP's next phase

Pitzele for ACEP Board

HENRY ZOLTAN PITZELE, MD

Work Experience

| | |
|---------------|---|
| 2/23-present | Chief Health Informatics Officer 2/23-present, Jesse Brown VA Medical Center, Chicago (50% clinical EM, 50% CHIO) |
| 6/07-present | Attending Physician, Emergency Medicine Service, Jesse Brown VA Medical Center, Chicago (Deputy Chief 6/2007-9/2012, Section Chief 9/2012-9/2015) |
| 11/11-present | Attending physician, Department of Emergency Medicine, Mesa View Regional Hospital, Mesquite NV (part-time/moonlighting) |
| 8/10-present | Attending physician, Department of Emergency Medicine, Advocate Illinois Masonic Medical Center, Chicago (Level I Trauma Center—part-time/moonlighting) |
| 3/16-12/18 | Attending physician, Department of Emergency Medicine, Advocate Trinity Hospital, Chicago (Part-time/moonlighting) |
| 6/03-7/10 | Attending physician, Department of Emergency Medicine, Mercy Hospital and Medical Center, Chicago (Full-time 2003-2007, part-time 2007-2010) |
| 11/02-6/03 | Attending physician at UIC O'Hare Medical Clinic, part-time |

Educational Experience

| | |
|-----------|---|
| 2000-2003 | University of Illinois at Chicago Emergency Medicine Residency Chief Resident at Mercy Hospital and Medical Center |
| 1996-2000 | University of Illinois at Chicago College of Medicine Graduated top quartile of class |
| 1992-1996 | University of Chicago BA in Economics with General Honors |

Publications

- Pitzele HZ. Scapular Winging (Chapter 62) and Maisonneuve Fracture (Chapter 37) in Atlas of Clinical Emergency Medicine. Edited by Sherman SC, et al, Lippincott 2015.
- Pitzele HZ, Kessler CS. Life-threatening Dermatoses. Chapter 96 in Clinical Emergency Medicine, Edited by Sherman SC and Weber JM, McGraw-Hill 2013.
- Garcia C, Pitzele HZ. Man with Shoulder Pain After a Fall. *Annals of Emergency Medicine*. 2011 58(6) p. 574, 578.
- Pitzele HZ, Tolia V. Twenty per Hour: Altered Mental State due to Ethanol Abuse and Withdrawal. *Emergency Medicine Clinics of North America*. 2010 28(3) p. 683.
- Unterman S, Kessler CS, Pitzele HZ. Staffing of the Emergency Department by non-Emergency Medicine-trained Personnel: The VA Experience. *American Journal of Emergency Medicine*. 2010 28(5) p. 622.
- Pitzele HZ. Acquired Lateral Rectus Palsy: A Case Report. *The Internet Journal of Emergency Medicine*. 2009 Volume 6 Number 1
- Aks S, Erickson TB, Paloucek F, Pitzele HZ. Famous Chicago Poisonings. Oral Presentation at North American Congress of Clinical Toxicology Annual Meeting, Chicago, IL, Aug 2003. Published as an article in *Mithridata: Newsletter of the Toxicological History Society* 2004 14(2) p. 6-10.
- Pitzele HZ, Eilbert WP. Abdominal CT Scan and Diagnostic Delay in Men and Women Undergoing Appendectomy. Oral Presentation at AAEM Scientific Assembly, New Orleans, LA, Feb 2003. Abstract published in *J Emerg Med* 2003 24(4) p. 479

Awards

Award of Teaching Excellence, UIC Internal Medicine Residency, 2011-2012

Oral Presentations

Lecturer, UIC Internal Medicine Residency Noon Conference (2-3 times per year) 2007-present
Lecturer, Illinois College of Emergency Physicians Written Board Review Course,
"EMBRi" 2004-2019
Lecturer, American Academy of Emergency Medicine Scientific Assembly, San Diego 2012
Lecturer, Third Dutch North Sea Emergency Medicine Conference, Netherlands, June 2009
Lecturer, American College of Emergency Physicians Scientific Assembly, Chicago 2008
Lecturer, American College of Emergency Physicians Spring Congress (New Speaker's Forum),
Las Vegas 2006

Leadership Experience

Illinois College of Emergency Physicians (Illinois Chapter of ACEP)
President, 2020-2021
Secretary/Treasurer 2019-2020
Board of Directors, 2015-2021
Chair, Written Board Review Course committee, Illinois College of Emergency Physicians 2012-2019
Medical Director (Section Chief) Emergency Medicine, Jesse Brown VAMC 2012-2015
VA National Emergency Medicine Field Advisory Committee, 2013-2016
Lead Physician for Emergency Medicine, VA Great Lakes Health Care System 2012-2015
Jesse Brown VAMC LEAN Steering Committee 2014-2015
Chair, ED Committee at Jesse Brown VAMC 2012-2015
Site Director, Medical Student Rotation in EM at Jesse Brown VAMC, 2007-2013

Hospital Committees

Peer Review (2014-present)
Inpatient Flow (2012-2015)
Utilization Management (2012-2015)
Emergency Management (2012-2015)
Medical Executive Council (2012-2015)
CPR (2012-2015)
Clinical Products and Resources (2012-2015)
Ebola Preparedness (2014-2015)

Certifications

BLS, ACLS, ATLS
LEAN Green Belt
AMIA 10x10

Professional Organizations

Associate Professor, Department of Emergency Medicine, University of Illinois at
Chicago, 2014-present (Clinical Assistant Professor 2003-2014)
Fellow, American College of Emergency Physicians, 2006-present
Examiner, Illinois College of Emergency Physicians, Oral Board Review Course 2004-present
Board Certified in Emergency Medicine, American Board of Emergency Medicine, 2004 and 2014
Board Certified in Clinical Informatics 2022

pitzele@gmail.com
617 S. Loomis, Chicago IL 60607
cell (312) 523-6080

2023 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

James L. Shoemaker Jr., MD FACEP

Question #1: How can ACEP optimize its financial resources to ensure future stability?

Over its 50+ year existence, ACEP emerged as the preeminent emergency medicine membership organization for our specialty. Through our collective membership, we have a tremendous megaphone and platform to advocate on behalf of our colleagues and our patients. As with many like organizations, the Covid-19 pandemic created substantial financial challenges for ACEP, including declining membership, meeting attendance, and corporate sponsorship and grants. ACEP can ensure future fiscal stability through a focus on the value of membership and meetings, while also developing sources of non-dues revenue.

ACEP must amplify its message to unite, protect, and empower our colleagues. ACEP is the EM organization fighting for the viability of our specialty in the face of threatening headwinds, including novel challenges to fair and adequate reimbursement, non-physician scope creep, ED boarding, ED violence, physician burnout and others. As an example, ACEP is the one organization that represents emergency medicine at the AMA's Reimbursement Update Committee (RUC), which is charged with providing the CMS with valuation recommendations for the services physicians provide. I am proud to be a part of that RUC team. I am convinced that, from the professional fee side, we are the best value in medicine. It is essential that our members view the payment of ACEP dues as an investment in themselves rather than just another bill to pay.

ACEP's comprehensive advocacy efforts benefit every practicing emergency physician—member or not. ACEP must better demonstrate the true value of ACEP membership to current members, candidate members, and those on the sidelines. Member benefits must be easily identifiable and tangible to members, while inaccessible to non-members. ACEP is positioned to be the emergency medicine home for members, replete with tools to drive excellent patient care while enhancing the wellness of those who provide it—from medical school to retirement. Young physicians today are less inclined to join professional membership organizations, leading to declining membership among this cohort and subsequent deterioration of operating capital. This revenue is vital to the execution of ACEP's strategic plan and its focus on the working emergency physician. Residency program director outreach is essential so that EM residents beg the question: "Where would I be without ACEP working and fighting for me?"

We need to streamline, consolidate, and reimagine our annual meetings to make them must-attend events with offerings that encourage networking, socializing and education in a format that is fun and interactive. CME now can be obtained in diverse ways, and ACEP must respond to this change and be nimble in our future destinations and meeting curricula as well as social events. In the last two years, I had the privilege to create and initiate a new meeting for emergency physicians that is co-hosted by ACEP and called The EM Independent Group Master Class--designed to assist our colleagues seeking to start, maintain, and/or advance their own independent Emergency Medicine group. The reimaged format of education and focus on networking, TED talk format and roundtable discussions driving this meeting were found to be successful in terms of attendee experience and revenue for the college. This may be a step in the right direction as we lean on meetings as a future pillar of financial stability.

Non-dues revenue is essential, and we must analyze each of ACEP's offerings and make some difficult decisions regarding the effective deployment of resources and capital. ACEP accreditation programs such as GEDA, PACED and the newly approved ED Accreditation programs will grow and provide vital non-dues revenue while also raising the bar on quality ED care. Leveraging EMDI/CEDR will help us maximize ED quality reporting to meet CMS reporting requirements and will provide marketable data to bolster our financial bottom line. ACEP needs to reevaluate some underperforming programs and refocus on our ability to fulfill our strategic plan and mission. As you can see, there is much work to do: challenge accepted.

Question #2: Describe how your election to the Board of Directors would enhance ACEP's ability to speak for and represent all emergency physicians.

I am privileged to be an incumbent ACEP Board of Directors candidate and the current ACEP Treasurer. The opportunity to serve in ACEP leadership has been the highlight of my career. Reelection to the ACEP Board will allow me to leverage my ACEP Board experience to enhance my effectiveness as a voice for the independent, actively practicing community emergency physician. Further, my reelection allows me to continue to deploy my expertise in advocacy and reimbursement. As a Board member, I focus on issues that impact our specialty and the patients we serve, and I look forward to the opportunity to continue to be a servant leader and voice for my colleagues. My mentors are some of the greatest emergency physicians and reimbursement champions in our specialty, and I've learned from my esteemed colleagues on the ACEP Board. Now, I bear an

obligation to fully apply my learnings in the service of my colleagues and my specialty. It is my goal to ensure that each of us has a voice and representation in the ACEP family. A consistent motivation of mine is to make this specialty financially and professionally vibrant and rewarding. To this end, it is my motivation as a leader to ensure that our colleagues, regardless of their practice environment, receive essential due process, transparency, fair reimbursement, equitable scheduling, and wellness resources to sustain a fulfilling career.

I do not always have the answer, but I am an active listener that works toward consensus and understanding. I am engaged, empathetic, persuasive, and confident. I strive to enthusiastically support and buoy others in the pursuit of their goals and provide them with a platform and voice. I was born into an impoverished environment. Through this, I learned that hard work, dedication, and motivation can produce remarkable success. I promise to bring this work ethic to the ACEP Board--working on behalf of our patients and our members. I am confident that my track record during my first term speaks for itself. I am proud of the work we have accomplished together.

I am an objective thinker that appreciates input from all sides to collaboratively work toward meaningful and tangible outcomes. I am not afraid to think outside of the box, and I do not hesitate to disagree with others and articulate my reasoning. ACEP has afforded me amazing opportunities to become an expert and champion in the reimbursement and advocacy arenas. One notable success is my state chapter's model legislation that requires that a physician be always present in all Indiana EDs. This successful state-level advocacy can serve as a template for other chapters to prevent the replacement of emergency physicians' unique expertise and body of knowledge.

One of my proudest accomplishments during my first Board term is the creation and implementation of the new ACEP/Emergency Medicine Business Coalition (EMBC) educational offering – the EM Independent Group Master Class. Feedback from attendees and faculty further my understanding of how we can collaborate to ensure that we control our destiny. I am honored to represent you as we negotiate fair Medicare reimbursement, implement our new strategic plan, and focus on the working emergency physician. ACEP's new policies creating guardrails for the use of non-physician providers and our statements regarding private equity and the corporate practice of medicine are vital to the preservation of the physician-patient relationship. As an ACEP leader, I share a megaphone that amplifies your voice and drives change. I will be your unfettered voice to bring each of us the most fulfilling career imaginable. My core motivation is to provide you with a loud, resounding voice and for you to enjoy an amazing EM career.

Question #3: From your perspective, what would you do to ensure that emergency medicine remains an attractive specialty?

Emergency medicine is truly the greatest specialty in medicine. Each day we treat all comers presenting to our emergency departments regardless of their ability to pay, circumstance or background. We are the true medical experts our patients seek for symptoms and concerns that scare them. Much like Hogwarts sorts students into their appropriate houses in the *Harry Potter* series, we sort and triage to separate the “sick” from the “not sick” and begin immediate resuscitative efforts when time is of the essence. We are hands on. The first fifteen minutes of the undifferentiated patient is where we thrive and apply our expertise and unique skill set. Emergent procedures such as airways, central lines, sedations, reductions and defibrillation are commonplace to us. We invite and embrace the full breadth and complexity constituting *all* of medicine. Many facets of emergency medicine make it highly attractive to the very best of medical students – the unpredictable variety of cases, high stakes decision-making, teamwork, the immediate impact of our interventions, and flexibility in scheduling and work-life balance.

To remain an attractive specialty, it is essential that we protect the integrity of our beloved specialty from the encroachment of non-physician providers and scope creep. With over 150 million annual ED visits, our patients expect – and deserve – to be seen by a BC/BE EM physician leading a high-quality treatment team. There is no substitute for medical school and EM residency training. None. Further, we must ensure that business interests and entities *never* interfere with our medical judgment. Profits over patients is an unthinkable and untenable potential outcome of private equity involvement in the absence of well-established and enforceable guardrails. In addition, we must continue efforts to ensure adequate and fair compensation for the care we provide. We should be unapologetic about the income we make – from the professional fee side we *are* the best value in medicine. It is essential that we tackle ED Boarding and ED violence head-on making patient and colleague safety an unwavering priority.

Emergency medicine is truly the “safety net” of our healthcare system and the work we do truly makes a difference. We *are* the frontline of healthcare. ACEP needs to continue its multipronged approach to tackle the “four corners” of EM that I define as membership, reimbursement, work force and ED violence/wellness to sustain the vibrancy of our specialty for colleagues past and present. Together we are stronger, and we must continue to educate future colleagues and the public about the integral role played by BC/BE emergency medicine physicians in every ED. Without us, the safety net will be forever broken, and patients will succumb to a lack of healthcare and societal resources. What we do *matters*. I will be your voice in the Boardroom, at the RUC, at the bedside and in the advocacy arena to propel our specialty forward and confront our challenges.

CANDIDATE DATA SHEET

James L. Shoemaker Jr., MD FACEP

Contact Information

14302 Southold Drive
Granger, IN 46530

Phone: cell/home (269) 267-3953

E-Mail: jshoemakermd@gmail.com

Current and Past Professional Position(s)

- 1 – Partner and Attending Emergency Physician with Elite Emergency Physicians, Inc. (EEPI) (2007-present)
- 2 – Director of Quality for EEPI (2016-present)
- 3 – Director of Compliance for EEPI (2016-present)
- 4 – Indiana University School of Medicine, South Bend Volunteer EM Clerkship Faculty (2011-present)
- 5 – Member of National ACEP Board of Directors – current Secretary/Treasurer (2020-present)

Education (include internships and residency information)

- 1 – Edinboro University of PA, Edinboro, PA (1993-94) attended Freshman year and transferred
- 2 – Dickinson College, Carlisle, PA (1994-97), B.S. Biology *cum laude*
- 3 – Indiana University Bloomington/Medical Sciences Program (1998-2000), M.A. Physiology with thesis
- 4 – Indiana University School of Medicine, Indianapolis, IN — (2000-2004), M.D. in 2004
- 5 – MSU/KCMS Kalamazoo, MI (2004-2007) — Emergency Medicine Residency Training Program

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

ABEM Board certified — certificate expires December 31, 2028

Professional Societies

- 1 – ACEP Member (2004-present)
- 2 – ACEP Fellow (2010-present)
- 3 – Indiana ACEP Member (2007-present)
- 4 – AMA Member (2018-present)
- 5 – EMRA Alumni Member (2020-present)
- 6 – Indiana State Medical Association (2007-present)
- 7 – EDPMA Group Member (2017-present)
- 8 – Member of the Emergency Medicine Business Coalition (EMBC) (2020-present)

National ACEP Activities – List your most significant accomplishments

- 1 – National ACEP Board of Directors (2020-present)
- 2 – Secretary/Treasurer ACEP Board of Directors (2022-present)
- 3 – Innovator, creator, and course co-director of ACEP/EMBC Independent EM Group Master Class conference
- 4 – ACEP Reimbursement Leadership and Development Program Fellow (2018-2020)
- 5 – Board Liaison to Small Democratic Group, Toxicology and Observation Sections (2020-present)
- 6 – Member of Council Steering Committee (2019-2020)
- 7 – ACEP Alternate Delegate for AMA/Specialty RVS Update Committee (RUC) (2019-present)
- 8 – Reimbursement Committee (2015-present) – Board Liaison 2020-present
- 9 – Reimbursement Committee Workgroup 2 (2018-present)
- 10 – Chairman, National Chapter Relations Committee (2020)

- 11 – Member of National Chapter Relations Committee (2013-2020)
- 12 – Coding and Nomenclature Advisory Committee Member (2018-present) – Board Liaison 2020-present
- 12 – ACEP Council Reference Committee ‘A’ Member (2018 Council)
- 13 – ACEP Clinical Resources Review Committee Member (2018-2020)

ACEP Chapter Activities – List your most significant accomplishments

- 1 – President of Indiana Chapter of ACEP (2015-2016)
- 2 – Vice-President of Indiana Chapter of ACEP (2014-2015)
- 3 – Secretary/Treasurer of Indiana Chapter of ACEP (2013-2014)
- 4 – Indiana State Chapter Councilor (2015-2020); Alternate Councilor (2013-2015)
- 5 – Indiana Chapter of ACEP Board of Directors Member (2011-2016)
- 6 – *Ex officio* Board of Directors Member of the Indiana Chapter of ACEP (2016-present)
- 7 – Part of annual Indiana ACEP delegation at Leadership and Advocacy Conference
- 8 – State advocacy with the Indiana Legislature on scope of practice, reimbursement and other issues

Practice Profile

Total hours devoted to emergency medicine practice per year: 2250 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

| | | | | | | | |
|---------------------|-------------|----------|------------|----------|------------|----------------|-------------|
| Direct Patient Care | <u>85</u> % | Research | <u>0</u> % | Teaching | <u>5</u> % | Administration | <u>10</u> % |
| Other: | _____ | | | | | | _____ % |

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I work in a private, independent and wholly democratic group in Northern Indiana near Notre Dame University. I began with Elite Emergency Physicians (EEPI) after residency and have been with the group continuously since 2007. We now have 40+ board-certified EM physician partners and employ multiple NPPs. EEPI holds contracts at four community-based hospitals in three different hospital systems. We annually care for over 185,000 patients among our sites. Physicians joining the group become full voting and profit-sharing partners after a one-year provisional process. The corporate structure of our group is managed by partners that are democratically voted into Administrative roles which are compensated and executed while also working shifts in the department providing direct patient care. Our community-based hospital Emergency Departments welcome Indiana University School of Medicine MS-IV students through our departments for ED Clerkship teaching.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

EEPI positions:

- 1 - EEPI Director of Quality (2016-present)
- 2 - Management Team Member of EEPI (2012-present)
- 3 - EEPI Compensation Committee Member (2010-present)
- 4 – EEPI Compliance Committee Chair (2016-present)
- 5 – Volunteer Clinical Faculty for IUSM EM Clinical Clerkship (2011-present)
- 6 – Member of the IUSM Interview Admissions Team (2017-present)

Elkhart General Hospital (EGH) Positions:

- 1 – Chairman and Medical Director of EGH Emergency Department (2012-2016)
- 2 – Chairman and member of EGH ED Quality Assurance Committee (2012-2016)
- 3 – Medical Co-Director EGH Chest Pain Center (2014-2017)
- 4 – Medical Co-Director for EGH EMS Program (2010-2012)
- 5 – Member of EGH Medical Executive Committee (2012-16, 2018-present)
- 6 – Member of EGH Trauma and Trauma QI committees (2012-present)

7 – Member of EGH Cardiovascular Services and Cardiovascular Services QI Committees (2012-present)

8 – Member of EGH Stroke and Stroke QI Committees (2016-present)

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert

0 Cases

Plaintiff Expert

0 Cases

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

James L. Shoemaker Jr., MD FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Elite Emergency Physicians, Inc. (EEPI)

Address: 600 E. Boulevard

Elkhart, IN. 46514

Position Held: EEPI Director of Quality (2016-present) | Department Chairman (2012-16)

Type of Organization: Small Democratic Group of EM physicians

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: 4650 W. Royal Lane

Irving, TX. 75063

Type of Organization: EM Membership Organization

Leadership Position: Member of the Board of Directors

Term of Service: 2020-present

Organization: ACEP

Address: 4650 W. Royal Lane

Irving, TX. 75063

Type of Organization: EM Membership Organization

Leadership Position: Secretary/Treasurer

Term of Service: October 2022-present

Organization: Indiana University School of Medicine

Address: 1234 N. Notre Dame Ave.

South Bend, IN. 46617

Type of Organization: School of Medicine EM Clerkship

Leadership Position: Volunteer Clinical Faculty and Candidate Interviewer

Term of Service: Fall 2011-present

Organization: Indiana Chapter of the ACEP

Address: PO Box 17136

Indianapolis IN. 46217

Type of Organization: State chapter of ACEP

Leadership Position: Chapter President (2015-16) | VP (2014-15) | Treasurer (2013-14) | Member (2007-present)

Term of Service: 2007-present as an officer and councilor

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: I am a medical consultant for Retrieve Medical Inc. and have been offered stock options in return for my work that have not been executed at this time.

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.

James L. Shoemaker Jr., MD FACEP

Date

9/2/2023



To Whom It May Concern:

I am the current president of the Indiana chapter of the American College of Emergency Physicians. I am writing on behalf of our state chapter to express our enthusiastic support for Dr. James Shoemaker's 2023 re-election campaign for the national ACEP Board of Directors. Dr. Shoemaker has been a leader within the Emergency Medicine community on the state as well as national levels. He has served as Treasurer/Secretary, Vice President, then President of Indiana ACEP (in 2015-2016), and continues to serve as an Ex Officio Board member. In these capacities, he has been active in tackling various issues affecting Hoosier emergency physicians and their patients, particularly fair reimbursement, balance billing, APRN scope of practice, and others. His expertise in these areas has been a huge asset to the state chapter Presidents who have followed him as we advocate for excellence in emergency care for all Hoosiers.

Dr. Shoemaker has also established himself as a leader on a national scale, most particularly during his current position as a member of the National ACEP Board. He has served on multiple National ACEP committees including the Reimbursement Committee, Coding and Nomenclature Advisory Committee, Chapter Relations Committee, Clinical Resources Review Committee, and National ACEP Steering Committee. His involvement in these varied committees gives him a broad understanding of the workings of the College and gives him the insight needed to recognize and address the highest-priority issues facing ACEP membership. His presence on the Board also has given him further experience into being an effective leader for our specialty and he had demonstrated his excellence in the role in his previous term.

As a member of a private democratic group, Dr. Shoemaker has also seen the value that independent emergency medicine groups provide to the specialty. He has been a leader and member of Elite Emergency Physicians in northwest Indiana for many years and has seen the challenges that private groups face in an ever-changing landscape of medical care delivery. He is a passionate advocate for independent emergency physicians and is a co-creator of a Master class on Independent EM groups to help teach his expertise to others.

Dr. Shoemaker has been an outstanding member of the National ACEP Board of Directors since his election and has been a strong advocate on reimbursement issues, scope of practice concerns, and balance billing. He is also a natural leader for others to join in advocating for the specialty of emergency medicine. I have found his leadership an encouragement to my own involvement with

Indiana ACEP Officers and Board of Directors 2023/2024

Lindsay Zimmerman MD, FACEP
President
Emily Fitz MD, FACEP
Vice President
Kyle English MD, FACEP
Secretary-Treasurer

Board Members:
Mary Blaha DO
Ty Kelly MD
Jacob Kennedy MD, FACEP
Tricia Kreuter MD, FACEP
Tracy Rahall MD, FACEP

Justin Ritonya MD, FACEP
Nick Sansone DO, FACEP
Edward "Ted" Seall MD, FACEP
Eric Yazel MD, FACEP

Daniel Elliott MD, FACEP, FAAEM
Immediate Past President

Cindy Kirchhofer
Executive Director



INDIANA CHAPTER
American College of Emergency Physicians
PO Box 17136, Indianapolis, IN 46217
Phone: (317) 455-3335
Email: inacep@inacep.org

ACEP and emergency medicine and know that he has similarly inspired countless others. For these reasons, I am honored to support Dr. Jamie Shoemaker for his re-election to the board.

Respectfully submitted,


Lindsay Zimmerman MD, FACEP

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Daniel Elliott MD, FACEP, FAAEM
Immediate Past President

Cindy Kirchhofer
Executive Director

James L. Shoemaker Jr., MD FACEP

Councillors and colleagues,

My name is Jamie Shoemaker and I am enthusiastically running as an incumbent candidate for the ACEP Board of Directors! I am proud of my accomplishments during my first Board term -- we certainly faced serious challenges head on. Your Board crafted a new strategic plan for the College while addressing the challenges you face in your everyday working lives -- ED Boarding, workplace violence, and emergency physician mental health. We created and revised policies involving CPOM, private equity, scope creep, physician-led care, and others.

I am a partner and quality director with Elite Emergency Physicians Inc., a private, democratic group. My voice is unencumbered by corporate restrictions. My drive and dedication are boundless. I am an active listener and servant leader able to build bridges to collectively solve problems. I am an advocacy champion at the local, state, and national levels and will continue fighting for my beloved specialty and colleagues, no matter the obstacles.

ACEP invested in me as an inaugural Reimbursement Fellow. This educationally immersive program provided me a skillset, foundation, and network to skillfully fight for fair reimbursement. It initiated my fight relative to NSA, IDR, and denials, which create financial havoc for our patients. I worked to become an expert on the issues of down codes and the new ED E/M documentation guidelines. I recognize that the true "enemy" impacting our reimbursement and our patients is the healthcare insurers, who deploy unscrupulous tactics to erode our fair compensation and shift out-of-pocket costs to patients. I understand reimbursement from the micro-level of a small group to the macro-level of RVU valuation at the AMA RUC, which I serve as ACEP's Alternate Representative. I am eager and uniquely equipped to serve. We must continue this multipronged fight and I am energized to fight on.

ACEP is the voice of our specialty and I bring a megaphone so that we can gather under the collective ACEP tent to amplify our voice such that we cannot be ignored. Often, I believe we act as a circular firing squad -- seeking the same goals through disparate messaging. I want to mend splintered relationships and unite all emergency physicians. We are stronger together.

We must denounce scope creep and protect our specialty from the encroachment of non-physician providers into inappropriate roles. Nurse practitioners and physician assistants can be part of a high-functioning ED team, but the ABEM/AOBEM physician is the quarterback and essential leader of the team. Period. We must explore EM attrition and future work force needs to ensure that we are not diluting our work force with the addition of unnecessary new residency programs.

ACEP must continue to advocate for supportive practice environments, transparency, due process, and fair contracts. Further, ACEP must ensure that we are a diverse organization and actively prevent healthcare inequities. We need to expand membership and improve awareness that ACEP dues are a fairly priced investment in you and your career. As initiator and co-course director for the ACEP/EMBC Indy class, we deliver the goods for those interested in starting, advancing, or maintaining their own independent ED group.

I am here to advocate on behalf of younger members whether they are new attendings or EMRA resident physicians, while bolstering the future of our specialty for medical students not yet within EM. I am ready to serve you. I am humbled by this opportunity and graciously ask for your vote to the ACEP Board of Directors. If I receive it, I shall continue advocating and working on the "4 corners" of ACEP essential for our success -- membership, reimbursement, work force and safety/wellness.

RE-ELECT

**JAMIE
SHOEMAKER**

TO THE ACEP BOARD



**REIMBURSEMENT
★ AND ADVOCACY ★
CHAMPION!**

JAMES L. SHOEMAKER JR., MD, FACEP

INCUMBENT ACEP BOD CANDIDATE

★ UNIQUELY POSITIONED! ★

PARTNER AND QUALITY DIRECTOR IN AN INDEPENDENT, DEMOCRATIC EM GROUP

A CONFIDENT AND UNENCUMBERED VOICE TO REPRESENT OUR SPECIALTY, PATIENTS AND COLLEAGUES

AN ACTIVE LISTENER AND LEADER THAT ENGAGES OTHERS TO FIND SOLUTIONS

UNDERSTANDS THE NUANCES OF HEALTHCARE AS A BUSINESS AND THE CHANGING LANDSCAPE OF EM

A PROBLEM SOLVER AND SOLUTION MAKER

★ COMMITTED TO ACEP ★

CO-FOUNDER, INNOVATOR AND CO-COURSE DIRECTOR OF ACEP/EMBC INDEPENDENT EM GROUP MASTER CLASS

PAST IN. STATE CHAPTER PRESIDENT, COUNCILLOR AND CURRENT EX OFFICIO BOARD MEMBER

PROUD FELLOW OF ACEP

PROUDLY ENDORSED BY THE INDIANA STATE CHAPTER OF ACEP



★ REIMBURSEMENT EXPERTISE ★

TREASURER OF NATIONAL ACEP & MEMBER OF EXECUTIVE TEAM

PAST ACEP REIMBURSEMENT AND LEADERSHIP DEVELOPMENT PROGRAM FELLOW

SERVES AS ACEP'S ALTERNATE REPRESENTATIVE ON THE AMA RUC

EXPERTISE AND TRACK RECORD OF TACKLING REIMBURSEMENT ISSUES AT THE LOCAL, STATE AND NATIONAL LEVEL

INSTRUCTOR ON THE 2023 DOCUMENTATION GUIDELINES

★ ADVOCACY CHAMPION ★

STRONG, IMPASSIONED AND EFFECTIVE COMMUNICATOR

FOCUSED ON THE 4 CORNERS OF ACEP AND EM:

MEMBERSHIP
REIMBURSEMENT
WELLNESS
WORK FORCE

**★ REIMBURSEMENT AND ADVOCACY ★
CHAMPION!**

EMAIL: JSHOEMAKERMD@GMAIL.COM DIRECT CELL: (269)-267-3953

JAMES L. SHOEMAKER JR., MD FACEP

14302 Southold Drive, Granger, IN 46530 | 269-267-3953 (cell) | jshoemakermd@gmail.com

EDUCATION

Western Michigan University (formerly MSU/KCMS) – Kalamazoo, MI
Emergency Medicine Residency Training 2004-2007

Indiana University School of Medicine – Indianapolis, IN
M.D. Allopathic Medicine 2000-2004

Indiana University – Bloomington, IN
M.A. Physiology 1998-2000

Thesis: “Oxygen-dependent binding of chloride to hemoglobin: The importance of the chloride shift in acid-base physiology.” Advisor: Henry Prange, Ph.D.

Dickinson College – Carlisle, PA
B.S. Biology 1994-1997

Graduated *cum laude*

Transferred to Dickinson from Edinboro University of PA after Freshman year with full scholarship

WORK EXPERIENCE

Elite Emergency Physicians, Inc. (EEPI)

Partner and Attending Emergency Medicine Physician
ABEM Board Certified in Emergency Medicine (renewal December 31, 2028) 2007-present

Attending physician at Elkhart General and St. Joseph Hospital Emergency Departments in a small, democratic group of Emergency medicine physicians

Member of the American College of Emergency Physicians (ACEP) Board of Directors 2020-present

Secretary/Treasurer American College of Emergency Physicians (ACEP) Board of Directors 2022-present

Chairman, Elkhart General Hospital Emergency Department 2012-2016

Work to streamline ED processes including direct bedding, decreasing LWBS, patient throughput, departmental representation on committees, handling all QA concerns and complaints, maximizing Press-Ganey performance and many other tasks to allow for smooth ED operations. Served as Vice-Chairman of the ED throughout 2011.

Chairman, Elkhart General Hospital ED Quality Assurance Committee 2012-2016

Review all ED deaths, 72-hour returns and any quality or behavioral concerns brought to the committee or hospital’s attention. Review charts to ensure the standard of care is met and provide feedback to providers and/or patients. Served on the committee from 2008-2011 before becoming Chairman.

Committee Member, Elkhart General Hospital ED Quality Assurance Committee 2008-present

Committee Member, Elkhart General Hospital Stroke and Sepsis Committees 2018-present

Member of the Emergency Medicine Business Coalition 2019-present
Member of the Education committee. Work to ensure stability and success of democratic ED groups

Medical Co-Director, Elkhart General Hospital Chest Pain Center 2014-2017

Work to streamline EMS, ED and hospital processes for all patients presenting with typical and atypical chest pain. Standardize processes for patient’s requiring urgent percutaneous intervention and cardiac rule-outs for acute coronary syndrome.

Implement best practices for all facets of coronary care from arrival to discharge, including aftercare.

Management Team Member of EEPI

2012-2016

Meet to discuss and act on the day-to-day operations of our multi-million-dollar Corporation. All facets of our dynamic group are discussed and acted upon by the Management Team for presentation to the Board of Directors by this Corporate Leadership group.

Member of EEPI Compensation and Compliance Committees

2010-present

This Corporate group meets to discuss Corporate compliance, chart audits, rules and regulations as well as pay structure and distribution. Address reimbursement issues and charting compliance.

Member of Elkhart General Hospital Medical Executive Committee

2011-2016, 2019-present

Represent the Emergency Department as Chairman on this vital committee that facilitates and manages the daily operations of the Hospital and Medical Staff.

Trauma Committee and Trauma Quality Assurance Committee Member

2008-present

Serve on this hospital committee to review all trauma deaths, transfers and procedures. Intimately involved with Elkhart General Hospital's roll-out of planning to become an ACS designated Level III Trauma Center. Review Trauma cases for Quality of Care under peer review processes. Serve as Trauma Liaison in ED. Serve as ED liaison for our Level III trauma center.

Cardiovascular Services and Cardiovascular Services Quality Assurance Committee

2008-2013; 2015-present

Serve on this hospital committee to review all Cardiovascular service line issues including, but not limited to, STEMI door-to-wire time, ECG interpretations, and CVS QI issues.

ED Delegate for the EGH Cardiovascular Services Committee

2018-present

Serve on this hospital committee to review all stroke patients presenting to the hospital for timely administration of thrombolytics or mechanical thrombectomy.

President (2015-2016) and Ex Officio Board Member, Indiana ACEP Board of Directors

2010-present

Serve on the Board for Indiana's chapter of the American College of Emergency Physicians. Intimately involved with State Chapter on issues germane to the practice of Emergency Medicine in IN and the Nation. Served as *Secretary Treasurer 2013-2014, Vice-President 2014-2015 and President 2015-2016*. Actively engage with state Legislator's to advocate on behalf of the specialty and the House of Medicine in Indiana.

Councilor for Indiana ACEP at ACEP Scientific Assembly

2015-present

Selected as one of allotted Councilors to represent IN ACEP at the National ACEP meetings. Councilors are responsible for synthesis, discussion and passage of ACEP's clinical guidelines, standing on issues of national importance and representing the interests of their state as voting members at Scientific Assembly.

ACEP Council Reference Committee 'A' Member

2018

Selected as one of the Reference committee members for ACEP SA 2018 Council meeting. Actively engaged in listening to Councilor testimony and discussing Resolutions as a committee for recommendations to the Council Speaker for council voting and Resolution outcomes. Selection is for one year only.

National ACEP Reimbursement Committee Member

2015-

present

Committee members actively participate in discussions with state Medicaid, HMO and PPO as well as National payors such as CMS and Medicare with billing and payment issues regarding emergency

medicine and access to care. Emphasis on prudent lay person standard, downcoding, and the No Surprises Act. Currently, serve as ACEP Board Liaison.

National ACEP Coding and Nomenclature Advisory Committee

2019-present

Committee actively involved in analyzing Medicare, Medicaid and 3rd party payor processing policies for Deviations from CPT principles; Track payor issues that impact reimbursement; monitor ICD-10 Implementation; advocate for EM issues via the AMA CPT construct; develop FAQs to support EM colleagues with up to date information; explore Alternative Payment Model constructs and other tasks. Currently, serve as ACEP Board Liaison.

National ACEP Chapter Relations Committee

2015-2020

Committee members actively participate in discussions state ACEP chapters and act as liaisons to National ACEP. Coordinate and responsible for the disbursement of grant funding to Chapters. Appointed Chairman in 2020.

Chairman, National ACEP Chapter Relations Committee

2020

Rotated off committee and as Chairman when elected to the ACEP Board of Directors

Member St. Joseph County, IN Board of Health

2021-2023

Appointed to the Board of Health as we deal with issues facing the public safety and health of my county.

National ACEP Steering Committee

2019-2020

Steering Committee members provide counsel to the speaker and vice speaker, provide leadership to councilors, coordinate the activities of the Council meetings, and develop policies, procedures, and resolutions as requested.

Medical Co-Director, Elkhart County EMS Medical Co-Director

2010-2012

Provided physician medical control and oversight of EMS Providers. Undertook complete revisions to EMS field protocols, provided QA feedback and educational opportunities.

EEPI Director of Quality and Compliance

2016-present

Director of Quality initiatives, peer review, evidence-based practice and performance metrics. Align group practice with ACEP Clinical Policies and Evidence-based practice. Compliance audits of charts. Representation for EM Legislative issues at the State and National level. Chair the EEPI QA Committee.

Course Co-Director and Curriculum Innovator, ACEP/EMBC Independent EM Group Master Class **2022-present**

Developed a course for colleagues interested in cutting-edge best practices for EM practice management including leaders looking to bring their established EM group to the next level of sophistication, future leaders of established EM groups, engaged members of independent EM groups who want to stay informed, and leaders who are considering starting a new independent EM group.

Indiana University School of Medicine Admissions Committee

2018-present

Appointed to the IUSM Medical school Admissions Committee to interview and rank prospective students for admission to the IUSM.

Indiana University School of Medicine Volunteer Clinical Faculty

2013-present

Actively engaged in the Emergency Medicine clerkship education for the MS-IV IUSM students through direct patient contact, didactics and lectures. Help teach procedural skills to the medical students (intubation, suturing, ultrasound, cardioversion, ACLS and many others)

ACEP Reimbursement and Leadership Development (RLDP) Fellow

2018-2020

Selected from a pool of over seventy highly-qualified candidates as one of five RLDP Fellows. This outstanding opportunity is led by ACEP's Reimbursement Director, David McKenzie, CAE, and is a totally immersive experience to help us develop the

skills necessary to continue ACEP's essential roles in the reimbursement arenas with CMS, commercial payors, Medicaid, RVS Committee and many committees/arenas. Some issues include balance billing, physician fee schedules, RVS committee, CPT, ERISA and many other arenas. Serve on the ACEP/EDPMA joint task force.

ACEP Alternate Representative for AMA/Specialty RVS Update Committee (RUC) present 2019-

Selected as the Alternate Delegate for ACEP at the AMA Resource-Based Relative Value Scale (RBRVS) Update committee to serve the specialty of Emergency medicine and the House of Medicine as a whole in assignment and updates to the model used to pay physicians for services rendered for CMS. I also serve on multiple committees within the RUC structure. The 5 members of the RUC team represent all of EM at the AMA RUC.

Member of AMA/Specialty RVS Update Committee (RUC) Research Committee present 2021-

Selected as a RUC representative on the Research committee that is responsible for evaluating the processes uses by Medical societies in surveying their members to make RVU recommendations.

PUBLICATIONS, PRESENTATIONS, LECTURES AND PAPERS

Multiple peer-reviewed publications, presentations, and lectures available upon request.

Peer reviewer and Editor for the ACEP/EMRA "Practice Essentials of Emergency Medicine" as well as "What Every EM Resident Needs to Know about Reimbursement."

Annual conferences attended: ACEP Scientific Assembly – ACEP Reimbursement and Coding – EDPMA Solution's Summit – ACEP LAC and multiple ACEP State Chapter meetings.

MEMBERSHIPS

Fellow, American College of Emergency Physicians (ACEP)
Ex Officio Board of Directors Member and Past President of Indian ACEP Chapter
 Member, American Medical Association
 Member, EDPMA
 EMRA Alumni Member

REFERENCES

Available upon request



ADVANCING EMERGENCY CARE 

Council Officer Candidates



Scientific Assembly

PHILADELPHIA, PA

23

2023 Council Officer Candidates

Speaker



Melissa W. Costello, MD, MS, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Vice-Speaker



Kurtis A. Mayz, JD, MD, MBA, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



Michael McCrea, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



Larisa M. Traill, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

2023 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Melissa W. Costello, MD, FACEP

Question #1: How do you see yourself advocating for the College as a non-voting participant at ACEP Board of Directors meetings?

An effective Council Officer must be able to quickly synthesize the information from the previous discussions/votes/committees during an often-fast-moving debate in order to offer the both the perspective and justification for the positions of the Council. Often, this involves the synthesis of information that has come to light between Council meetings. Occasionally, that new information may have changed the outcome of a vote. While I may have strong opinions on many topics, when it comes to advocacy at the Board level, I set my personal feelings and opinions to the side and advocate for the position of the Council. I listen carefully during all the testimony and discussion of each resolution or policy to understand the *intent* of the Council and that is what guides my advocacy on behalf of the Councilors. It allows me to present well-reasoned arguments and shape the conversation to build consensus around the viewpoint of the Council.

Question #2: What is your vision for disseminating the work of the Council more broadly?

The “work” of the Council is the resolution writing, testimony and votes that occur to make effective policy within the organization. The basics of that information are distributed in the reports from the Council Officers issued quarterly. Additionally, the action on every item debated in Council since 1993 is archived in a searchable database on the ACEP website at <https://www.acep.org/what-we-believe/actions-on-council-resolutions>. Further dissemination of the processes, outcomes and action items can come through multiple ACEP-associated venues like, member communications, posts from marketing, PR materials, the ACEP Frontline podcast, 9-1-1 network spokespersons and the legislative/congressional updates. Too broad a distribution of the work lends itself to losing control of the information in venues where we (the Council officers, the Board, or ACEP Communications office) do not have the opportunity to effectively respond as an organization. The reputational damage of this can be significant and requires careful and deliberate efforts at transparency, without allowing others to control the narrative about the extremely important work done each year by the Council on behalf of EM physicians around the country.

Question #3: How would you navigate through the challenges that may arise when the Council and the Board of Directors do not share the same view on an issue?

The work to avoid serious discord at the Board-level starts long before the resolutions come from Council to the Board for approval. Participation in resolution writing workshops and mentorship of resolution authors is the responsibility of all members of the Council, but it is particularly important for the Council officers. Getting solid ideas with sound language in front of the Council on the first try will significantly “grease the skids” towards making new policy. Writing and editing the background material in order to help frame the debate and allowing asynchronous testimony to hash out the arguments ahead of time all help us arrive at our annual Council meeting at “first-and-goal” rather than “fair-catch at the 50”, or (to further torture this analogy) it is like arriving at Council as an SEC football team rather than ____ (fill in your team here)____. [cough – Roll Tide – cough]. Building friendships and relationships over the long term is also critical so that coalition-building around any issue begins long before the gavel taps to open debate at the Council meeting or at the Board. The biggest challenge when the Council and the Board have different views is the same as in any organization: how to “disagree without being disagreeable”. After many years of Council meetings, it is not hard to predict which issues will be contentious on the floor and contentious in the Board meetings. The beauty of our parliamentary process is that we do not close debate until both sides have been heard on an issue. This allows the Speaker and Vice-Speaker to prepare solid arguments in favor of the Council’s position and be well prepared to refute opposition from the Board members who try to alter the intent of a resolution passed by Council. Ultimately, it is about maintaining respect and decorum so that common ground can be found and the group can arrive at a constructive solution that contributes to the success of ACEP as a whole.

CANDIDATE DATA SHEET

Melissa W. Costello, MD, FACEP

Contact Information

109 Myrtlewood Lane, Mobile, AL 36608

Phone: 251-753-2698

E-Mail: emsdoc1@gmail.com, mcostello@acep.org

Current and Past Professional Position(s)

Current:

Global Medical Response – National Medical Director for Revenue Cycle, Lewisville, TX
Baldwin Emergency Group, PC: Infirmiry Health System – Emergency Physician, Mobile, AL
Emergency Room Group, PC: Singing River Health System – Emergency Physician, Pascagoula, MS
Mobile Police Department – Police Surgeon, Mobile, AL

Previous:

Air Methods Corporation – EMS Medical Director, SouthFlight and LifeSaver Aircraft - Alabama
Augustine Emergency Physicians, Sacred Heart Health System – Emergency Physician, Pensacola, FL
Acadian Ambulance Company – EMS Medical Director, Mississippi Operations
Mobile Emergency Group, Infirmiry Health System – Medical Director, Mobile, AL
Ascension Providence Hospital Emergency Group – Emergency Physician, Mobile, AL
University of South Alabama - Associate Professor of Emergency Medicine, Mobile, AL
University of South Alabama – Adjunct Professor for EMS and Dept of PA Studies
William Carey University College of Osteopathic Medicine – Adjunct Professor of Emergency Medicine

Education (include internships and residency information)

Emergency Medicine Residency – Johns Hopkins Medical Institutions 2000 – 2003

Doctor of Medicine: University of Alabama at Birmingham: 1996-2000

Masters of Science- Science of Healthcare Delivery: Arizona State University: 2017-2019

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

Emergency Medicine Board Certified: American Board of Emergency Medicine

Original 2004, Recert 2014, Recert for 2024 complete

Emergency Medical Services Board Certified: American Board of Emergency Medicine

Original 2013, Recert for 2023 complete

Professional Societies

American College of Emergency Physicians

National Association of EMS Physicians

Alabama ACEP

Medical Association of the State of Alabama

Mobile County Medical Society

National ACEP Activities – List your most significant accomplishments

Council Vice Speaker – Elected 2021

Finance Committee – 2021-2023
 Wellness Committee: 2020-2022
 Steering Committee: 2017-2019
 Education-EMS Subcommittee: 2015-21
 Tellers, Elections and Credentials Committee: 2012-2019: **Chair 2014-18**
 EMS Committee: 2008-2015, **Chair: 2011-2014**
 EMS Section: Councilor: 2009, Sec-Treas: 2012 Chair-elect: 2014 **Chair: 2016-18**
 Tactical Medicine Section: Councilor 2007-2012
 Excited Delirium Task Force: 2008-2009
 EMS Subspecialty Board Review: **Course Committee 2012-2014**
 ACEP/Emergency Medicine Foundation Teaching Fellowship: 2006

ACEP Chapter Activities – List your most significant accomplishments

Alabama ACEP
 Board of Directors 2008-2016
 President 2014-15
 Councilor/Alt Councilor 2012-present

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 5 %
 Other: EMS Med Director (10%), EMS Peer-to-Peer & Grievance Hearings (40%) 50 %

Describe current emergency medicine practice.

I am the National Medical Director for Revenue Cycle for Global Medical Response. I currently lead the medical side of the revenue division dealing with insurance appeals, representing patients in grievance hearings with their insurance companies, managing quality improvement for the documentation and coding divisions among other responsibilities.

I am clinically active as an EMS medical director and work clinically with two practices (BEP and Singing River ERG- see above). ER clinical time varies between about 50-70 hours per 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.)

National Medical Director – Revenue Cycle, GMR

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 0 Cases

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Melissa W. Costello, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Global Medical Response

Address: 4400 State Hwy 121, Suite 700
Lewisville, TX 75056

Position Held: National Medical Director for Revenue Cycle

Type of Organization: EMS Transport Company

Employer: Baldwin Emergency Group, PC Emergency Room Group, PC

Address: 5 Mobile Infirmary Circle 2809 Denny Ave
Mobile, AL 36606 Pascagoula, MS 39581

Position Held: Emergency Physician Emergency Physician

Type of Organization: Private EM group Private Democratic EM 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: Mobile County EMS Systems, Inc

Address: 10394 Moffett Rd.
Semmes, AL 36575

Type of Organization: County EMS Agency

Leadership Position: Board of Directors

Term of Service: 2007-present

Organization: Alabama ACEP

Address: 19 South Jackson St
Montgomery, AL 36104

Type of Organization: ACEP State Chapter

Leadership Position: Board of Directors, President

Term of Service: 2008-2016, President 2014-2015

Organization: Medical Association of the State of Alabama

Address: 19 South Jackson St

Montgomery, AL 36104

Type of Organization: State Medical Association

Leadership Position: Council on Medical Service, Chair-YPS, Vice President

Term of Service: CMS 2005, YPS Chair 2009-2010, VP 2011

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than \$100.

NONE

If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

NONE

If YES, Please Describe: See employment (GMR above). Receive share purchase options as part of my compensations structure

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

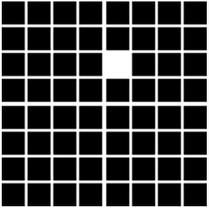
YES

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.

Melissa Costello

Date

6/22/23



ALABAMA CHAPTER American College of Emergency Physicians

OFFICERS

President

Hamad Husainy, MD, FACEP

President-Elect

Sean Vanlandingham, MD,
MBA, FACEP

Secretary-Treasurer

Annalise Sorrentino, MD, FACEP

Immediate Past President

Bryan Balentine, MD, FACEP

BOARD OF DIRECTORS

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Shea Duerring, MD, FACEP
Will Ferguson, MD, FACEP
David Garvey, MD, FACEP
Bobby Lewis, DMD, MD, FACEP
Stephen Knight, MD
Jaron Raper, MD
Robert Schneider, MD, FACEP
Annalise Sorrentino, MD, FACEP
Michael Sternberg, MD, FACEP
Benjamin Von Schweinitz, MD
Christopher White, MD

EXECUTIVE DIRECTOR

Meghan Martin

Dear Fellow Councillors,

It is with great pleasure that the Alabama College of Emergency Physicians endorses Melissa Costello, MD, FACEP for ACEP Council Speaker. Melissa served with distinction as a member of ALACEP's Board of Directors for eight years including a term as president. She has been a strong supporter of ALACEP Leadership and our annual education program, The EMerald Coast Conference. In addition to her work at the state level, Melissa has been a tremendous asset to national ACEP. She has been active in ACEP leadership, chapter support as well as the ACEP Council where she has served as councillor numerous times on behalf of ALACEP And the Tactical Medicine Section. She has also actively served on the Tellers Committee and the Council Steering Committee which has allowed her to cultivate successful relationships with current and past leaders. In addition, she has led or served on various committees including Wellness and EMS.

With each endeavor, Melissa has built upon and proven her ability to lead by determination and dedication to strengthening the future of ACEP. These many responsibilities she has taken on with our organization have not diminished her roles in her clinical positions here in Alabama as she is still an active full-time clinician in Alabama, Mississippi, and Florida and leads four different agencies as EMS Medical Director. I would respectfully ask that you join our chapter in support of the election of Melissa Costello, MD, FACEP as Council Speaker of the American College of Emergency Physicians.

Sincerely,

Hamad Husainy, MD, FACEP

President

ALACEP

Melissa W. Costello, MD, FACEP

Dear Colleagues/Friends,

Thomas Jefferson said, “the most valuable of all talents is that of never using two words when one will do”. I hope you will indulge me these two: Thank You.

It has been my pleasure to serve as your Council Vice Speaker for the last two years. I thank all of you for putting your trust in me and I ask for your support as the next ACEP Speaker.

The steady handed guidance of Dr. Kelly Gray-Eurom has been indispensable, and she leaves me with big shoes to fill as she moves to the “Immediate Past Speaker” role. I hope to demonstrate to all of you, my colleagues, that she has taught me well and that I am fully prepared to represent you as your Council Speaker.

My goals as Speaker are very similar to those I wrote about as a candidate for Vice Speaker: running efficient and effective Council meetings, speaking clearly with *your* voice to the Board of Directors, and keeping the Council informed on the progress of our business.

There have been tough issues to handle in the past two years and there are many more to come. The financial headwinds we are facing as an organization cannot be understated and will be the constant lens through which all Council work will need to be viewed. It is critical that the Speaker and Vice Speaker work together to keep the Council *laser-focused* on the issues that make up the core of both our clinical practice and our organizational identity as the true voice of the Emergency Physician. I humbly offer my service to you, the Council, in this new role and look forward to working with any of the three wonderful candidates for Vice Speaker.

Melissa Wysong Costello, M.D., M.S., FACEP, FAEMS

emsdoc1@gmail.com

109 Myrtlewood Lane, Mobile, Alabama 36608

*251-753-2698 (cell) 251-202-9110 (google voice) 251-652-3133 (home)

Education:

Arizona State University, Tempe, AZ

Master of Science, Science of Health Care Delivery, Dec 2019

University of Alabama School of Medicine, Birmingham, AL

Doctor of Medicine, May 2000

Georgetown University, Washington, DC

Bachelor of Science in Biology, May 1995

Internship/Residency Training:

Johns Hopkins University School of Medicine, Baltimore, MD

Emergency Medicine: 2000-2003

Board Certifications:

American Board of Emergency Medicine

Emergency Medicine – 2004, current including MOC through 12/31/2024

Emergency Medical Services – 2013, current including MOC through 12/31/2023

Current Positions/Appointments:

Global Medical Response, National Medical Director – Revenue Cycle 1/2023-present

Mobile Infirmery Medical Center, Mobile, Alabama

Staff Emergency Physician: Baldwin Emergency Group, PC 12/2018-present

Facility Medical Director: Mobile Emergency Group, LLC 7/2014-11/2018

Singing River Hospital System, Pascagoula, Mississippi

Staff Emergency Physician - Emergency Room Group, LLC 1/2019-present

EMS Medical Director Positions:

Mobile Fire & Rescue, Urban Search and Rescue 6/2006-present

Federal Bureau of Investigation, Mobile Division, SWAT Medical 9/2007-present

Baptist LifeFlight/Alabama Lifesaver (ext 6/2023) 11/2008-present

Mobile Police Department, Police Surgeon 2/2016-present

US Department of Health and Human Services: NDMS

Medical Officer – Trauma Critical Care Team -South (TCCT-S) 10/2018-present

Supervisory Medical Officer: AL-3 DMAT 10/2003-10/2018

Credentials:

Licenses:

Alabama: exp. 12/31/23 with unrestricted DEA/ACSC

Mississippi: exp. 06/30/2023

Georgia: exp. 7/31/2025

Florida: exp. 1/31/2025

DEA X-Waiver with MAT training 6/2020

Fellow, American College of Emergency Physicians (FACEP), 2006

Fellow, National Association of EMS Physicians (FAEMS), 2016

Epic: Physician Builder Certified 11/2016

Lean Six Sigma: Green Belt: April 2018

Biocontainment Training: November 2019

Specialized immersive training in the University of Nebraska Biocontainment Unit via the NDMS Isolation, Simulation and Quarantine Program for highly infectious diseases.

COVID-19 Experience:

Full-time EM employment throughout COVID-19 beginning in March 2020. Hospital census at COVID peak was 140 with 30+ on vents.

Vaccine – Pfizer 12/16/2020, 1/6/2021, 11/1/2021

Previous Positions:

| | |
|--|----------------|
| AirMethods Corporation , Denver, CO | 1/2017-1/2023 |
| Clinical Appeals Consultant/Utilization Review/Medical Director | |
| Ascension Sacred Heart Hospital , Nine Mile Free Standing ED, Pensacola, FL | 12/2020-9/2022 |
| Staff Emergency Physician – Augustine Emergency Physician, LLC | |
| Singing River Hospital System , Pascagoula, MS | 10/2010-8/2014 |
| Emergency Physician/Partner, Emergency Room Group, LLC | |
| Acadian Ambulance | 6/2011-5/2014 |
| EMS Medical Director, Mississippi Operations | |
| University of South Alabama College of Medicine, Mobile, Alabama | 7/2003-9/2010 |
| Associate Professor of Emergency Medicine (adjunct 2010-2019) | |
| Adjunct Assoc. Professor of EMS Studies | |
| Joint Associate Professor of Physician Assistant Studies | |
| Clinical Instructor – Pediatric Emergency Medicine | |
| Providence Hospital, Mobile, Alabama | 2/2008-12/2010 |
| Emergency Physician-Department of Emergency Medicine | |
| Gulf Coast MedEvac , Helicopter EMS, Mobile, Alabama | 3/2006-9/2008 |
| Medical Director, AirMethods Corporation | |
| South Baldwin Regional Medical Center | 10/2005-9/2007 |
| Emergency Physician- Emerald Healthcare Group, LLC | |

Consulting:

Subject Matter Expert for Emergency Medicine and EMS:

Independent Review Panel Aurora, CO: 2020-2021

Expert Witness Consulting for Emergency Medicine and EMS – since 2007

Awards and Appointments:

American Board of Emergency Medicine

Oral Board Examiner: 2008-present

American College of Emergency Physicians

Council Vice Speaker – Elected 2021

Wellness Committee: 2020-2022

Steering Committee: 2017-2019

Education-EMS Subcommittee: 2015-21

Tellers, Elections and Credentials Committee: 2012-2019 Chair 2014-18

EMS Committee: 2008-2015, Chair: 2011-2014

EMS Section: Councilor: 2009, Sec-Treas: 2012 Chair-elect: 2014 Chair: 2016-18

Tactical Medicine Section: Councilor 2007-2012

Excited Delirium Task Force: 2008-2009

EMS Subspecialty Board Review: Course Committee 2012-2014

ACEP/Emergency Medicine Foundation Teaching Fellowship: 2006

Alabama ACEP

Board of Directors 2008-2016

President 2014-15

Councilor/Alt Councilor 2012-present

Mobile Infirmary Medical Center

Chair, Critical Care Committee: 2016-2018

Medical Executive Committee: Division Representative 2016-2018

Electronic Health Record Committee: 2015-present

TeamHealth

Nomination for Medical Director of the Year for Southeast Group: 2017

American Medical Association

2008 Excellence in Medicine Leadership Award

Alabama Office of EMS and Trauma

EMS Advisory Committee Chair 2009-2011, HEMS subcommittee

Mississippi Office of EMS

EMS Performance Improvement Committee 2012-2015

Mississippi Department of Public Health:

Trauma System Surveyor 2015-2019

Mobile County EMS Systems

Board of Directors, 2007-present

University of South Alabama College of Medicine

Faculty Senator: 2004-2006

Admissions Committee: 2005-2008

Red Sash Teaching Award: 2004, 2005, 2007, 2008, 2009

Medical Association of the State of Alabama

Vice-President 2010-2011

Chair, Young Physician Section, 2006-2009

Council on Medical Education 2005

Residency and Student Activities:

United States Secret Service

Clinical Instructor- Paramedic Refresher Courses 2001-2003

Medical Support- 2002 Olympic Winter Games, Salt Lake City, UT

Instructor- USSS Rescue Swimmer Certification Course

Medical Association of the State of Alabama (MASA)

State Chair: MASA-MSS 1999-2000

University of Alabama School of Medicine

Class President, Tuscaloosa Class of 2000,

Honor Court, 1998-2000

Personal:

Spouse: Sean P. Costello, United States Attorney: Southern District of Alabama, Criminal Chief

Children: Catherine (21), Ashley (18), Reagan (17)

Publications:

Refereed/Peer Reviewed

- Vilke GM, Debard ML, Chan TC, Ho JD, Costello MW, et al. “Excited Delirium Syndrome (ExDS): Defining Based on a Review of the Literature”. *J Emerg Med.* 2011 Mar 24.
- Costello MW, Bolling R., Gonzalez R. “Colon Perforation with High Pressure Water Injection – a Case Report”. *Journal of Trauma: Injury Infection and Critical Care.* 65(1):222-224, July 2008.
- Costello MW, Heins A, Zirkin D. “North American Snake and Scorpion Envenomation: Diagnosis and Treatment”. *Emergency Medicine Practice.* September 2006.
- Heins A, Grammas M, Heins JK, Costello M, Huang K, Mishra S. Determinants of variation in analgesic and opioid prescribing practice in an emergency department. *Journal of Opioid Management.* 2006;2(6):335-340.
- Heins JK, Heins A, Grammas M, Costello M, Huang K, Mishra S. Disparities in Analgesia and Opioid Prescribing Practices for Patients with Musculoskeletal Pain in the Emergency Department. *J Emerg Nurs.* 2006;32:219-24.
- Costello MW. “Images in Emergency Medicine: Atlanto-occipital dislocation (AOD)”. *Annals of Emergency Medicine.* 44(3): 277, 2004 Sep.

Other Publications

- Smith J, Costello MW, Villasenor R. Investigation Report and Recommendations, City or Aurora, Colorado February 22, 2021. Available at: https://www.auroragov.org/news/whats_new/independent_report_released_in_mc_clain_case
- Costello MW. 5 chapters in Mattu A, Chanmugam A et al (Eds) Avoiding Common Errors in the Emergency Department. Lippincott 2010.
- AAOS, ACEP, UMBC Authors (Costello MW - Reviewer) Critical Care Transport. Jones & Bartlett 2009.
- Costello MW. EMRA Top 30 Clinical Problems in Emergency Medicine. 2nd edition. Editors: Katz G, Moseley M. June 2008.
- Costello MW, McNair WS. Intussusception. Chpt 34 In Cline D, Stead L Abdominal Emergencies. McGraw Hill 2007.
- Costello MW. “Ultrasound Guided Vascular Access”. ACEP News. 2005 Dec.
- Costello MW. “Tissue Plasminogen Activator in Advanced Cardiac Life Support”. Practical Reviews in Emergency Medicine. 2003.
- Wysong MH. “P31 NMR Spectroscopy in Highly Trained Athletes”; Georgetown University Senior Thesis 1995
- Ward KM, Rajan SS, Wysong M, Radulovic D, Clauw DJ. Phosphorus nuclear magnetic resonance spectroscopy: in vivo magnesium measurements in the skeletal muscle of normal subjects. [Journal Article] *Magnetic Resonance in Medicine.* 36(3):475-80, 1996 Sep.

Poster Presentations

- Heins A, Grammas M, Heins JK, Costello M. Disparities in Emergency Department (ED) Pain Management. SAEM Annual Meeting, New York, NY. May 2005.

Significant Lectures/Presentations/Speaking Engagements:

- Air Methods: New Hire Orientation Cadaver Lab instructor (quarterly 12/2017-12/2018)
- ACEP Scientific Assembly 2017: Weed Wars and Gun Battles 10/2017
- Air Methods: Case Reviews in Airway and Vent Management 8/2016
- Pinnacle EMS Conference: Understanding Current EMS Research 7/2016
- TeamHealth: 2-day High Fidelity Simulation Education for Emergency Medicine 6/2016
- Assoc. for Prof in Infection Control and Epidemiology: Sepsis Care for EMS/ED 4/2016
- Mobile Infirmiry Stroke Symposium: Golden Hour of Stroke Care 3/2015
- Surviving Trauma Conference: 10 Commandments of EMS 11/2014
- Mississippi Trauma Symposium: Ketamine and Tourniquets 5/2014
- Gathering of Eagles: Ketamine: Another Way to Break the Ache 2/2014
- ACEP/NAEMSP EMS Board Review Course Faculty: 8/2012,9/2013, 10/2013
- Mississippi Trauma Symposium 5/2013
- Surviving Trauma Conference: Bomb and Blast Injury 11/2012
- Mississippi Stroke Symposium: Golden Hour of Stroke Care 6/2012
- Surviving Trauma Conference: EMS and Law Enforcement 11/2011
- Tactical Medicine 3-day Course Faculty: 8/2011
- Gulf Coast Regional Trauma Symposium: Tactical Emergency Medicine 11/2010
- Homeland Security Professionals Conference: Tactical EMS for Law Enforcement, 10/2010
- Gulf Coast Regional Trauma Symposium: Pediatric Trauma, 8/2010
- Orthopedics Grand Rounds, Procedural Sedation and Regional Anesthesia, 12/2009
- AMEC, Difficult Airway Management for EMS, 2/08, 11/08, 7/09, 8/09, 5/10, 8/10
- NDMS Training Summit, The Use of Real-time Ultrasound in DMAT: 3/08, 4/09
- Surgery Grand Rounds, Post-Disaster Medical Care 2/2009
- Gulf Coast Regional Trauma Symp., Disaster Preparedness for Medical Providers, 9/2008
- FBI, Buddy Aid and Basic First Aid for the SWAT operator, 11/2007
- NDMS Conference, The Use of Real-time Ultrasound in DMAT 3/2007
- ACEP New Speakers Bureau, Cocaine Overdose: An Unexpected Source, 10/2006
- Gulf Coast Regional Trauma Symposium, Post-Disaster Medical Care, 4/2006
- Teaching Fellowship, Ultrasound Curriculum for EM Faculty, 3/2006
- American Medical Women's Association, Balancing Life and Medicine, 3/2005

2023 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Kurtis A Mayz, JD, MD, MBA, FACEP

Question #1: How do you see yourself advocating for the College as a non-voting participant at ACEP Board of Directors meetings?

As Vice Speaker the job of advocacy as a non-voting member of the Board starts long before seated in the boardroom. Effective advocacy involves establishing relationships and a friendly rapport with both members of the Council and the Board, as well as members of the College. That process leads to the sense of mutual trust which helps the Vice Speaker effectively advocate for the Council. If I have the honor of becoming Vice Speaker, I will work with the Speaker to cultivate these relationships in order to help the Council reach its goals and objectives. Discussing issues in both a personal as well as group setting is instrumental in guiding the Board in the direction that the Council has intended to go. This is instrumental in achieving what is most important to me, the will of the Council.

As Vice Speaker, I will work with the Speaker to keep the Council informed of current events. I will engage the membership, soliciting their valuable input so I can strongly advocate for them when I meet with the Board. I will synthesize and distill the Council meeting testimony and directives from the Council resolutions and use that information to formulate and support arguments which uphold the principles set forth by the Council. When there are points of controversy or issues not already well defined or considered by the Council, I will engage the steering committee and solicit input from the Council, to ensure that the will of the Council is well represented.

As an attorney I understand my role as an advocate well. As Vice Speaker and advocate for the Council and membership at large, I see my role as at times a partner and other times the loyal opposition to the Board. Sometimes partnering, and sometimes challenging them to consider issues from the broader perspective of the entire College. As a skilled advocate, I know my job is to understand the position of the Council, understand what is important to the Board, and why those ideas are important. That way, when you graciously cast your vote for me as Vice Speaker, I am convinced that I can help craft solutions that create the win/win scenarios which ultimately benefit all of us.

Question #2: What is your vision for disseminating the work of the Council more broadly?

The work of the Council is essential to the strength of the College, yet is not always well known to its members. Ensuring that this important work is disseminated more broadly recognizes its importance to the College, encourages the transparency that the membership desires, and creates an external presence that is strategically useful in furthering the mission of the College.

As Vice Speaker I will work with the Speaker and chapter leaders at the chapter level to help disseminate the work of the Council by both providing regular written updates on the work of the Council and attending chapter meetings as requested. At the Council level I will continue to make robust use of the engagED Council forum to share Council work and seek input as needed. At the membership level, having a regular "Council Minute" column in ACEP Now as well as providing Council updates in the ACEP weekend review can help highlight to the general membership, the work that the Council is doing throughout the year and direct them to the "Council Corner" for additional resources.

I will work with the Speaker to develop the "Council Corner," an online resource that incorporates the existing online Council resources and highlights the ongoing work of the Council in a way that demonstrates how that work benefits the membership. This resource can be used to by the Council and membership at large and will help continue to drive the narrative that being a member in ACEP brings value thereby assisting in recruiting and retaining members.

I would also consider having Council social media accounts to be able to provide highlights and updates in real time. This creates the added benefit of providing an external face of the Council which spotlights its important work to other stakeholders and collaborators as well as the community at large. Strategically communicating the work of the Council through social media and other media outlets can also help the College in its advocacy efforts.

Finally, I will work with the Speaker to ensure that the work of the Council is well represented in our legislative advocacy efforts. The work of the Council can be used to highlight the great work of our members in a way that furthers our legislative advocacy. The storylines that are derived from the work of the Council should be effectively communicated and cultivated for use by our legislative partners.

Question #3: How would you navigate through the challenges that may arise when the Council and the Board of Directors do not share the same view on an issue?

The Vice Speaker and Speaker are the advocates in chief for the Council to the Board. My primary responsibility as Vice Speaker is to ensure that your voice is heard and the goals of the Council are achieved. When there are differing views I will use my skill as an attorney and registered parliamentarian to **anticipate** the challenges, **collaborate** with the Board, **engage** relevant parties, and **propose** alternative solutions.

As Vice Speaker, when conflict arises it is important that I clearly understand the intent and will of the Council. That work begins with careful study of the resolutions prior to and after council and thoughtful consideration and understanding of the testimony provided at Council. With the Council's clear intent in mind, I can then **anticipate** the conflict and determine whether it is based on the position or viewpoint expressed or the underlying interest and intent of the Council. I will then advocate for positions that represent the underlying interests of the Council in a way that best represents the intent of the Council while addressing the concerns of the Board.

Just as the Council floor can be a challenging place to work out the finer details of a resolution, the boardroom too can be a difficult place to resolve conflict. Fostering relationships with individual board members and having personalized discussions regarding their concerns in advance, can help get to the heart of the underlying reasons, motivations, or values driving the disagreement. As Vice Speaker, I will work to **anticipate** specific conflicts, **engage** board members early in the process of discussing our differences, and **collaborate** to find solutions that satisfy the intent of the Council and allay the concerns of the Board.

As an advocate for the Council, I will also look to you, the Council membership for your expertise and opinions. I will use the engagED forum to disseminate information regarding Board discussions and concerns and use it as a place for councillors to bring up concerns, discussion points and proposed solutions. I recognize that to be your voice I also need to hear your voice throughout the process and not just on the Council floor.

If the Board makes a decision that does not reflect the will of the Council I will bring that decision back to you with detailed information regarding the Board's decision including the positions and votes of individual Board members. I will then work with Council members to **propose** additional resolutions and alternative solutions to help resolve the disagreements in favor of the will of the Council.

As Vice Speaker I will listen as effectively as I speak, guide as effectively as I lead, and encourage as effectively as I advocate. Ultimately I will work to foster a spirit of **collaboration** and engage with the Board in ways which will allow the collective wisdom of College leadership to emerge in a way that meets our unified purpose, a strong College which represents all of its members well and ensures that **your voice is heard**.

CANDIDATE DATA SHEET

Kurtis A Mayz, JD, MD, MBA, FACEP

Contact Information

420 E Archer Street, Apt 405 Tulsa, OK 74120

Phone: 914-420-7927

E-Mail: drmayzesq@gmail.com

Current and Past Professional Position(s)

CURRENT POSITION

Chairman Pediatric Emergency Medicine
Medical Director Pediatric Emergency Center
Saint Francis Hospital, Tulsa, OK

PREVIOUS

Emergency Medicine Physician
Heart of Mary Hospital, Urbana, IL

Firefighter (Traveling Physician)
United States Acute Care Solutions

Emergency Medicine Physician
Presence Saint Joseph Medical Center, Joliet, IL

Associate Director and Vice Chairman-Department of Emergency Medicine
Presence Saint Joseph Medical Center, Joliet, Illinois

Interim Medical Director and Chairman- Department of Emergency Medicine
Presence Saint Joseph Medical Center, Joliet, Illinois

Assistant Director-Department of Emergency Medicine
Presence Saint Joseph Medical Center, Joliet, Illinois

Attending Physician- United States Acute Care Solutions (USACS)
Genesys Regional Medical Center, Grand Blanc, Michigan

Education (include internships and residency information)

Education

Masters of Business Administration: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois

Medical Doctor: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois

Juris Doctor: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois

BA: Political Science; BA: Biology
Certificate in Lobbying: Center for Congressional and Presidential Studies
The American University, Washington, DC

Post Graduate Training

Pediatric Emergency Medicine Fellowship
University of Michigan Health System, Ann Arbor, Michigan

Chief Resident, Emergency Medicine, Patient Safety and Quality Improvement
Stony Brook University Medical Center, Stony Brook, New York

Emergency Medicine Resident
Stony Brook University Medical Center, Stony Brook, New York

MD: 2011

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine-Pediatric Emergency Medicine (2019)
American Board of Emergency Medicine (2016)

Professional Societies

American Institute of Parliamentarians
National Association of Parliamentarians
American College of Emergency Physicians
Emergency Medicine Resident Association
Oklahoma College of Emergency Physicians
American Academy of Emergency Medicine
American Academy of Pediatrics
American College of Legal Medicine
American Bar Association
American Health Lawyers Association
American Medical Association

National ACEP Activities – List your most significant accomplishments

ACEP Teaching Faculty- Medical-Legal

Council:
Vice Speaker Candidate (21)
Steering Committee Member (20-21)
Reference Committee Member (19, 20, 22)
Tellers and Credentials Committee Member (20-Present)
Special Task Force on Council Elections (19)
Councillor (OK/IL): (17-Present)

Committees:
Pediatric Emergency Medicine
Medical Legal
Bylaws

ACEP Chapter Activities – List your most significant accomplishment

Board of Directors: Oklahoma College of Emergency Physicians
Bylaws Committee Chair: Oklahoma College of Emergency Physicians
Councillor: Oklahoma College of Emergency Physicians
Councillor: Illinois College of Emergency Physicians

Practice Profile

Total hours devoted to emergency medicine practice per year: 1680 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 50 % Research 0 % Teaching 10 % Administration 40 %

Other: _____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am the Chairman of Pediatric Emergency Medicine and Medical Director of the Pediatric Emergency Center at the Children’s Hospital at Saint Francis in Tulsa, Oklahoma. The hospital is one of 6 sites in the Saint Francis Health System and is one of two Children’s Hospitals in the state of Oklahoma. We are a referral hospital for the state and surrounding region with multiple subspecialties and operate as a level 1 trauma center although not currently designated by ACS. We play host to 6 different residency programs in Emergency Medicine, Pediatrics, and Family Medicine.

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.)

Chairman of Pediatric Emergency Medicine
Medical Director Pediatric Emergency Center

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 2 Cases Plaintiff Expert 0 Cases

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Kurtis A. Mayz, JD, MD, MBA, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: United States Acute Care Solutions

Address: 4535 Dressler Rd NW, Canton, OH 44718

Position Held: Chairman Pediatric Emergency Medicine
Medical Director Pediatric Emergency Center
Saint Francis Hospital Tulsa, OK

Type of Organization: _____

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Oklahoma College of Emergency Physicians

Address: _____

Type of Organization: _____

Leadership Position: Board of Directors, Chair of bylaws committee.

Term of Service: July 2022- 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:

Stock ownership as a physician with United States Acute Care Solutions

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:

Mother- Tele ICU nurse at Westchester Medical Center, Valhalla, NY

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.

Kurtis A Mayz

Date

6-15-23

OKLAHOMA COLLEGE OF EMERGENCY PHYSICIANS



A true servant leader and educator, his business and legal backgrounds are unique assets among EM physician leaders, and they have thus far started to pay dividends towards our chapter organization and to any organization he serves. Already one of the most credentialed individuals you are likely to ever encounter, Kurtis recently earned certification as a Registered Parliamentarian. He has previously served on the ACEP Council Steering Committee, the ACEP Council Tellers and Credential Committee, Pediatric Emergency Medicine Committee, Medical-Legal Committee as well as several risk management and claims committees for USACS. An active ABEM oral examiner, he is also a graduate of the ACEP ED Director's Academy Phase 1, which has served him well in his impressive body of work.

In essence, Kurtis is as articulate, devoted, energetic, wise and qualified an individual as you will ever meet and would unquestionably make an exceptional ACEP Speaker.

The Oklahoma College of Emergency Physicians unequivocally nominate Dr. Kurtis Mayz for Vice-Speaker of the Council of the American College of Emergency Physicians and look forward to his continued candidacy and years of dedicated service.

Yours Very Sincerely and Respectfully,

James R. Kennedy MD, MPH, FACEP

EXECUTIVE COMMITTEE

President James Kennedy, MD, MPH, FACEP
Vice-President Cecilia Guthrie, MD, FACEP
Treasurer Timothy Hill, MD, PhD, FACEP
Resident Liaison: Derek Martinez, DO

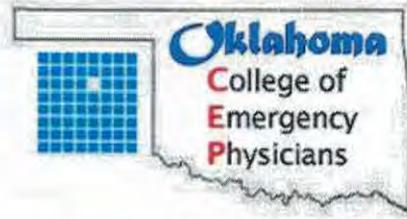
BOARD

James Kennedy, MD, MPH, FACEP
Timothy Hill, MD, PhD, FACEP
Kurtis Mayz, JF, MD, MDA, FACEP
Laura Janneck MD, MPH, FACEP

BOARD

Cecilia Guthrie, MD, FACEP
Jeff Goodloe, MD, FACEP
Chad Phillips, MD
Jeffrey Johnson MD, FACEP

OKLAHOMA COLLEGE OF EMERGENCY PHYSICIANS



August 6th, 2023

James R. Kennedy MD, MPH, FACEP
President
Oklahoma College of Emergency Physicians
3101 NE 119th Street
Oklahoma City, OK. 73131

Sonja Montgomery CAE
American College of Emergency Physicians
4950 W. Royal Lane
Dallas, TX. 75063-2524

Dear Sonja,

It is with great enthusiasm and honor that the Oklahoma College of Emergency Physicians (OCEP) endorse Dr. Kurtis Mayz MD, JD, MBA, RP, FACEP, FAAP, FAAEM, FCLM for the office of Vice-Speaker of the Council of the American College of Emergency Physicians.

Dr. Mayz came to Oklahoma from Illinois in 2021, where he was extraordinarily active in ACEP/ICEP, to take over as Chairman of the Pediatric Emergency Department at St. Francis Hospital in Tulsa, our state's largest emergency department.

While his education, training and work experience have carried him far and wide across our great country, we were extremely blessed and fortunate to have him join us here in Oklahoma. While his CV speaks for itself, he immediately impressed us all with his clinical acumen, his willingness to help contribute to and lead our state ACEP chapter and with his wit and wisdom. In short order, he was elected to the OCEP Board of Directors, served as one of our 2022 councilors and, as an active ACEP by-laws committee member, took over as Chair of our own by-Laws committee, where he has effectively brought our by-laws into compliance and functionality. He also served on one of the Council's prestigious Reference committees while we were all at ACEP 2022, a duty he also performed in 2019 and 2020.

EXECUTIVE COMMITTEE

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Treasurer Timothy Hill, MD, PhD, FACEP
Resident Liaison: Derek Martinez, DO

BOARD

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BOARD

Cecilia Guthrie, MD, FACEP
Jeff Goodloe, MD, FACEP
Chad Phillips, MD
Jeffrey Johnson MD, FACEP

Kurtis A. Mayz, JD, MD, MBA, FACEP, FACLM

Fellow Councillors:

Thank you for your efforts to advance emergency medicine, and your invaluable service to the College as Councillors. I am humbled by the opportunity to seek your vote and serve as Vice Speaker as we work to move the College forward.

My efforts as your next Vice Speaker, are simply summarized, “**ACEP Physicians, your voice heard.**” I view our organization as a family united by the common goals of “promoting the highest quality of emergency care,” and being “the leading advocate for emergency physicians, their patients, and the public.”

As an organization, as I look at our “house,” physician members serve as the foundation above which all else rests. Without them the organization would not exist. ACEP operates on a daily basis under the covering of its Board of Directors and administrative staff. As the voice of chapters and sections, the Council serves as the representative pillars between the physician and the organization. As Vice Speaker and your advocate when Council is not in session, my vision is to improve:

Accountability: I will hold the Board accountable to the will of the Council. I will sometimes partner with the Board in accomplishing the goals of the College and at other times act as the loyal opposition to ensure that the voice of the Council is heard and followed.

Collaboration: In these challenging times, now more than ever we need to understand that there will be issues that we will not agree on. While these are important issues that need discussion, it is important that we discuss these issues internally rather than creating division externally. Moreover, we need to focus on issues on which we can find common ground. This process should not be one that is initiated on the Council floor. I will work to create collaborative work groups to discuss these issues in an effort to create common ground as well as reduce redundancy.

Engagement: Council work extends beyond the Council meeting. With many new Councillors annually, it’s important to ensure that we keep the Council engaged and informed throughout the year and ensure the appropriate resources and training to ensure effective participation in the Council. In addition, we must continue to demonstrate the importance of Council service and develop qualified leaders to carry out the business of the Council. I will work to continue to improve communication within the Council and work with individual Chapters and Sections to create opportunities for leadership development.

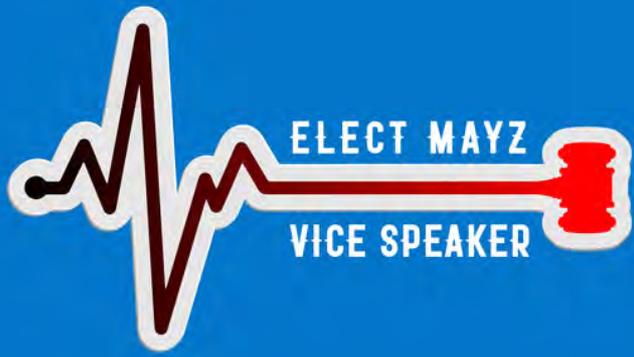
Process: The pandemic era taught us that we must continue to keep pace with the changing flow of information and be nimble in the way we conduct business. I will work to improve processes by leveraging technology and resources to create an effective environment to conduct Council business.

As a first generation Venezuelan-American I recognize the importance of diversity and inclusion. I am the product of leadership that believed in me as a resident physician and continued to encourage me and provide opportunities for me to engage in the College. Ultimately this led to the opportunity to lead. We need to continue to work towards a leadership that is as diverse as our membership and our patients. We need to create and foster opportunities for leadership development amongst our diverse group of members. I will work to create opportunities to develop Council leaders that embody this goal.

As Vice Speaker I will listen as effectively as I speak, guide as effectively as I lead, and encourage as effectively as I advocate. Thank you for this opportunity to serve you, as I work to ensure ***your voice is heard.***

Respectfully,

Kurtis



ELECT

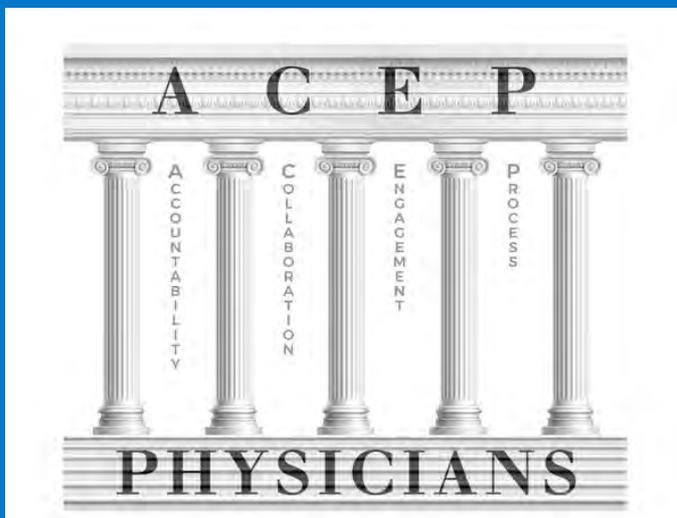
KURTIS A MAYZ

JD, MD, MBA, RP, FACEP

**A C E P
V I C E S P E A K E R**

"I will listen as effectively as I speak, guide as effectively as I lead, and encourage as effectively as I advocate."

**EVERY
VOICE
HEARD**



VISION

Physician members are the foundation of our organization, without which it would not exist. ACEP operates on a day to day basis under the covering of its Board of Directors and administrative staff. As the voice of chapters and sections, the Council serves as the representative pillars between the physician and the organization. As Vice Speaker and a leader of the Council, your advocate when Council is not in session, I will work with the Speaker to:

- Hold the Board **ACCOUNTABLE** to the will of the Council
- Foster **COLLABORATION** through workgroups and a more longitudinal Council workflow throughout the year
- Encourage **ENGAGEMENT** by working with chapters and sections to improve communication and leadership development, and demonstrate the importance of Council service.
- Improve **PROCESSES** by leveraging technology and resources to create an efficient and effective environment to conduct Council business and improve Councillor experience.

EXPERIENCE

ACEP

- Educational Faculty- Medical Legal and Risk Management
- Bylaws, Medical-Legal, and Pediatric Emergency Medicine Committees
- Oklahoma Chapter: Board of Directors, Parliamentarian, Bylaws Committee Chair

Council

- Steering, Reference, and Tellers Committees
- Chair- Steering sub-committee on Council Meeting
- Member- Special task force on elections

Clinical

- Board Certified in Emergency and Pediatric Emergency Medicine
- Chairman of Pediatric Emergency Medicine and Medical Director of Pediatric Emergency Center, Saint Francis Children's Hospital, Tulsa, Oklahoma
- Former Traveling Physician- licensed in 10 states, academic, non-academic, urban, suburban, and rural settings, has a broad understanding of what it is like to practice EM across the country
- Telemedicine physician

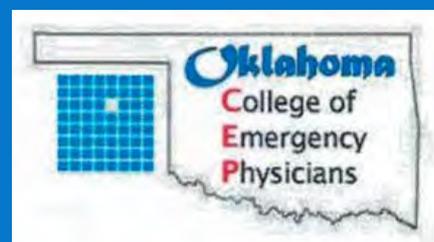
Professional

- Registered Parliamentarian-National Association of Parliamentarians, Experience with parliamentary procedure and meeting facilitation.
- Certified Parliamentarian Candidate- American Institute of Parliamentarians
- Candidate- American College of Parliamentary Lawyers
- Attorney- Trained as an advocate, able to see issues from multiple different perspectives, anticipate arguments, frame the narrative, and defend/advocate for positions that are not his own. Trained to understand the client's needs and develop the strategy that best meets those needs.
- MBA concentration in healthcare and human resources- leadership skill in healthcare administration and organizational management.



*Actions that speak.
Results that last.*

Proudly Endorsed By



Kurtis A Mayz, JD, MD, MBA, RP, FAAP, FCLM, FAAEM, FACEP

420 E Archer St
Apt 405
Tulsa, OK 74120
drmayzesq@gmail.com
914-420-7927



Education

- 08/2008-05/2011 Masters of Business Administration: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois
- 08/2006-05/2011 Medical Doctor: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois
- 08/2004-12/2006 Juris Doctor: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois
- 08/2000-05/2004 BA: Political Science; BA: Biology
Certificate in Lobbying: Center for Congressional and Presidential Studies
The American University, Washington, DC

Post Graduate Training

- 07/2014-06/2016 Pediatric Emergency Medicine Fellowship
University of Michigan Health System, Ann Arbor, Michigan
- 07/2013-06/2014 Chief Resident, Emergency Medicine, Patient Safety and Quality Improvement
Stony Brook University Medical Center, Stony Brook, New York
- 07/2011-06/2014 Emergency Medicine Resident
Stony Brook University Medical Center, Stony Brook, New York

Post Graduate Certifications

- 11/2022 Registered Parliamentarian-National Association of Parliamentarians
- 09/2014-04/2016 GME Scholars Program: Healthcare Administration Certificate
University of Michigan Health System, Ann Arbor, Michigan
- 2013 ACEP Emergency Department Director's Academy: Phase 1
American College of Emergency Physicians, Dallas, TX
- 08/2004-05/2006 Graduate Teaching Certificate

University of Illinois, Champaign-Urbana, Illinois

Board Certifications

2019 American Board of Emergency Medicine-Pediatric Emergency Medicine

2016 American Board of Emergency Medicine

Medical Licensure

California
Connecticut
Florida
Illinois
Maryland
Michigan
Ohio
Oklahoma
New York
Pennsylvania

Legal Licensure

2008-Present New York State Bar

2007-Present New Jersey State Bar

2007-Present Federal District Court of New Jersey Bar

2005-Present Notary Public: State of New York

Certifications

2011-Present Advanced Cardiac Life Support (ACLS)

2011- Present Advanced Trauma Life Support (ATLS)

2011-Present Pediatric Advanced Life Support (PALS)

2014 Neonatal Resuscitation Program (NRP)

2013 Difficult Airway Course

Work Experience-Medical

| | |
|------------------|---|
| 12/2021-Present | Chairman Pediatric Emergency Medicine Medical Director Pediatric Emergency Center Saint Francis Hospital, Tulsa, OK |
| 11/2018- Present | Emergency Medicine Physician Heart of Mary Hospital, Urbana, IL |
| 1/2017-12/2021 | Firefighter (Traveling Physician) United States Acute Care Solutions |
| 11/2017-09/2018 | Emergency Medicine Physician CEP America Presence Saint Joseph Medical Center, Joliet, IL |
| 9/2017-10/2017 | Associate Director and Vice Chairman-Department of Emergency Medicine United States Acute Care Solutions (USACS) Presence Saint Joseph Medical Center, Joliet, Illinois |
| 5/2017-8/2017 | Interim Medical Director and Chairman- Department of Emergency Medicine United States Acute Care Solutions (USACS) Presence Saint Joseph Medical Center, Joliet, Illinois |
| 7/2016-4/2017 | Assistant Director-Department of Emergency Medicine United States Acute Care Solutions (USACS) Presence Saint Joseph Medical Center, Joliet, Illinois |
| 11/2014-6/2016 | Attending Physician- United States Acute Care Solutions (USACS) Genesys Regional Medical Center, Grand Blanc, Michigan |

Work Experience-Legal

| | |
|----------------|--|
| 2/2020-Present | Medical Legal Mayz Consulting, LLC Champaign, IL |
| 5/2005-8/2005 | Law Intern-Hon. William K Nelson New York State Supreme Court, New City, New York |

Research Interests

1. Risk Management and Medical Legal Review
2. Patient Safety and Quality Improvement
3. Operations

Committee Appointments

National

| | |
|--------------|--|
| 2022 | ACEP Council Reference Committee American College of Emergency Physicians, Dallas, TX |
| 2020-21 | ACEP Council Steering Committee American College of Emergency Physicians, Dallas, TX |
| 2020-Present | ACEP Council Tellers and Credentials Committee American College of Emergency Physicians, Dallas, TX |
| 2019-20 | ACEP Council Reference Committee American College of Emergency Physicians, Dallas, TX |
| 2020 | Risk-Underwriting Committee United States Acute Care Solutions, Canton, OH |
| 2019-Present | Bylaws Committee American College of Emergency Physicians, Dallas, TX |
| 2017-Present | Claims Committee United States Acute Care Solutions |
| 2016-Present | Risk Management Committee United States Acute Care Solutions, Canton, OH |
| 2015-Present | Medical Legal Committee Sub-committee Chair: Criminal vs Civil Testimony for ED Physicians (2016) American College of Emergency Physicians, Dallas, TX |
| 2016-2020 | Political Action Committee: Board of Directors United States Acute Care Solutions, Canton, OH |
| 2014-2018 | Pediatric Emergency Medicine Committee American College of Emergency Physicians, Dallas, TX |
| 2012-2014 | Health Policy Committee Emergency Medicine Residents Association, Dallas, TX |

Local

| | |
|-----------|---|
| 2015-2016 | Medical Legal Review Committee University of Michigan Health System, Ann Arbor, MI |
| 2013-2014 | Hospital Quality Assurance Review Committee Stony Brook University Medical Center, Stony Brook, NY |

| | |
|-----------|--|
| 2013-2014 | Emergency Medicine Quality Improvement Committee Stony Brook University Medical Center, Stony Brook, NY |
| 2012-2014 | Hospital Patient Safety Committee Stony Brook University Medical Center, Stony Brook, NY |
| 2011-2014 | Graduate Medical Education Committee Stony Brook University Medical Center, Stony Brook, NY |
| 2009-2011 | Progress and Promotions Committee University of Illinois, Champaign-Urbana, Illinois |
| 2004-2011 | Medical Scholars Program Advisory Committee University of Illinois, Champaign-Urbana, Illinois |

Honors and Awards

| | |
|-----------|--|
| 2019 | Finalist: Firefighter-Physician of the Year United States Acute Care Solutions |
| 2015 | Emeriquiz Best Case Discussant American Academy of Pediatrics Annual Meeting |
| 2013 | Emergency Department Directors Academy Scholarship Emergency Medicine Residents Association, Dallas, TX |
| 2012 | Leadership and Advocacy Scholarship Emergency Medicine Residents Association, Dallas, TX |
| 2009 | Beta Gamma Sigma Business Honor Society University of Illinois, Champaign-Urbana, Illinois |
| 2008 | NSHMBA Foundation Scholar National Society of Hispanic MBAs, Irving, TX |
| 2006-2010 | List of Teachers Rated as Excellent (9 semesters) University of Illinois, Champaign-Urbana, Illinois |
| 2004 | Land of Lincoln Legal Scholarship University of Illinois, Champaign-Urbana, Illinois |

Professional Societies

| | |
|--------------|---|
| 2014-Present | American College of Emergency Physicians |
| 2008-Present | Emergency Medicine Resident Association American College of Emergency Physicians |

| | |
|--------------|---|
| 2008-Present | American Academy of Pediatrics |
| 2008-Present | American College of Legal Medicine |
| 2004-Present | American Bar Association |
| 2004-Present | American Health Lawyers Association |
| 2004-Present | American Medical Association |
| 2011-2016 | Society for Academic Emergency Medicine |

Community and Professional Service

| | |
|---------------|--|
| 2022-Present | Oral Boards Examiner American Board of Emergency Medicine |
| 2022- Present | Board of Directors Oklahoma College of Emergency Physicians |
| 2021-2022 | Mock Oral Boards Examiner Illinois College of Emergency Medicine |
| 2016-Present | Litigation Stress Support Team: United States Acute Care Solutions |
| 2012-Present | Leadership and Advocacy- Legislative Advocacy American College of Emergency Medicine |
| 2007-Present | Competition Judge: Moot Court, Client Counseling, Negotiations University of Illinois College of Law, Champaign-Urbana Illinois |
| 1999-Present | American Red Cross Health and Safety Instructor and Instructor trainer: Lifeguarding, CPR, Water Safety Instruction |
| 1998-2015 | New York State First Responder & Emergency Medical Technician Spring Hill Community Ambulance W.P. Faist Volunteer Ambulance (1 st Lt-training officer '00-'03) |

Teaching

University Courses

| | |
|------|---|
| 2014 | Medical Emergencies: <i>Instructor</i> Stony Brook University, Stony Brook, NY |
|------|---|

CV- K Mayz JD MD MBA (03/2023)

- 2009-2010 Business Ethics: *Teaching Assistant*
University of Illinois, Champaign-Urbana, Illinois
- 2007-2010 Anatomy: *Lab Instructor*
University of Illinois, Champaign-Urbana, Illinois
- 2004-2006 Introduction to Molecular and Cellular Biology: *Lab Instructor*
University of Illinois, Champaign-Urbana, Illinois

Other Courses

- 2016-2019 American Heart Association: BLS, ACLS, PALS,
Presence Saint Joseph Medical Center, Joliet, IL
- 2014-2016 American Heart Association: BLS, ACLS, PALS,
University of Michigan Health Systems Simulation Center, Ann Arbor, MI
- 2013-2014 Difficult Airway Course: EMS
Difficult Airway Course Northeast, Stony Brook, NY
- 2012-2014 American Heart Association: BLS, PALS
Stony Brook University Medical Center, Stony Brook, NY

Clinical Teaching

- 2014-2016 Pediatric Emergency Medicine Fellow
University of Michigan Health System, Ann Arbor, MI
 Bedside teaching and supervision of Emergency Medicine, Pediatric,
 Family Medicine, and Psychiatry residents and 3rd and 4th year medical
 students in the pediatric Emergency Department

 Pediatric Observed Structured Clinical Education (OSCE) Facilitator in
 twice-yearly teaching module for Emergency Medicine residents

 Pediatric procedure lab Instructor for annual hands-on teaching of
 pediatric emergency procedures to Emergency Medicine residents
- 2011-2014 Clinical Assistant Instructor of Emergency Medicine
Stony Brook University Medical Center, Stony Brook, NY
 Bedside teaching and supervision of emergency medicine interns,
 internal medicine, ob/gyn, family medicine residents, and 3rd and 4th
 year medical students in the emergency department setting

Lectures and Presentations

National

9/2022 *Little Plaintiffs, Big Lawsuits*

- ACEP21: ACEP National Conference, Boston, MA
- 9/2022 *Liability Concerns & Controversies Working with Non-Physician Providers*
ACEP21: ACEP National Conference, Boston, MA
- 9/2022 *Medical Legal Risk in Psychiatric Emergencies*
ACEP21: ACEP National Conference, Boston, MA
- 4/2022 *Private Equity in Emergency Medicine*
ACEP Leadership and Advocacy Conference, Washington, DC
- 10/2021 *Little Plaintiffs, Big Lawsuits*
ACEP21: ACEP National Conference, Boston, MA
- 10/2021 *Liability Concerns & Controversies Working with Non-Physician Providers*
ACEP21: ACEP National Conference, Boston, MA
- 10/2021 *Top 5 Legal Risks in 5 minutes or Less*
ACEP21: ACEP National Conference, Boston, MA
- 10/2020 *Little Plaintiffs, Big Lawsuits*
ACEP20: ACEP National Conference, Dallas, TX (virtual)
- 10/2019 *Double Jeopardy: Risk in Psychiatry*
ACEP19: ACEP National Conference, Denver, CO
- 10/2019 *Smile: You're on Candid Camera: Invasions of Privacy in the ED*
ACEP19: ACEP National Conference, Denver, CO
- 10/2018 *Double Jeopardy: Risk in Cardiology*
ACEP18: ACEP National Conference, San Diego, CA
- 10/2018 *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*
ACEP18: ACEP National Conference, San Diego, CA
- 10/2017 *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*
ACEP17: ACEP National Conference, Washington, DC
- 10/2015 *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*
ACEP15: ACEP National Conference, Boston, MA
- 10/2015 *16 year old Male with Altered Mental Status*
Discussant: *And that's when I thought I had died*
Emergiquiz: 2015 American Academy of Pediatrics, Washington, DC

State/Local

CV- K Mayz JD MD MBA (03/2023)

05/2022 *Top 5 Legal Risks in 5 minutes or Less*
Oklahoma Emergency Medicine Residencies Conference
Tulsa, OK

11/2020 *Medical Legal Considerations for the Pediatric Emergency Medicine Physician*
Pediatric Emergency Medicine Fellowship
University of Michigan, Ann Arbor, MI

10/2020 *3-2-1 Contract*
Emergency Medicine Residency
Pennsylvania State University at Hershey

2/2016 *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*
Genesys Emergency Medicine Residency Program, Grand Blanc, MI

04/2010 Pre Hospital Pediatric Emergency Care
04/2009, 11/2009 Rockland County Fire Training Center, Pomona, NY
04/2008, 10/2008

Intramural

Emergency Medicine Residency Core Lectures

10/2015 *Evaluation of Pediatric Limp*
10/2015 *Journal Club: Pediatric Resuscitation and Therapeutic Hypothermia*
11/2013 *Pediatric Trauma*
05/2013 *Bariatric Surgery Complications*
01/2013 *Pediatric Rashes*
06/2012 *Emergency Department Employment Contracts*
01/2012 *Crystal Arthropathies*

Pediatric Emergency Medicine Core Lectures

03/2015 *Medical-Legal: Basics of Testifying*
02/2015 *Pediatric Head Trauma*

Pediatric Emergency Medicine Ethics Conferences

08/2015 *Parental Refusal of Medical Treatment*
03/2015 *Minors and Medical Decision Making*

Pediatric Emergency Medicine and Critical Care Medicine Joint Lectures

03/2016 *Initial sepsis management in the Emergency Department and Pediatric Intensive
Care Unit*
06/2015 *Acetaminophen Toxicity*

Pediatric Emergency Medicine Case Conference

02/2016 *8 y/o male with shortness of breath*
03/2015 *16 y/o with altered mental status*

Pediatric Emergency Medicine Board Review
09/2015 *Board review questions*

Pediatric Emergency Medicine Simulation
03/2016 *15 y/o in a motor vehicle collision*
06/2015 *3 y/o with iron toxicity*

Research

Extramural Presentations

Mayz KA, Sroufe N, Kelker H, Cranford J, Goldfarb A: *Implementation of a Whiteboard Communication tool in the Pediatric Emergency Department and its Impact on Communication*
Lecture Presentation. National Pediatric Emergency Medicine Fellows Conference, Charlotte, NC
March 2015

Intramural Presentations

Mayz KA, , Kelker H, Cranford J, Pham K, Goldfarb A, Sroufe N: *Implementation of a Whiteboard Communication tool in a Pediatric Emergency Department: A Quality Improvement Initiative Shows Improved Communication and Parent Satisfaction.*
William Barsan Research Day, University of Michigan, Ann Arbor, MI April 2016

Mayz KA, Johnson S: *Emergency Department Attending and Resident Attitudes towards Quality Improvement and Patient Safety.* Lecture Presentation. Stony Brook Emergency Medicine Research Symposium. Stony Brook, NY June 2014

Quality Improvement Projects

2016 *Pediatric Resident Trauma Simulation Video*
University of Michigan Health Systems, Ann Arbor, MI
Creation of a “model” trauma simulation video as a training module to enhance the ability of pediatric residents to effectively run a trauma resuscitation

2013-2014 *Patient Safety Reporting System workgroup*
Stony Brook University Medical Center, Ann Arbor, MI
Workgroup study to redesign or purchase new patient safety reporting system with the goal of creating ease of use and enhancing employee reporting

2013-2014 *Emergency Department Workflow Study Committee Member*
Stony Brook University Medical Center, Stony Brook, NY
Workflow study looking at provider location and patient flow in emergency department. Implementation of teaming concept, relocation of provider workstations, and reordering of patient rooms

2013-2014 *Root Cause Analysis: Central Line Guidewire Retention*
Stony Brook University Medical Center, Stony Brook, NY
Root cause analysis for sentinel event of retained guidewire and
subsequent implementation of new two person verification and
documentation system for central line placement

2013 *Anticoagulation Order Set Review workgroup*
Stony Brook University Medical Center, Stony Brook, NY
Worked on revising anticoagulation order set to make it more
streamlined and user friendly as well as less error prone

Bibliography

Publications

Declan A, Dietrich A, Mayz KA on behalf of the ACEP Pediatric Emergency Medicine Committee, *Why Pursue Pediatric Emergency Medicine?* EM Resident. December 2015.

Manuscripts

Mayz KA, , Kelker H, Cranford J, Pham K, Goldfarb A, Sroufe N: *Implementation of a Whiteboard Communication tool in a Pediatric Emergency Department: A Quality Improvement Initiative Shows Improved Communication and Caregiver Satisfaction.*

Mayz KA *Emergiquiz Case Report: Sleepy, Starving, and Sexual: A 16 year old male with Altered Mental Status.*

Abstracts

Mayz KA, , Kelker H, Cranford J, Pham K, Goldfarb A, Sroufe N: *Implementation of a Whiteboard Communication tool in a Pediatric Emergency Department: A Quality Improvement Initiative Shows Improved Communication and Parent Satisfaction.*
Poster Presentation-Pediatric Academic Society Annual Meeting April 2016

Languages

Norwegian (Intermediate)
Spanish (Intermediate)

Biographical

Hobbies and Interests:
Music: Piano and Singing
Sports: Baseball, Swimming, Tennis
Watching sports
Foodie

Travel/Beach

2023 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Michael J. McCrea, MD, FACEP

Question #1: How do you see yourself advocating for the College as a non-voting participant at ACEP Board of Directors meetings?

I believe that the Council Officers are in a unique position to advocate for the College, our members, and Council as non-voting participants of the Board meetings. Not having a vote does not mean not having a voice. Our Officers attend all Board meetings to ensure that our members' voice, as expressed through Council's will, is heard by the Board and is faithfully executed as the Board considers resolutions as they guide the College. As your voice at Board meetings, the officers listen to the Board's debate while providing additional information or guidance based on the testimony heard from reference committees and provided by Council and Council Steering Committee. Together we keep the priorities of Council at the forefront of Board discussion.

The vast majority of the time, resolutions adopted by Council are subsequently adopted by the Board without amendment. However, our Bylaws do provide guidance when there is difference in the Board's final decision from the will of the Council. It is then that our Council Officer's presence is most critical to advocate for the Council and ultimately our members whom the Council represents. The Board has up to two meetings after Council to act on adopted resolutions. It is during these intervals between board meetings that your Council Officers can best advocate to shape the direction of discussion to maintain the Council's will.

I propose to utilize the voice of the Steering Committee and work with the originating authors to find the path forward that best represents Council's directives, including how the Board prioritizes college actions. When the Council's voice is needed to be heard by the Board, this collaborative style is the best way to bridge the gap between Board proposals and Council's will.

Question #2: What is your vision for disseminating the work of the Council more broadly?

Since 2021 our Council Officers are required to provide a written summary of the Council meeting to the entire College. Despite this significant advance in communicating the work of our Council to our members, perhaps all too often this passive "push" via email and other electronic notification may not truly reach our members.

I believe our members would benefit from a more active dissemination of the Council's work, including real time via social media and other more interactive notifications to our members. Chapters, sections, and perhaps most importantly, individual members, whose resolutions are adopted should be highlighted and celebrated for their accomplishments and their hand in guiding the future of the College. Short social media videos with the authors explaining their resolutions could be posted in real time at Council and in the days following during Scientific Assembly. Such direct communication could help demystify the Council and parliamentary process to our members, showing the faces and work of our members. Additionally, after the Board adopts resolutions and begins the work through the committee process, whenever an committee objective is finished that began with a resolution, that too should be celebrated again with the authors as well as assigned committee members.

For example, if a resolution called for the College to develop a policy statement, when the final policy statement is adopted by the Board, that should be shared as broadly as possible. Some type of "council action alert" for council resolutions could be developed as the College already does through the 911 Network and "advocacy action alerts" that would be pushed to members when a resolution has resulted in a final product. Given that the process from Council resolution, Board action, committee work, to final version may take multiple years, it would be wonderful to be reminded what work has been accomplished for those who serve in Council but even more broadly to show our members on what the College and Board is doing for them. The more the College can regularly show our members the extraordinary work being accomplished by Council the more we can continue to show member value and how each individual member can participate in the College.

Question #3: How would you navigate through the challenges that may arise when the Council and the Board of Directors do not share the same view on an issue?

The Council Officers actively participate in ACEP Board Meetings to ensure that the Council's will and voice is represented. Similarly, the Board attends and listens to Council debate to understand each resolutions' intent along with the tenor of discussion so they can understand the impetus behind each Council action. In the rare instance the Board would propose an action contrary to Council's will, the Council Officers are the crucial link between the Board and the Council to assure ACEP keeps members' interests at the core. While not burdened with a vote, the Council Officers can devote their time fostering debate and building consensus that considers Councils' directives.

The most likely scenario in which the Board would differ from Council would be on a controversial issue, especially a late breaking issue after the resolution deadline. We saw this just this past year during the rapidly changing landscape around reproductive health with its potential profound effect on both our members and our patients. Our Council Officers ensured that the original intent and will of the Council was maintained while the Board amended the original resolution adopted by Council.

When it comes to maintaining our principles and building consensus around a time critical issue that impacts our members, I have proven expertise. I acted as our council officers did when I was serving as Ohio Chapter president. In our state a residency program was thrown into turmoil when a contract group was abruptly changed. Over several days I actively listened to our members and gathered information to inform our Board how we could best help our members, especially the program's residents. In the end, we were able to facilitate placement for many of the program residents to stay in Ohio and provide employment guidance for numerous faculty. Additionally, I helped arrange free access for the residents to the Chapter's educational materials during the unexpected transition. Through this difficult time, I made sure all sides were heard to help build consensus within our Board while continuing to serve our members' interests.

From this experience, I demonstrated the leadership skills to facilitate dialogue and navigate debate when viewpoints diverge. Combined with my experience on the Council Steering Committee and having served as Chair of Reference Committee and the College Bylaws Committee, I have the proven experience to represent the Council as your voice at Board meetings. If and when differences arise, I have the expertise to bring all sides together while adhering to our governing principles. As your council officer, I commit to ensuring your voice contributes to the best outcome for our College, our members, EM Residents, and our patients.

CANDIDATE DATA SHEET

Michael J. McCrea, MD, FACEP

Contact Information

13100 Five Point Rd
Perrysburg, OH 43551

Phone: 614-975-5370

E-Mail: mmccrea2@gmail.com

Current and Past Professional Position(s)

Attending Physician, residency core faculty

Mercy Emergency Care Services, Team Health

October 2014 - Present

Lucas County Emergency Physicians, Inc., Premier Physician Services

September 2009 – October 2014

Wood County Emergency Physicians, Inc., Premier Physician Services

Medical Director, March 2013 – June 2014

Mid-Ohio Emergency Physicians, LLP

Staff Physician, August 2009 – May 2010

Richland County Emergency Physicians, Inc., Premier Health Care Services

Assistant Medical Director and Staff Physician, December 2008 – August 2009

Emergency Medicine Physicians of Richland County, Ltd.

Staff Physician, November 2006 – December 2008

Emergency Medicine Physicians of Guernsey County, Ltd.

Staff Physician, September 2006 – December 2006

Education (include internships and residency information)

THE Ohio State University Medical Center

Emergency Medicine Residency 2004 – 2007

Medical College of Ohio at Toledo

M.D. 2000 – 2004

Ohio Wesleyan University

B.A. Biochemistry 1996 – 2000

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine

Initial certification 6/27/2008

Recertified 2017, valid through 12/31/2028

Professional Societies

American College of Emergency Physicians
Ohio Chapter ACEP
American Academy of Emergency Medicine
Great Lakes Chapter AAEM
American Medical Association
Ohio State Medical Association

National ACEP Activities – List your most significant accomplishments

Educational Meetings Committee, 2021 – present
Task Force on Supply Chain and PPE, 2020
Task Force on Council Size, Chair, 2019
Bylaws Committee, 2015 – present
-Chair 2021 – 23
-Vice-Chair 2020 – 21
State Legislative and Regulatory Committee, 2012 – 2019
-Subcommittee Chair, EM Practice 2016 – 19
ACEP Teaching Fellowship alumnus 2010-11

ACEP Council

- Council Reference Committee A Chair, 2021
- Council Horizon Meritorious Service Award recipient, 2020
- Council Steering Committee, 2016 – 17
- Council Horizon Award recipient, 2014
- Council Tellers, Election, and Credentials Committee, 2013 – 16
- Council Reference Committee, 2012

ACEP Chapter Activities – List your most significant accomplishments

Ohio Chapter President, 2015-16, 2016-17
Ohio Chapter Immediate Past President, 2017-18
Ohio Chapter President Elect, 2013-14, 2014-15
Ohio Chapter Secretary, 2011-12, 2012-13
Ohio Chapter Board of Directors, 2011 – present
Chair, Midwest Medical Student Symposium, 2015 – present
Councillor, 2011 – present
Course Co-Director, Oral Board Review Course, 2012 – 17
Lecturer, Emergency Medicine Review Course, 2011 – 20

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 70 % Research <1 % Teaching 30 % Administration 0 %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Employee, Mercy Emergency Care Services, TEAM Health, staffing a single site tertiary care urban community teaching hospital.

Core faculty Bon Secour Mercy Health - St. Vincent Medical Center Emergency Medicine Residency for forty-two EM residents

Moonlight at a single coverage rural ED within Mercy Health 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.)

No titles or leadership positions within group, company, medical staff, or hospital

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert

0 Cases

Plaintiff Expert

0 Cases

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Michael J. McCrea, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

2. Employer:

Mercy Emergency Care Services, Inc. Team Health

Address: 2213 Cherry St

Toledo, OH 43608

Position Held: Attending physician, residency core faculty

Type of Organization: Employee model

Employer: Emergency Professionals of Ohio, Inc, Team Health

Address: 7123 Pearl Rd

Middleburg Heights, OH 44130

Position Held: Part time staff physician

Type of Organization: Independent contractor model

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: Ohio Chapter ACEP

Address: 5980 Venture Dr, Suite B

Dublin, OH 43017

Type of Organization: Professional medical association

Leadership Position: Board of Directors, Past President

Term of Service: 2011 – present

Organization: Ohio ACEP Political Action Committee

Address: 5980 Venture Dr, Suite B

Dublin, OH 43017

Type of Organization: Political action committee

Leadership Position: Board of Directors

Term of Service: 2014 - present

Organization: Ohio State Emergency Medicine Alumni Society

Address: 791 Prior Hall, 376 W 10th Ave

Columbus, OH 43210

Type of Organization: Alumni society for Ohio State emergency medicine residency graduated

Leadership Position: Board of Governors, Past President

Term of Service: 2017 - 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:

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.

Michael James McCrea, MD

Date

6/18/23, updated 9/3/23



August 2, 2023

Councillors
ACEP 2023 Scientific Assembly
Philadelphia, PA

Dear Councillors,

The Ohio Chapter, American College of Emergency Physicians, enthusiastically endorses our friend and colleague, **Michael J. McCrea, MD, FACEP for ACEP Council Vice-Speaker.**

The Ohio Chapter has benefited immeasurably from Dr. McCrea's leadership and dedication to our chapter since 2010. He was awarded, by Ohio ACEP, the 2017 *Bill Hall Award for Service*, the chapter's highest honor for service with distinction. He has served on our Board of Directors since 2011 and served the chapter as President for two terms from 2015 – 2017. He has also actively participated in key chapter committees including our Education and Government Affairs Committee. He is also the Chair of our Bylaws Committee and has served as an invaluable resource in this role. His leadership is also appreciated with our Midwest Medical Student Symposium. While extremely active with the chapter's educational programs as a contributing faculty member for courses and textbooks, his ability to testify and speak to legislators has also been of great value to the chapter. He is a compelling and powerful advocate for his profession. In fact, the chapter awarded him with the 2019 *Emergency Physician Advocacy Award* to celebrate his leadership in advocacy efforts. Dr. McCrea has also represented the Chapter as a Councillor annually since 2011, after a year as an Alternate Councillor with the Ohio ACEP Leadership Development Academy. This past year he served as the chapter's council delegation leader.

Dr. McCrea has additionally always demonstrated the highest level of commitment to Emergency Medicine and the College. He has shared without hesitation his expertise on committees of the College, including the Educational Meeting Planning Committee, the Bylaws Committee (Chair) and the State Legislative-Regulatory Committee. His leadership in the College has been recognized by appointments to the Council Reference Committee; Tellers, Election, and Credentials Committee; and Council Steering Committee. His engagement and effectiveness at Council was further recognized in 2020 when he received the Council Meritorious Service Award. A skillful listener, communicator, and leader, he has demonstrated at every turn his commitment to the cause and mission of emergency medicine and is well prepared to serve as Council Vice-Speaker.

The Ohio Chapter ACEP is pleased to endorse Michael J. McCrea, MD, FACEP for ACEP Council Vice-Speaker.

Sincerely,

B. Bryan Graham, DO, FACEP
President

President
B. Bryan Graham, DO, FACEP

Secretary
Christina Campana, DO, FACEP

President-Elect
Joseph Tagliaferro, DO, FACEP

Immediate Past President
Nicole A. Veitinger, DO, FACEP

Treasurer
Dan C. Breece, DO, FACEP

Executive Director
Holly Dorr, MBA, CAE, CMP

Michael McCrea, MD, FACEP

Fellow Councillors,

I attended my first Council in 2010 in Las Vegas as an Alternate Councillor. I hardly had any idea what the Council was or how to prepare. I didn't even bring a suit. Even though I was uncomfortable and overwhelmed, I was enthralled with the process and amount of business conducted in just two days. I returned year after year, better prepared and attired, encouraged by serving on ref com and becoming more and more engaged. While mentoring our chapter's leadership class, I created an "Unofficial Insiders Guide to Council" that a decade later we still provide to new Ohio Councillors.

I saw, I did, I taught. And I will do the same as your Vice Speaker. One-third of the Council is new every year, and I can create a similar guide for first-time attendees to supplement new Councillor orientation. This is just one of many examples of how my leadership and experience will empower me as your next Vice Speaker.

Fast forward thirteen years later. Like so many of you, I look forward to Council like nothing else; it is my favorite ACEP event. I have served the Council in all aspects, from committees including Council Steering Committee, Tellers, and Reference Committee, the latter having also chaired. I also had the privilege to chair the Growth of the ACEP Council Task Force. Through each of these leadership positions, I have better understood the inner workings of Council while sharing the excitement we all have for our specialty. I was humbled to receive the Council Horizon Award in 2014 and the Council Meritorious Service Award in 2020.

I believe in the voice of the individual member, including our young physician and candidate members. This led me to author a chapter bylaws amendment to ensure at least one of our chapter's Councillors is a resident, the first chapter to do so. In my career I have practiced in diverse environments: downtown trauma centers, tertiary academic centers, rural critical access hospitals. I have worked in a wide range of practice models, from smaller democratic groups, to large group employee, to independent contractor, to EM residency core faculty. This breadth of practice experience gives me insight into what makes our careers the same yet unique. I will build from this depth of knowledge to connect members who are drafting resolutions to best guide the policies and practice of emergency medicine.

Outside of Council I have demonstrated consistent leadership to the College as Bylaws Committee chair, planned the health policy track for ACEP22 and ACEP23, and served many years on State Leg as subcommittee chair for EM practice. At the chapter level, I served two terms as Ohio Chapter President, founded and now chair the Midwest Medical Student Symposium, and have taught in all aspects of the chapter's education courses.

Serving as a Council Officer is not a two-day a year job. Just like our day jobs, it's 24/7/365. As for the other 363 days, I would represent the voice and will of the Council during all Board of Directors meetings. Ultimately it is the will of our members, as manifested by council resolutions, that guides the College and the Board. Ensuring that all members have the opportunity to help guide the College is one of the most important functions of our Council Officers.

I have the proven leadership skills, passion, and service to the Council and the College to serve as your next Council Vice Speaker. I humbly ask for your vote, and I promise to bring my suit.

Yours in service,

Mike

MICHAEL MCCREA, MD, FACEP FOR COUNCIL VICE SPEAKER

PRINCIPLES & VALUES

Leverage technology for year-round member engagement

Facilitate quality Resolution and policy development

Represent your voice to the ACEP Board of Directors

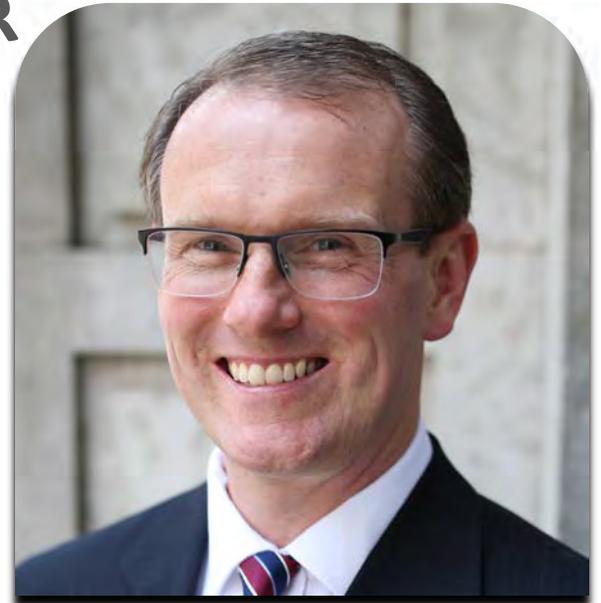
SERVICE TO ACEP

ACEP & Council

- !Bylaws Committee Chair
- !Council Steering Committee
- !Reference Committee Chair
- !Council Meritorious Service Award
- !Tellers, Credentials & Elections Committee
- !Task Force on Council Size Chair
- !Council Horizon Award
- !Educational Meetings Planning Committee
- !State Legislative and Regulatory Committee

Ohio Chapter ACEP

- !Chapter Council Delegation Leader
- !Two-Term Chapter President
- !Midwest Medical Student Symposium Chair
- !Chapter Bylaws Committee Chair
- !Championed HB 7 "I'm Sorry" Law
- !Bill Hall Award for Service
- !Advocacy Award



Bylaws
Committee
Chair

2020

Task Force on
Council Size

Ohio ACEP Bill
Hall Award
For Service

Council Steering
Committee

2015

Council Horizon
Award

Tellers, Election, &
Credentials
Committee

Ohio ACEP Board
of Directors

2010

Ohio ACEP Council
Delegation Leader

Reference
Committee
Chair

Council Meritorious
Service Award

Ohio ACEP
Advocacy Award

Midwest Medical
Student Symposium

Two-term Ohio ACEP
Chapter President

Reference
Committee

Councillor

Alternate
Councillor

Michael James McCrea, MD, FACEP, FAAEM

13100 Five Point Rd
Perrysburg, OH 43551
(614)-975-5370 (cell)
mmccrea2@gmail.com

EDUCATION:

THE Ohio State University Medical Center

- ◆ Columbus, OH
- ◆ Emergency Medicine Residency
July 2004 – June 2007

Medical College of Ohio at Toledo

- ◆ Toledo, OH
- ◆ Doctor of Medicine
August 2000 – June 2004

Ohio Wesleyan University

- ◆ Delaware, OH
- ◆ Bachelor of Arts in Biochemistry, minor in History
- ◆ Phi Beta Kappa
- ◆ *Magna cum laude*
August 1996 – May 2000

PROFESSIONAL EXPERIENCE:

Mercy St. Vincent Emergency Medicine Residency

- ◆ Curriculum Director
September 2021 - Present
- ◆ Associate Program Director
January 2020 – September 2021
- ◆ Assistant Program Director
May 2012 – December 2019
- ◆ Simulation Director
September 2009 – June 2018
- ◆ Core Faculty
September 2009 - Present

Mercy Emergency Care Services, Team Health

- ◆ Attending Physician
October 2014 - Present

Lucas County Emergency Physicians, Inc., Premier Physician Services

- ◆ Attending Physician
September 2009 – October 2014

Wood County Emergency Physicians, Inc., Premier Physician Services

- ◆ Medical Director
March 2013 – June 2014

Mid-Ohio Emergency Physicians, LLP

- ◆ Staff Physician

August 2009 – May 2010

Richland County Emergency Physicians, Inc., Premier Health Care Services

- ◆ Assistant Medical Director
Staff Physician
December 2008 – August 2009

Emergency Medicine Physicians of Richland County, Ltd.

- ◆ Staff Physician
November 2006 – December 2008
- ◆ Quality Director
July 2008 – December 2008

Emergency Medicine Physicians of Guernsey County, Ltd.

- ◆ Staff Physician
September 2006 – December 2006

LICENSURE AND CERTIFICATIONS:

- ◆ American Board of Emergency Medicine
June 2008 Initial Certification, recertified 2018
- ◆ State Medical Board of Ohio
May 2006, renewed June 2020
- ◆ Drug Enforcement Agency
May 2006, renewed January 2018
- ◆ Advanced Cardiac Life Support (ACLS), expires 2022, instructor
- ◆ Pediatric Advanced Life Support (PALS), expires 2022, instructor
- ◆ Advanced Trauma Life Support (ATLS), initial 2004

LEADERSHIP EXPERIENCE:

American College of Emergency Physicians

- ◆ ACEP Educational Meeting Planning Committee
October 2021 – Present
ACEP23 track chair health policy, airway/anesthesia/analgesia
ACEP22 track chair health policy
- ◆ ACEP Task Force on Supply Chain
April 2020 – August 2020, member
- ◆ ACEP Task Force on Council Size
January 2019-October 2019, Task Force Chair
- ◆ ACEP Bylaws Committee
Chair 2021-2023
Vice Chair 2020-2021
Member 2015 - Present
- ◆ ACEP Council Steering Committee
Member 2016-17
- ◆ ACEP State Legislative/Regulatory Committee
Member 2012-2020
Subcommittee Chair, EM Practice, 2016-2019
Objective leader 2013-2014, 2014-2015, 2015-2016, 2019-2020

- ◆ ACEP Council Reference Committee
Committee Member 2012
- ◆ ACEP Council Tellers, Election, and Credentials Committee
Member 2013-2016

Ohio Chapter of American College of Emergency Physicians

- ◆ Chair, Bylaws Committee
2019 – Current
- ◆ Chair, Midwest Medical Student Symposium
2015 – Current
- ◆ Chapter Immediate Past President
2017 – 2018
- ◆ Chapter President
2015-2016, 2016-2017
- ◆ Chapter President-elect
2013-2014, 2014-2015
- ◆ Chapter Secretary
2011-2012, 2012-2013
- ◆ Board of Directors
2011- Current
- ◆ Councilor
2011- Current
- ◆ Leadership Development Academy
2011-12
- ◆ Chapter Government Affairs Committee member
2010 – Present
- ◆ Chapter Education Committee member
2020 – Present, Board Liaison
2010 – Present, Member
- ◆ Alternate Councilor
2010

Mercy St. Vincent Medical Center - Toledo, OH

- ◆ Graduate Medical Education Committee
Member, 2018 - 2021
- ◆ Code Blue Committee
Chair, 2017 - 2021

MedCentral Hospital - Mansfield, OH

- ◆ ICU Committee member
2009
- ◆ Trauma Committee member
2009

The Ohio State University Medical Center

- ◆ Resident's Advisory Council
2004 – 2007

- Co-Chair 2006 – 2007
- Emergency Medicine Residency Representative, 2006 – 2007
- ♦ Graduate Medical Education Committee, Resident Representative 2006 – 2007

Medical College of Ohio

- ♦ School of Medicine Curriculum Committee 2001 – 2004
- ♦ School of Medicine Year III and IV Curriculum Subcommittee 2002 – 2004
- ♦ School of Medicine Year I and II Curriculum Subcommittee 2000 – 2002

PROFESSIONAL MEMBERSHIPS:

- ♦ American College of Emergency Physicians (ACEP)
- ♦ Ohio Chapter American College of Emergency Physicians (Ohio ACEP)
- ♦ Emergency Medicine Resident's Association (EMRA)
- ♦ American Academy of Emergency Medicine (AAEM)
- ♦ Council of Residency Directors (CORD)
- ♦ American Medical Association (AMA)
- ♦ Ohio State Medical Association (OSMA)

RESEARCH EXPERIENCE AND SCHOLARLY ACTIVITIES:

Mercy St Vincent's Medical Center

- ♦ Scholarly Publications and Presentations
 - Murali, S, Davis, C, **McCrea, M**, Plewa, M. Orbital Compartment Syndrome: Pearls and Pitfalls for the Emergency Physician. *J Am Coll Emerg Physicians Open*. 2021 Mar 6;2(2):e12372. PMID: 33733246
- ♦ Curriculum Director for Emergency Medicine Residency April 2016 – Present
 - Oversaw complete curriculum overhaul for residency didactics
- ♦ Director of Simulation Education for Emergency Medicine Residency, September 2009 – June 2018
 - Have implemented a curriculum to assess core competency in ACLS and PALS for Emergency Medicine Residents
 - **McCrea, MJ**, Orqvist, AM, Burgard, K. Assessment of Advanced Cardiac Life Support and Pediatric Advanced Life Support Competency by Emergency Medicine Residents Using a Simulation Based Curriculum. Poster presentation, Midwest Regional SAEM Meeting, October 2012.
 - **McCrea, MJ**. Assessment of Advanced Cardiac Life Support and by Emergency Medicine Residents Using a Simulation Based Curriculum. Poster presentation, ACEP Research Forum, October 2011.

- **McCrea, MJ.** *Ann Emerg Med.* 2011;**58**:S335.
- Developed a comprehensive high-fidelity simulation case library to assess Milestones for our Emergency Medicine Residency

Ohio ACEP

- ♦ Chapter author for Carol Rivers' Preparing for the Written Board Exam in Emergency Medicine, 8th Ed (released January 2017)
- ♦ Chapter author for Carol Rivers' Preparing for the Oral Board Exam in Emergency Medicine, 11th Ed (released January 2016)
- ♦ Chapter author for Carol Rivers' Preparing for the Written Board Exam in Emergency Medicine, 7th Ed (released January 2014)
- ♦ Chapter author for Carol Rivers' Preparing for the Oral Board Exam in Emergency Medicine, 10th Ed (released January 2013)
- ♦ Article reviewer for Ohio ACEP 2011 LLSA Express

The Ohio State University Medical Center

- ♦ Scholarly Project and Quality Improvement Project
 - Diagnostic Accuracy and Appropriate Antibiotic Treatment of Pelvic Inflammatory Disease and Cervicitis by Emergency Physicians

Medical College of Ohio

- ♦ Research Fellowship at Medical College of Ohio Family Practice Center, in Toledo, OH
Summer 2001

TEACHING EXPERIENCE:

Michigan College of Emergency Physicians

- ♦ Winter Symposium, faculty lecture, "Themes and Variations of M&M," January 2022
- ♦ Winter Symposium, faculty lecture, "The Day I Almost Quit," January 2021

All Ohio EM Conference

- ♦ Faculty lecture, "The Day I Almost Quit," January 2020
- ♦ Faculty panelist, "Airway Emergencies," January 2019

American College of Emergency Physicians

- ♦ ACEP Teaching Fellowship, completed March 2011
- ♦ Project selected for Poster Presentation at 2011 ACEP Research Forum

Ohio Chapter of American College of Emergency Physicians

- ♦ Ohio ACEP Resident Connect, "My Worst Birthday Ever: The Day I Got Sued," August 2021
- ♦ Emergency Medicine Board Review Course – Faculty
September 2011 - Present
- ♦ Oral Board Review Course
Course Co-Director
April 2012 – 2017

Faculty examiner
April 2010 – September 2017

The Ohio State University Medical Center

- ◆ Teaching resident for monthly procedure labs for fourth-year medical students rotating on Emergency Medicine Clerkship
- ◆ Teaching resident for ultrasound skills lab for fourth-year medical students enrolled in Emergency Ultrasound Honors Elective

**VOLUNTEER AND
COMMUNITY SERVICE**

Douglas A. Rund Emergency Medicine Alumni Society

- ◆ Co-founder of alumni society for graduates of The Ohio State University Emergency Medicine Residency to plan continuing education, social, community service, and life-long learning events.
- ◆ Society Immediate Past President
September 2021 - Present
- ◆ Society President
October 2019 – September 2021
- ◆ Society Vice-president
September 2017 – October 2019
- ◆ Board of Governors
September 2017 - Present

University of Toledo College of Medicine Alumni Affiliate

- ◆ Board Past-President
May 2020 – May 2021
- ◆ Board President
May 2018 – May 2020
- ◆ Scholarship Committee
Spring 2015 – Present
- ◆ Board of Trustees
2013 - Present

HONORS AND AWARDS:

Ohio Chapter American College of Emergency Physicians

- ◆ Emergency Physician Advocacy Award, 2019
- ◆ Bill Hall Award for Service, 2017, the Chapter's highest award

American College of Emergency Physicians

- ◆ ACEP Council Meritorious Service Award, 2020
- ◆ ACEP Council Horizon Award, 2014

Premier Physician Services

- ◆ Newcomer Medical Director of the Year, 2013

Mercy St. Vincent Medical Center

- ◆ Best Poster Presentation, Midwest Regional SAEM Regional
October 2012
- ◆ Attending of the Year, Emergency Medicine Residency, 2011-2012

The Ohio State University Medical Center

◆ Resident Research Award, 2007

REFERENCES:

Available upon request

PERSONAL INFORMATION:

Married to wife Pamela in 2000

Son Mitchell born 2004, daughter Abigail born 2006

Hobbies and Interests: golf, powerlifting, college football, lighthouses,
LEGO, JRR Tolkien, Game of Thrones, Star Wars, and GO BUCKS!

2023 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Larisa M. Traill, MD, FACEP

Question #1: How do you see yourself advocating for the College as a non-voting participant at ACEP Board of Directors meetings?

I believe in the importance of continuing to reach out to stakeholders, not only for input on challenges facing our specialty, but also, more importantly, for potential solutions for the Board and the College to consider. To optimize the work of the Council, the Speaker and Vice Speaker must be capable of digesting the complicated and often voluminous information in the Council materials in advance of the Council meeting to be respectful of the Council's time and efficiently guide the Council deliberations and resolution modifications. Familiarity with parliamentary procedure as well as skill in leading a discussion with divergent opinions can often elicit nuanced views that might otherwise go unrecognized. Such expertise, which I possess, would help to enhance the Council Officers' ability to advocate for the Council at ACEP Board meetings.

The primary role of the Council Officers is to promote the work of the Council in their assigned duties and as directed by the ACEP Board. Council Officers may seek areas that require further clarification or additional information that could bring consensus to an issue. Moreover, the Council Officers should bring forward matters that may benefit from further communication with stakeholders (e.g., Council, ACEP, public, etc.) for the Board to consider. I believe that engagement with stakeholders, of which the Council is one, is key to the success of the work of the Board.

It is essential to have quality data on a breadth of issues, not the least of which is understanding stakeholder opinions, because without the necessary reliable information, we accomplish little. Procuring such information is all the more challenging when topics are polarizing, and I will continue to ensure that members' deeply held individual values and beliefs are respected. As a Council Officer I would not be advancing my own opinions or agenda but rather focusing entirely on what I understand the will of the Council and the College to be. The Council has a formal process by which to pass resolutions, as well as an informal process to accomplish its work through member engagement, both in person and online. With tens of thousands of members and only a few hundred Councillors, increasing communication throughout the year, as I outline below, will enhance effective advocacy of behalf of the College—all ACEP members should be afforded the opportunity to contribute to the conversation.

I believe that one role of the Council Officers is to inform the Council as to what they *can* do and to inform the Board what they *should* do based on the deliberations of the Council. "To advocate" comes from the Latin verb *advocare*, "to call to" (one's aid). I mention this because an advocate aids others, not themselves, and being an advocate means putting others first. Possessing the right to vote should have little bearing on how effectively one might advocate for an issue. Few ACEP members possess a vote in Congress, but that does not stop the many other engaged members from effectively advocating. The key to successful advocacy is to engage and collaborate with the Board and the College as a whole.

Question #2: What is your vision for disseminating the work of the Council more broadly?

My vision is a multimodal approach that recognizes that our speciality, the second youngest in the house of medicine, has become increasingly multigenerational. Generative leaders foster and encourage innovative thinking and I believe they are essential to the long-term vision and, perhaps, even the survival of many professional organizations. Council Officers must seek to inspire and enrich the Council experience by building an engaged and receptive culture for the Council to do its best work. My approach would include disseminating the work of the Council even more broadly and pursuing new technologies and ideas to exchange information: one example would be a quarterly newsletter that provides status updates on that year's Resolutions, such as where the work brought forth by the Council stands? Another example, already adopted by many academic institutions, is a regular, more personal monthly or quarterly podcast or Instagram Story, "*Council Chats for Change*", with Council updates, and, if it is the will of the Board, also interviews with Board members and section chairs. There are members who may feel marginalized at Council, or too intimidated to speak, and I want all Council members to feel that they have been heard, that their opinions matter, that they are part of the community, and most importantly, that they belong.

Question #3: How would you navigate through the challenges that may arise when the Council and the Board of Directors do not share the same view on an issue?

A Council Officer must possess substantial experience in moderating debate; I possess the skills necessary including the diplomatic talent and emotional and social intelligence, to not only negotiate interpersonal conflicts, but also to encourage a spirit of collaboration essential for the achievement of our shared goals. Anyone, who has successfully, and affably, chaired such excitements as Reference Committee A, as I have, has proven to be capable of advocating for all manner of issues, ranging from the esoteric to the straightforward. Moreover, there may be resolutions for which a novel or innovative way to present the background information might help to better inform the Council's discussion (e.g., tables, graphics, hyperlinks, etc.). Greater clarity might minimize either anticipated or unexpected challenges on the Council floor.

The Council's efficiency is paramount to navigating the challenges that may result from differing opinions. I will ensure that all opposing voices are heard, and I will also solicit opinions or considerations that may not have been previously expressed. I believe that with informed discussion, the Council would have the ability to reach a consensus, enabling it to cast a majority vote decision without having to repeatedly refer issues to the Board. The expertise of the Board should be primarily reserved for issues related to the strategic mission of the College, issues which require executive level insight and deliberations. I would also offer a friendly reminder to the Council Officers and the Board of their deliberative and strategic responsibilities to the College. Just as physicians have a fiduciary obligation to act in good faith and loyalty, not allowing their personal interests to conflict with their professional duty, so must the elected bodies of the College act in its best interests and attempt to reach consensus whenever possible. I am invested in exploring innovative approaches to optimize the potential of the Council. We must all strive for clarity of purpose in the pursuit of growth, change, and development: I am committed to this agenda.

Our Council should function not in rivalry with other organizations, not imitating others, but serving as an example to them, whether or not we all share the same views; such should be the Council in the hands of the many, not the few.

“Our form of government does not enter into rivalry with the institutions of others. Our government does not copy our neighbors’ but is an example to them. It is true that we are called a democracy, for the administration is in the hands of the many and not of the few”— Pericles, Athenian General and Statesman.

CANDIDATE DATA SHEET

Larisa M. Traill, M.D., FACEP

Contact Information

2280 Ivy Hill Drive, Commerce Township, MI 48382

Phone: 347-426-6610

E-Mail: larisa.traill@gmail.com

Current and Past Professional Position(s)

Greater Midland Emergency Physicians (GMEP), Director of Quality, Compliance, and Safety, 2022-present

Attending Physician, GMEP, Alma, Mt Pleasant, West Branch, and Alpena, MI, 2017-present

Clinical Assistant Professor, MSU College of Human Medicine, Department of Emergency Medicine, 2017-present

American Board of Emergency Medicine, Oral Examiner, 2017-present

Attending Physician (Locums), Windsor Regional Hospital, Windsor, Ontario, Canada, 2011-present

Volunteer Clinical Assistant Professor of Emergency Medicine, Indiana University, School of Medicine, 2016-2018

ApolloMD Strike Team Physician, 2015-2017

Attending Physician (Locums), Dickinson County Memorial Hospital, Iron Mountain, MI, 2014-2017

Attending Physician, Emergency Medicine Specialists, PC, Macomb, MI, 2013-2015

Attending Physician, Medical Center Emergency Services, PC, Detroit, MI, 2008-2013

Clinical Assistant Professor, Department of Emergency Medicine, Wayne State University, 2009-2015

Education (include internships and residency information)

Hons. BSc, Latin & Biology, University of Toronto, Victoria College, Toronto, Ontario, Canada, conf. 1999

Doctor of Medicine, St. George's University School of Medicine, Grenada, W.I., conf. 2005

Wayne State University/Detroit Medical Center Emergency Medicine Residency, Detroit, MI, grad. 2008

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine, 2009-present (recertification 2019)

College of Physician & Surgeons of Ontario, 2011-present

Professional Societies

American College of Emergency Physicians

Michigan College of Emergency Physicians

College of Physicians & Surgeons of Ontario (CPSO)

Emergency Medicine Residents' Association (alumni membership currently)

American Association of Women Emergency Physicians

American Medical Association

Michigan State Medical Society

Oakland County Medical Society

American Academy of Emergency Medicine

Great Lake Chapter Division, American Academy of Emergency Medicine

International Federation of Business and Professional Women

Michigan State Volunteer Registry, Office of Public Health Preparedness

Iota Epsilon Alpha (IEA) International Honor Medical Society

National ACEP Activities

Council Steering Committee, 2020-2022
Chair, Steering Committee, Bylaws and Council Standing Rules Subcommittee, 2021-2022
Chair, Council Reference Committee A, 2019
Chair, Bylaws Committee, 2017-2020
Member, Ethics Committee, 2022-present
Member, Bylaws Committee, 2010-present
Member, State Legislative and Regulatory Committee (SL/R), 2013-2017 & 2021-present
Subcommittee Chair, Telemedicine Objective, SL/R Committee, 2015-2016
Councillor, 2011-present
Alternate Councilor, 2009-2010
Section Member, American Academy of Women Emergency Physicians
Section Member, Locum Tenens Section, 2018-2019

ACEP Chapter (Michigan) Activities

Advisory Member, Statewide Psychiatric Bed Registry, Michigan Inpatient Admissions Discussion
Michigan Department of Health and Human Services, 2018-2022
Chair, Physician Wellbeing Task Force, 2018-2019
Chair, Board of Trustees, Michigan Emergency Medicine Foundation, 2017-2018
Member, Board of Trustees, Michigan Emergency Medicine Foundation, 2017-present
Chapter President , 2016-2017
Board Member, 2012-2018
Member, Quality Committee, 2016-present
Member, Legislative Committee, 2013-present
Chair, Education Committee, 2013-2018
Member, Education Committee, 2009-present

Practice Profile

Total hours devoted to emergency medicine practice per year: 1700 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 90 % Research 0 % Teaching 5 % Administration 5 %

Other: _____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Physician employed by an independent physician-owned, four-hospital (two community, one critical access, one free-standing) emergency medicine group practice.

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.)

Greater Midland Emergency Physicians (GMPEP), Director of Quality, Compliance, and Safety

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases Plaintiff Expert 0 Cases

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Larisa M. Traill, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Greater Midland Emergency Physicians

Address: Natalee Cergnul, Business Manager, Greater Midland Emergency Physicians

PO Box 2579 Midland, MI 49641

Position Held: Attending Emergency Physician and Director of Quality, Safety, and Compliance

Type of Organization: Physician Owned Emergency Medicine 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: Michigan College of Emergency Physicians

Address: 6647 W. St. Joseph Hwy. Lansing, MI 48917

Type of Organization: Non-Profit/ACEP Chapter

Newsletter Editor, Education Committee Chair, Physician Wellbeing Taskforce Chair, Legislative Committee, Quality Committee, Leadership Development Program (LDP) Taskforce Leader, Executive Director Search Committee,

Leadership Position: Board of Directors, Executive Committee, Chapter President

Term of Service: 2008-present, see CV. Board of Directors 2012-1018

Organization: American College of Emergency Physicians

Address: 4950 W. Royal Lane, Irving, TX 75063-2524

Type of Organization: Non-Profit

Councillor, Council Steering Committee, Steering Committee Bylaws and CSR Subcommittee Chair, Ref Com A Member & Chair, Bylaws Committee Member & Chair, SL/R Committee Member & Telemedicine Subcommittee Chair, Ethics

Leadership Position: Committee Member

Term of Service: 2008-present, see CV.

Organization: Michigan Emergency Medicine Foundation
Address: 6647 W. St. Joseph Hwy. Lansing, MI 48917
Type of Organization: Non-Profit
Leadership Position: Member, Board of Trustees & Chair Board of Trustees
Term of Service: 2017-present (Chair 2017-2018)

Organization: American Board of Emergency Medicine
Address: 3000 Coolidge Rd. East, Lansing, MI 48823
Type of Organization: Non-Profit
Leadership Position: Oral examiner
Term of Service: 2017-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:

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.

Larisa M. Traill, MD, FACEP

Date

06/20/2023



**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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**51st Michigan EM
Assembly
July 28-31, 2024
The Highlands**

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 Larisa M. Traill, MD, FACEP for the office of ACEP Council Vice Speaker.

Dr. Traill serve with distinction as a member of MCEP's Board of Directors for six years. During her 2016-17 term as MCEP President, she worked tirelessly to shepherd the College through the sudden illness and passing of MCEP's beloved Executive Director, Diane Kay Bollman, taking on additional leadership duties during this turbulent time for our College. She has been a steadfast supporter of the MCEP Education programs, including serving six years as Education Committee Chair. She continues her involvement as an invaluable member of the Michigan College, remaining active with the Education and State Legislative Committees, as well as faculty for MCEP's Leadership Development Program. In 2019, she was awarded one of the MCEP's highest honors, the Ronald L. Krome, MD Meritorious Service Award.

Dr. Traill possesses the necessary skills and experience to not only excel in the offices of Council Vice Speaker and Speaker, but also to represent the mission and values of the College. As a member of the Bylaws Committee for fourteen years, including three as Chair, she possesses an in-depth familiarity with ACEP's governing documents and principles and each Chapter's bylaws, as well as expertise in parliamentary procedure.

Dr. Traill has served on the Council Steering Committee for the past two years and continues to serve on ACEP's State Legislative and Regulatory Committee, Bylaws Committee, and Ethics Committee. As a past Chair of Council Reference Committee A, she has demonstrated an ability to efficiently summarize testimony, ensure all Councillors are afforded the opportunity to be heard, and facilitate a meeting that is efficient, congenial, and enjoyable.

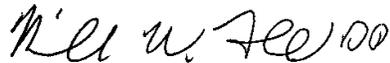
Dr. Traill, an AAWEP section member for many years, continues to actively engage and support female members to serve on MCEP and ACEP committees and in other leadership roles. She remains a staunch advocate for women physicians and the empowerment of women.

Larisa Traill, MD, FACEP
Page Two

Additionally, Dr. Traill is a full-time clinician with Greater Midland Emergency Physicians (GMEP) at MyMichigan Health/University of Michigan Health, and also serves as GMEP's Director of Compliance, Quality, and Safety. She demonstrates the qualities and skills that represent the legacy of emergency medicine while fostering a vision for its future aiming to bring our specialty forward to new and greater heights. Her work, both in Michigan and at the national level, demonstrates that she would shine on the Council stage.

I would respectfully ask that you join our Chapter and the ACEP American Association of Women Emergency Physicians Section in supporting the nomination of Larisa Traill, MD, FACEP for the office of Council Vice Speaker of the American College of Emergency Physicians.

Regards,



Michael Fill, DO, FACEP
President, MCEP



Alecia Gende, DO, CAQSM, FACEP
Chair, ACEP AAWEPE Section



Larisa M. Traill, MD, FACEP

ACEP is at a pivotal moment. While we grapple with increasingly complex and contentious issues, as Councillors we must come together to focus on the most important issues that have the greatest impact on Emergency Medicine. We must respect and hear each other to build consensus aligned with the College's mission. We must find the right solutions for the specialty and for the individual practicing emergency physician. We must strive for clarity of purpose in the pursuit of growth, innovation, and self-governance.

My vision recognizes that our specialty is increasingly multigenerational. Innovative, cross-generational thinking is essential to the long-term mission of ACEP. A Council Officer must enrich the Council experience by building an engaged and receptive culture. My approach would include broader communication of the Council's work through innovative methods to exchange ideas: this could include "*Council Chats for Change*" to update Council members about resolutions, brainstorm, and connect for collaborative change.

As faculty for MCEP's Leadership Development Program, I understand the importance of engaging future leaders. Giving a voice to each member requires an inclusive environment. I want all Council members to know that their opinions will be heard, that thought diversity matters, that they have a voice, and most importantly, that they belong. This sense of belonging is paramount to navigating our specialty's challenges and leveraging our strengths. Emergency Medicine has thrived in an imperfect environment, and so will the Council. As a Council Officer, I would be solution-oriented, focusing on important details while maintaining the 'big picture' perspective. My familiarity with parliamentary procedure and consensus-building skills will help elicit and integrate nuanced views that might otherwise go unrecognized.

Council members donate their valuable time to the work of the Council. The Council's precious time must be focused on issues critical to the specialty, not on simply "wordsmithing". I possess the knowledge, experience, diplomacy, and social intelligence to moderate debate, maximize efficiency, and encourage a spirit of collaboration. I will summarize testimony swiftly while balancing parliamentary procedure, decorum, and good-natured humor.

I am deeply committed to the ACEP Council, having represented MCEP at the Council for fifteen years and having served on several Council committees, including two years on Reference Committee A (one year as Chair), a member of the Steering Committee, and a Steering Subcommittee Chair. I am the longest serving Past Chair of the Bylaws Committee, and a member for fourteen years. My love for bylaws and governance will bring an approachable, authentic, and compelling enthusiasm that is invaluable to an effective Council meeting. Through my work with ACEP and MCEP, I have found deep professional fulfillment which I hope to return in full through preparation, leadership, and thoughtful deliberation. My familiarity with parliamentary procedure and skill in leading a discussion with divergent opinions may elicit nuanced views that might otherwise go unrecognized and will enhance my ability to advocate for the Council at ACEP Board meetings. This is your Council. I will ensure that your voice is heard.

The Michigan College of Emergency Physicians and the American Association for Women Emergency Physicians jointly endorse me as the best candidate for ACEP Council Vice Speaker. Join them in supporting me, Larisa Traill, MD, FACEP, and I promise you an engaging and effective Council experience and one that will make you look forward to returning the next year.

#TIME4TRAILL

Larisa Traill, MD, FACEP for ACEP Council Vice Speaker

Your Voice, Your Council, Your Leader



Larisa is a full-time clinical emergency physician in an independent community-based group, a Past President of the Michigan College of Emergency Physicians (MCEP), and the longest-serving ACEP Bylaws Committee Past Chair. Larisa has an unparalleled passion for bylaws and governance. She has the knowledge, experience, diplomacy, and social intelligence to moderate debate, maximize efficiency, and encourage a spirit of collegiality that is needed at this pivotal point in Council history.

Proudly Endorsed By:



**MICHIGAN COLLEGE OF
EMERGENCY PHYSICIANS**



Servant Leadership

- Longest serving Past Chair ACEP Bylaws Committee
- Past Chair Council Ref Committee A
- MCEP Leadership Development Program Faculty
- Past MCEP President

Commitment

- 15 years MCEP Councillor
- 2 Council Committees
- 1 Council Subcommittee Chair
- 3 ACEP Committees, including 14 years on Bylaws
- Past Chair Michigan EMF

Vision

- Solution-oriented
- Diversity of thought with consensus building
- Engagement
- Collaboration and follow through
- Collegiality
- Professional fulfillment

Contact Larisa

- Email: larisa.traill@gmail.com
- Twitter: @lm_traill
- Instagram: [larisatraill](https://www.instagram.com/larisatraill)
- Cell: 347-426-6610

This is your Council. I will ensure that your voice is heard.

#TIME4TRAILL

Date of Preparation: November, 2022

Larisa M. Traill, MD, FACEP

Larisa M. Traill, MD, FACEP, FAAEM

Home Address:

2280 Ivy Hill Drive
Commerce Township, MI
48382-5122

Telephone:

347-426-6610 (C)

Email: ltraillmd@gmepdocs.com or larisa.traill@gmail.com

Education:

George Marasleion 16th Lykeion, Athens, Greece

Honors Bachelor of Science, Biology & Latin
University of Toronto (U of T)

conferred 06/1999

Doctor of Medicine
St. George's University School of Medicine (SGUSOM)

conferred 06/2005

Post-Doctoral Training:

Emergency Medicine Residency, Sinai-Grace Hospital
Wayne State University (WSU) / Detroit Medical Center (DMC)

07/2005-06/2008

Michigan College of Emergency Physicians (MCEP)
Leadership Development Program, Lansing, MI

03/2009-12/2010

American College of Emergency Physicians
(ACEP) Teaching Fellowship, ACEP, Dallas, TX

08/2009-03/2010

Board Certification:

American Board of Emergency Medicine (ABEM) Expires: 12/31/2029

Faculty Appointments:

Clinical Assistant Professor 06/2009-05/2015
Department of Emergency Medicine
WSU School of Medicine, Detroit, MI

Volunteer Clinical Assistant Professor of Emergency Medicine 09/2016-09/2018
Indiana University, School of Medicine, Terre-Haute, IN

Clinical Assistant Professor 12/2017-present
Michigan State University, College of Human Medicine
Department of Emergency Medicine

Hospital Appointments:

Attending Physician, Emergency Department 07/2008-05/2013
Medical Center Emergency Services, PC, Detroit, MI
DMC Sinai-Grace Hospital, Harper University Hospital,
And DMC Surgery Hospital

Attending Physician (Locums), Emergency Department 01/2011-present
Windsor Regional Hospital, Metropolitan Campus
Windsor, Ontario, Canada

Attending Physician, Emergency Department 05/2013-02/2015
Emergency Medicine Specialists, PC (group sold contract)
St John Providence Hospital, Macomb

Attending Physician (Locums) 12/2014-12/2017
Emergency Department
Dickinson County Memorial Hospital
Iron Mountain, MI

Attending Physician (Locums) 11/2015-11/2018
Emergency Department, Mid-Michigan Medical Center-Alpena
Michigan Medicine/University of Michigan
Alpena, MI

| | |
|---|--|
| ApolloMD Strike Team Physician/Locums Staff Attending Physician, Emergency Department Aiken Regional Medical Center, Aiken, SC | 03/2015-07/2015 |
| ApolloMD Strike Team Physician/Locums Staff Attending Physician, Emergency Department MetroSouth Medical Center, Blue Island, IL | 09/2015-01/2016 (group lost contract) |
| ApolloMD Strike Team Physician/Locums Staff Attending Physician, Emergency Department Union Hospital, Terre-Haute, IN | 05/2016-09/2016 (group lost contract) |
| ApolloMD Strike Team Physician/Locums Staff Emergency Department, Moses Taylor Hospital Scranton PA | 09/2016-01/2017 |
| Attending Physician, Locums Staff Emergency Department, Mercy Rockford Memorial Hospital Rockford, IL | 01/2017-01/2018 |
| Greater Midland Emergency Physicians (GMEP) Attending Physician, Emergency Department, Mid-Michigan Medical Center-Gratiot, Mt Pleasant, Alpena, MI Michigan Medicine/University of Michigan | 01/2017-present |

Major Professional Societies:

American College of Emergency Physicians (ACEP), Fellow
Michigan College of Emergency Physicians (MCEP), Past-President
American Academy of Emergency Medicine (AAEM), Fellow
Great Lake Chapter Division, American Academy of Emergency Medicine (GLAAEM)
College of Physicians & Surgeons of Ontario (CPSO)
Michigan State Volunteer Registry, Office of Public Health Preparedness
Iota Epsilon Alpha (IEA) International Honor Medical Society, SGUSOM
Kaplan Medical Honor Society

Medical Licensure & Certifications:

| | |
|--|---------------------|
| State of Michigan Board of Medicine Physician License | Expires: 11/14/2024 |
| State of Michigan Board of Pharmacy Controlled Substance License | Expires: 11/14/2024 |
| DEA Registration, Michigan | Expires: 11/30/2025 |
| Ontario Medical License, CPSO #946072 | Expires: 05/31/2023 |
| State of Illinois, DFPR, Licensed Physician and Surgeon | Expires: 07/31/2023 |
| State of Illinois, DFPR, Controlled Substance License | Expires: 07/31/2023 |
| ACLS/Instructor | Expires: 03/27/2023 |
| PALS | Expires: 03/27/2023 |

| | |
|---|---------------------|
| BLS | Expires: 03/27/2023 |
| NIH Stroke Scale Certification | Completed 2007 |
| National Incident Management System (NIMS) | |
| Incident Command System (ICS) Certification (IS: 100, 200, 700) | Completed 2007 |

Service & Awards:

Professional:

Greater Midland Emergency Physicians:
Director of Quality, Compliance, and Safety 10/2022-present

Wayne State University Pathologists' Assistant Program
Advisory Board Member 07/2022-present

ABEM: Oral Board Examiner 07/2017-present

MCEP: Member, Executive Director Search Committee 03/2022-7/2022
Ronald L. Krome, MD, Meritorious Service Award 07/2019
Advisory Group Member, Statewide Psychiatric Bed Registry 07/2018-present
Michigan Inpatient Admissions Discussion (MIPAD)
Michigan Department of Health and Human Services
Chair, Board of Trustees, 07/2017-07/2018
Michigan Emergency Medicine Foundation
Immediate Past Chair, Board of Trustees, 07/2018-07/2019
Michigan Emergency Medicine Foundation
Member, Board of Trustees, 07/2017-present
Michigan Emergency Medicine Foundation
Chair, Physician Wellbeing Task Force 01/2018-01/2019
Committee Member, Quality Committee 09/2016-09/2018
Immediate Past President 08/2017-07/2018
President 07/2016-07/2017
President-Elect 07/2015-07/2016
Executive Committee Member 07/2013-07/2018
Board Member 07/2012-07/2018
Chair, Education Committee 05/2013-07/2018
Committee Member, Education Committee 07/2009-present
Committee Member, Legislative Committee 07/2013-07/2015
Editor, MCEP Newsletter, "News & Views" 07/2018-present
Resident Mentor, MCEP Membership Committee 01/2010-06/2013
2011-2012

ACEP: Council Steering Committee 09/2020-9/2022
Chair, Steering Committee, Bylaws and 09/2021-09/2022
Council Standing Rules Subcommittee
Chair, Council Reference Committee A
"Governance & Membership" 08/2019
Chair, Bylaws Committee 09/2018-09/2021

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|---|-----------------------|
| Committee Member , Bylaws Committee | 09/2010-present |
| Committee Member , State Legislative and Regulatory Committee | 2013-2017 & 2021-2022 |
| Subcommittee Chair , Telemedicine Objective, State Legislative and Regulatory Committee | 2015-2016 |
| Councilor , ACEP Council, MCEP Chapter | 2011-present |
| Alternate Councilor , ACEP Council, MCEP Chapter | 2009 & 2010 |
| Section Member , American Academy of Women Emergency Physicians | 2015-2017 |
| Section Member , Locum Tenens Section | 2018-2019 |
| AAEM: Great Lakes Chapter Division (GLAAEM) Member | 2020-present |
| GLAAEM Board of Directors , MI State Representative | 07/2021-present |
| Windsor Regional Hospital (Ontario, Canada): Committee Member , Planning Committee, “City of Roses Annual Community Emergency Medicine Conference” | 2017-2019 |
| Expert Testimony: | |
| House Judiciary Committee Hearing HB 4354: <i>Access To Quality Emergency Care Act</i> In Support, Bill Introduced by MCEP | 10/24/2013 |
| House Health Policy Committee Hearing HB 4135, Opposed, Representing MCEP | 05/24/2017 |
| Teaching: | |
| Clinical Educator Medical Students and Emergency Medicine Residents Emergency Medicine Residency, Department of Emergency Medicine | 07/2009-05/2013 |
| Sinai-Grace Hospital, WSU/DMC Department of Emergency Medicine Grand Rounds: Lecture series: “Oncologic Emergencies” & “Oncologic Jeopardy” | 05/2011 |
| Sinai-Grace Hospital, WSU/DMC, Department of Emergency Medicine Grand Rounds: Lecture series: “Domestic Violence” Lecture: “Toxic Flora” | 08/2007 02/2006 |
| WSU School of Medicine & Department of Emergency Medicine: Instructor, Procedure Workshop for Medical Students | 07/2006 & 07/2007 |

Children’s Hospital of Michigan, Emergency Medicine Grand Rounds:

Case Presentation: “Chest Pain in a Pediatric Patient;
A Review of Hypertrophic Cardiomyopathy” 10/2005

Clinical Instruction

Volunteer Clinical Assistant Professor of Emergency Medicine 09/2016-09/2018
Indiana University, School of Medicine, Terre-Haute, IN

ABEM Oral Board Review Seminars

Emergency Medicine Residency Program, 09/2011-05/2013
WSU/DMC, Sinai-Grace Hospital

ACEP Teaching Fellowship, Project & Presentation

“Oral Cases Are Fun!” ACEP, Dallas TX 03/2010

ACEP Teaching Fellowship, Microteaching Presentation

ACEP, Dallas TX 08/2009

Penn State College of Medicine

Faculty Instructor: Lytics In Practice: 10/2008
Clinical Expertise for Emergency Medicine Residents,
Scholarship Program and Workshop

Mentorship: Dr. Rebecca Byrd

2009-2012

Dr. Brooke Frakes 2010-2012

Emergency Medicine Residency Program,
WSU/DMC, Sinai-Grace Hospital

Community Education

DCT Aviation, Oakland County International Airport

Annual Lecture & Seminar Director: “Aviation Medicine & CPR Training” 2013-2016

Research & Publications:

Medical:

President’s Column:

Traill, L.M., *MCEP News & Views*, Volume XXXVII, No. 2, p2. May/June 2017 06/2017

President’s Column: “Advocacy: To Change What Is Into What Should Be” 04/2017

Traill, L.M., *MCEP News & Views*, Volume XXXVII, No. 2, p2. March/April 2017

President’s Column: “Physician Wellness & Burnout” 02/2017

Traill, L.M., *MCEP News & Views*, Volume XXXVII, No.1, p2. January/February 2017

| | |
|--|---------|
| President's Column: "MCEP's 2017 Strategic Plan and Physician Wellness" Traill, L.M., <i>MCEP News & Views</i> , Volume XXXVI, No. 8, p2. November/December 2016 | 12/2016 |
| President's Column: "Farwell to the Dog Days of Summer" Traill, L.M., <i>MCEP News & Views</i> , Volume XXXVI, No. 7, p2. September/October 2016 | 10/2016 |
| Incoming President's Address: "A Scientific Assembly Recap and Looking Ahead" Traill, L.M., <i>MCEP News & Views</i> , Volume XXXVI, No. 6, p2. August 2016 | 08/2016 |
| "MCEP's 2012-2013 Strategic Plan: Where's the Value?" (Editorial) Traill, L.M., <i>MCEP News & Views</i> , Volume XXXIII, No. 2, p3. March 2013 | 03/2013 |
| "MCEP Kudos!" (Editorial) Traill, L.M., <i>MCEP News & Views</i> Volume XXXII, No. 9, p3. November 2012 | 11/2012 |
| "Emergency Medicine and HealthCare Reform: What Questions Do We Need To Ask" (Editorial) Traill, L.M., <i>MCEP News & Views</i> , Volume XXXII, No. 8, p3. October 2012 | 10/2012 |
| "10 Reasons Not to Miss the 2012 Scientific Assembly in Denver" (Editorial) Traill, L.M., <i>MCEP News & Views</i> , Volume XXXII, No. 7, p3. September 2012 | 09/2012 |
| "North American Medication Shortages: Should We Grow Our Own?" (Editorial) Traill, L.M., <i>MCEP News & Views</i> , Volume XXXII, No. 4, p3. May 2012 | 05/2012 |
| "Healthcare Reform and National Legislative Update" (Editorial) Traill, L.M., <i>MCEP News & Views</i> , Volume XXXII, No. 3, pp. 3-4. April 2012 | 04/2012 |
| "EMS Design in Japan and Tsunami Relief Efforts in Michigan" (Editorial) Traill, L.M., <i>MCEP News & Views</i> , Volume XXXI, No. 3, p5. May 2011 | 05/2011 |
| "Aviation and Patient Safety" (Editorial) Traill, L.M., <i>MCEP News & Views</i> , Volume XXX, No. 9, pp. 6-7. November 2010 | 11/2010 |
| "Medicinal Uses of Honey-A Historical Perspective" (Editorial) Traill L.M., <i>MCEP News & Views</i> . Volume XXX, No. 7, pp. 4-5. September 2010 | 09/2010 |
| "Leadership and Advocacy" (Editorial) Traill, L.M., <i>MCEP News & Views</i> . Volume XXX, No. 5, pp. 4-5. June 2010 | 06/2010 |
| "Emergency Physician Burnout" (Editorial) Traill, L.M., <i>MCEP News & Views</i> . Volume XXX, No. 4, pp. 3-4. May 2010 | 05/2010 |
| "Community Service and the Emergency Department" (Editorial) Traill, L.M., <i>MCEP News & Views</i> . Volume XXX, No. 3, pp. 4-5. April 2010 | 04/2010 |
| "Epidural Abscess: When the MRI Counts", Traill, L.M. & Barton, M.A. L.M. Traill, M.D., FACEP | 04/2010 |

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American College of Emergency Physicians, *ACEP News, 'Focus On'*
CME article. Volume 29, No. 4, pp. 16-18. April 2010

“Acute Chest Syndrome: The Critical Cough”, Traill, L.M. & Barton, M.A. 11/2008
American College of Emergency Physicians, *ACEP News, 'Focus On'*
CME article. Volume 27, No. 11, pp. 21-23. November 2008

References Available Upon Request

ACEP HONORS 2023 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

The 2023 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

Paul D. Kivela, MD, MBA, 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

Andy S. Jagoda, 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

Jesse Pines, MD, MBA, FACEP

Presented to a member who has made a significant contribution to achieving the College's health policy objectives, or who has demonstrated outstanding skills, talent and commitment as an administrative or political leader. The award is named after Colin C. Rorrie, Jr., PhD, who served as ACEP's Executive Director from 1982 to 2003.



Judith E. Tintinalli Award for Outstanding Contribution in Education

Stuart P. Swadron, MD, FACEP

Presented to a member who has made a significant contribution to the educational aspects of emergency medicine.

ACEP HONORS 2023 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



John A. Rupke Legacy Award

J. Mark Meredith, 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

Lewis S. Nelson, MD, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.



Award for Outstanding Contribution in EMS

J. Brent Myers, 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

Mark S. Rosenthal, DO, PhD, 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

Reb J.H. Close, MD, FACEP

Presented to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.

ACEP HONORS 2023 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



Innovative Change in Practice Management Award

Christopher "Toff" R. Peabody, MD, MPH, FACEP

Presented to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.



Pamela P. Bensen Trailblazer Award

Amish M. Shah, MD, FACEP

Presented to a current College member for seminal contributions over time to the growth of the College and to the specialty of emergency medicine. The award is named after Pamela P. Bensen, MD, a charter member of ACEP and the first woman resident in emergency medicine (1971).



Diane K. Bollman Chapter Advocate Award

Shari Augustin

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

Harry Monroe

Presented to individuals who have rendered outstanding service to the College or the medical profession.



Policy Pioneer Award

Cameron J. Gettel, MD

Presented to early- and mid-career members who have made outstanding contributions to the College's health policy and advocacy initiatives.

ACEP HONORS 2023 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



Council Meritorious Service Award

Gary R. Katz, MD, MBA, 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

Roneet Lev, 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

Debra E. Houry, MD, FACEP

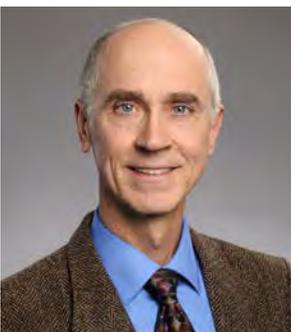
Presented to an individual who has made a significant contribution in advancing public health care and injury prevention measures locally, statewide, or nationally.



Leon L. Haley, Jr. Award for Excellence in Diversity, Equity & Inclusion

Omar Guzman, 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

Michael A. Ross, MD, FACEP

In recognition of emergency physicians who have made a significant contribution to the field of observation medicine within emergency medicine.

ACEP HONORS 2023 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



EM Wellness Center of Excellence Award

University of Cincinnati

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.

2023 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



Council Meritorious Service Award

Gary R. Katz, MD, MBA, FACEP

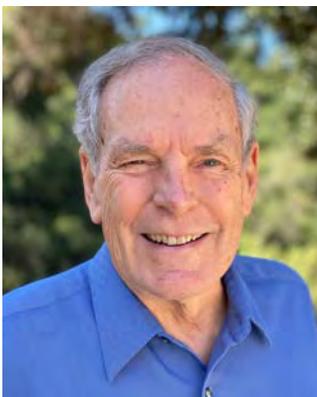
- Purpose:** Presented to a member of the College who has served as a councillor for at least three years and who, in that capacity has made consistent contributions to the growth and maturation of the ACEP Council.
- Criteria:** The nominee must be an active, life or honorary member of the College, and must have served as a councillor for at least three years. The nominee's contributions to the Council should include, but are not limited to, one or more of the following: Steering Committee membership; reference committee participation; participation on other Council committees; resolution development and debate; longevity as a councillor; or service as a Council officer.



Council Horizon Award

George RJ Sontag, 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 Curmudgeon Award

John D. Bibb, 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.

2023 ACEP COUNCIL AWARDS



Council Champion in Diversity & Inclusion Award

Adetolu Odufuye, MD, FACEP (Posthumously)

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 Teamwork Award

Pain Management & Addiction Medicine Section

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.

OUR MISSION: To promote the highest quality of emergency care and serve as the leading advocate for emergency physicians, their patients, and the public.

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.

2023 EMF REPORT

The Emergency Medicine Foundation strives to be the principal sponsor of scientifically rigorous research and education that improves the care of the acutely ill and injured.

EMF celebrated a milestone in the summer of 2023, reaching \$20 million in funding to more than 300 grant projects since 1972.



COUNCIL CHALLENGE IMPACT

425 Councillors and leaders at ACEP22 contributed over \$188,000 to EMF. The ACEP Council is the largest and longest sustaining supporter of EMF, having contributed \$2.7 million over 27 years.

UPCOMING RESEARCH PROPOSALS



EMF releases six new RFPs for 2024, totaling more than \$1.0 million in grant funding. The grant proposal process has been updated to maximize EMF's responsiveness to critical issues impacting emergency medicine.



NEW 2023 GRANTS

The 2023 grant cycle funded more than \$1.0 million to 21 grant projects on the following topics: health disparities, best practices, critical care, and diagnostic excellence.

2023 GRANTEE WORKSHOP



The EMF/SAEMF Grantee Workshop was held in March 2023, providing training and networking opportunities with NIH program officers and EM research leaders.

Donors at LAC23 helped EMF reach our 2023 Anniversary Challenge, surpassing the \$100,000 goal.

Grantees Drs. Adrian Haimovich and Mo Canellas representing EMF on ACEP Frontline Podcast

EMF supporters Drs. Brooks F. Bock, John C. Moorhead, Leonard M. Riggs Jr. and Michael J. Bresler

Medical student grantees at the 2023 EMF/SAEMF Grantee Workshop



SEE THE MISSION IN ACTION AT ACEP23



EMF RESEARCH SHOWCASE

October 9, 3:30 PM EST

PCC 104AB

See how your donor dollars are spent on practice-changing research by EMF grant recipients.

VIP RECEPTION: NIGHT AT THE MUSEUM



October 9, 6 PM EST

Pennsylvania Academy of Fine Arts

Donors who give \$600 and above annually can join us for a night to remember at the historic PAFA, located across from the Philadelphia Convention Center.



MAJOR DONOR LOUNGE

October 9 - October 11, 7 AM - 4 PM EST

PCC 116

The donor lounge allows those who give \$600 and above annually to relax and enjoy refreshments and breakfast each day.

SILENT AUCTION



October 9 - October 11

PCC Broad Street Atrium

One-of-a-kind experiences, sports, music, celebrity memorabilia, art, jewelry, and more. Bid, buy, and support EMF.

ACEP22 attendees offered their insight on what big questions in EM should be answered next.

EMF board members and supporters at ACEP22: Michelle Fox, RN, BSN and Drs. Michael Ward, Lynne Richardson, and Jeffrey Goodloe

Grantee Dr. Lise Nigrovic presenting at EMF's ACEP22 Research Showcase

Past EMRA Presidents and EMF board members Drs. RJ Sontag and Angela Cai at EMF's LAC22 VIP Reception



Report to the ACEP Council

The National Emergency Medicine Political Action Committee (NEMPAC)

and

Grassroots Advocacy

October 2023



NEMPAC

NEMPAC celebrates more than 40 years of success in 2023. A small, forward-thinking group of ACEP members founded NEMPAC back in 1980 to help ACEP promote our legislative goals and express the concerns of emergency medicine to members of Congress. Back then, the founders determined they would need to raise \$10,000 to have influence on the issue of independent contractor status for emergency physicians. Today, due to the increased costs of running for office and the many issues of importance to the specialty that ACEP can influence in Congress, our goal is to raise more than \$1 million annually. For the past ten years, this goal has been closely met and, in some years, exceeded, despite challenges that continue to confront the specialty.

Just like [the NEMPAC Board of Trustees](#) today, NEMPAC's founders were from all parts of the country and were "party" blind when it came to selecting candidates worthy of NEMPAC support. And just like today, NEMPAC is the only national PAC solely dedicated to representing our bi-partisan interests in our nation's capital.

Over the years, NEMPAC has opened doors, educated new and veteran lawmakers, and helped emergency medicine identify friends and champions in the U.S. Congress. This access created opportunities to express our well-reasoned viewpoints on the issues of the day for 40+ years. The past several years and election cycle have been particularly challenging as our nation emerges from the greatest public health crisis in decades and increasing political partisanship and volatility. Despite many challenges, NEMPAC remains one of the top five medical specialty PACs and continues to play a critical role in ACEP's federal advocacy efforts.

The Council Challenge has been in place for more than 25 years. Councilors collectively contribute more than \$250,000 annually to NEMPAC, which is more than one-quarter of our total raised annually. Each year during the Council Meeting, NEMPAC challenges all Councilors attending the meeting to support NEMPAC with the goal of reaching 100% participation.

2022 Election Cycle

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. A complete report of NEMPAC's activities during the 2022 Election can be found [here](#). This report was mailed to all active ACEP members as an insert in the March 2023 issue of *ACEPNow*.

2024 Election Cycle

The NEMPAC federal candidate budget is developed and approved by the NEMPAC Board of Trustees with guidance of ACEP staff. It is subject to modifications as the election cycle progresses and the congressional agenda takes shape. The budget will be consistently evaluated to reflect NEMPAC's fundraising efforts in 2023 and 2024.

In the 2024 election cycle, the NEMPAC Board of Trustees adopted the following strategies which are 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;
- 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;
- Prioritize check deliveries and attendance at 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, in particular those new to the committees.

Additional Evaluation Criteria

Candidates and incumbents who receive NEMPAC support are expected to exhibit behavior and actions consistent with the mission, vision and values of the American College of Emergency Physicians and uphold the principles of our democratic process and orderly governance. NEMPAC supported candidates should affirm science, evidence and fact in their words and actions.

The integrity and character of the candidate will be assessed on an ongoing basis and NEMPAC may consider ceasing contributions to a candidate or committee if credible, specific, and serious allegations about the candidate's behavior arise. NEMPAC also continues our commitment to inclusiveness and respect for diversity.

2024 election cycle evaluation criteria also follow past NEMPAC practice of focusing on a candidate's support of ACEP's key legislative and regulatory initiatives, co-sponsorship of ACEP legislation, committee assignment, leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions.

The NEMPAC 2024 Election Cycle Guidelines and a complete list of candidates supported are available on the [NEMPAC website](#) and by request from ACEP staff.

NEMPAC 2023 Fundraising and Candidate Contribution Highlights to Date:

Amount Raised in 2022: \$900,000

Amount Raised in 2023 as of 9/7: \$462,407

Donations to Candidates: \$592,582 donated to candidates, leadership committees, party committees, and independent expenditures/SuperPACs as of 9/7.

Party Breakdown: 53% to Republicans and 47% to Democrats

See the [NEMPAC website](#) for specifics.

We carried over \$451,380 in hard dollars from the previous election cycle, so have a balance of \$285,002 as of this report dated September 7.

Other Highlights:

Co-host of the "House Call on the Mall" event with NRCC and multiple physician specialty organizations – donating \$15K for access to party and committee leaders along with many members of the GOP Doctors Caucus.

Continued support of the Healthcare Freedom SuperPAC organized in 2022 to help elect republican physicians, run by former and current physician members of congress including Drs. Roe, Harris, Burgess and Wenstrup – NEMPAC is one of the inaugural donors.

Educating ACEP members about running for office and physicians and congressional champions currently in office through articles in ACEPNow, monthly NEMPAC Pulse newsletter and on the ACEP/NEMPAC website.

Developed the 2022 NEMPAC Election Report for distribution in March of 2023 as an insert in ACEPNow.

ACEP co- hosts annually and serves on the planning committee of the Physician PAC Forum and the Specialty Physician Candidate Forum.

As of early September, DC staff and ACEP members attended nearly 400 fundraisers and meet and greets for incumbents and candidates running in the 2024 election cycle with about 15% attended in person by ACEP members. Twenty percent of these events were hosted or co-hosted by NEMPAC/ACEP. Each event is an opportunity to discuss the concerns of emergency medicine and legislative solutions.

2023 Dine-arounds at LAC23: Rep. Larry Bucshon, MD (R-IN) and Rep. John Joyce, MD (R-PA) who were also our special guests at the NEMPAC VIP reception. Other events during LAC sponsored by NEMPAC where individual ACEP members attended were for Sen. Maggie Hassan (D-NH), Sen. Gary Peters (D-MI), Sen. Ben Cardin (D-MD), Sen. Bill Cassidy (R-LA), Sen. Jackie Rosen (D-NV) and Sen. Michael Bennet (D-CO).

The 911 Legislative Network

Along with NEMPAC, the 911 Legislative Network plays a significant role in promoting ACEP's legislative agenda to Congress. When ACEP recognized that it was competing for federal legislators' time and attention in an environment burgeoning with important legislative issues, ACEP's Federal Government Affairs Committee and the Board of Directors voted to create a technically sophisticated grassroots network. Launched in April 1998, the 911 Legislative Network encourages ACEP members to cultivate relationships with their federal legislators for long term, ongoing lobbying, and educational efforts. The goal is to have emergency physicians across the country available as resources and healthcare issue experts for federal legislators. As "citizen lobbyists," 911 Network members carry ACEP's concerns directly to policy makers and staff to explain how legislation or regulation affects medical care provided in an emergency department. ACEP provides the tools and the training to help 911 Legislative Network members effectively communicate with their legislators.

We have been kick starting our grassroots advocacy with ACEP members and federal legislators and staff both quantitatively and qualitatively in the past year. Over 6,000 ACEP members including Residents are actively engaged in our 911 Grassroots Advocacy and we continue to grow our "grasstops" program through our ACEP Advocacy Leaders Program. Advocacy Leaders receive specialized training and communications from our DC staff to help them develop long-term productive relationships with members of congress and their staff.

We have a robust [ACEP Advocacy Action Center](#) where you can find active action alerts, information about your legislators and access to the ACEP 911 Weekly Update.

LAC23 resulted in 405 emergency physicians from 46 states participating in 298 meetings on Capitol Hill with federal legislators and/or their healthcare staff. We covered 207 House offices and 91 Senate offices.

911 Network Member of the Year

Each year, a "911 Network Member of the Year" is selected from among the most active advocates in the Network based on an accrued point system which includes attending events, hosting ED visits, responding to action alerts, and recruiting new members to the Network.

2023 Member of the Year: Bradley J. Uren, MD, FACEP

As Chair of the ACEP Federal Government Affairs Committee, a member of the NEMPAC Board of Trustees, and inaugural member of the ACEP Advocacy Leaders program, Dr. Uren is a leader in the development and advocacy of sound legislative policy on behalf of emergency physicians and patients. Dr. Uren is a frequent visitor to legislative offices in Lansing, Michigan and Washington, DC. He has testified before the Michigan Legislature on issues affecting public health and has authored opinion pieces and given media interviews on issues such as impaired driving, cardiac arrest, and injury prevention. He has worked with the State of Michigan on Medicaid patient access to emergency departments and was instrumental in the establishment of MEDIC, a Blue Cross Blue Shield of Michigan collaborative to improve emergency department care.

His mission to educate and empower medical students and residents at the University of Michigan Medical School in health policy and political engagement has brought a new generation of emerging leaders and advocates into medicine.

ACEP ED Visit Program for Legislators

We have revived our **Emergency Department Visit Program**, which had been on hiatus due to the pandemic, where ACEP Advocacy Leaders invite legislators and/or their staff to tour emergency departments in their communities. We are finding that the current August Congressional Recess has provided some excellent opportunities to highlight the boarding crisis through these visits in anticipation of our Boarding Summit in September. Legislators receive an up-close look at the challenges our members face every day in providing care to their constituents. Showing elected officials and their staff the people, places, and health care delivery system that their legislation impacts helps to build long-term meaningful relationships, distinguish our members, patients, and issues from other specialties, and establish emergency physicians as health care experts in their communities.

ED visits that have taken place already this year include:

- Ryan Reece, MD, FACEP hosted Rep. Dan Kildee (D-MI-08)

- Christina Millhouse, MD, FACEP hosted Rep. William Timmons (R-SC-04)
- Thomas Bernard, MD, FACEP hosted Rep. Deborah Ross (D-NC-02)
- Nathaniel Schlicher, MD, JD, MBA, FACEP hosted Rep. Derek Kilmer (D-WA-06)
- Heidi Knowles, MD, FACEP hosted Rep. Beth Van Duyne (R-TX-24)
- Ryan Shanahan, MD, FACEP hosted Rep. Julia Brownley (D-CA-26)
- Blake Buchanan, MD, FACEP hosted staff for Sen. Marco Rubio (R-FL) and Rep. Laurel Lee (R-FL-15)
- Jeffrey Goodloe, MD, FACEP hosted Rep. Kevin Hern (R-OK-01)
- Stephen Wolf, MD and Anna Engeln, MD, FACEP hosted staff for Sen. Michael Bennet (D-CO)
- Sara Chakel, MD, FACEP hosted Rep. Rashida Tlaib (D-MI-12)
- Kathryn Groner, MD, FACEP hosted Sen. Chris Coons (D-DE)
- Mark Baker, MD, FACEP hosted Rep. Ed Case (D-HI)
- Valerie Norton, MD, FACEP hosted staff of Sen. Alex Padilla (D-CA).

Many additional visits are in the process of being scheduled.

Our DC staff helps in setting up the visits, including scheduling, providing talking points and tips on coordinating the visit with hospital staff and administration, and pre-visit calls to prep the hosting physicians. We plan to hold a panel discussion at LAC with several of the visit hosts sharing their experiences and anticipate an upcoming article in *ACEPNow* to highlight this program.

You can join the 911 Network here: <https://www.acep.org/federal-advocacy/federal-advocacy-overview/911grassrootsadvocacy/>

NEMPAC and the 911 Legislative Network help promote the specialty of emergency medicine. We thank the Council for your past support and encourage all Councilors to contribute to NEMPAC and sign up for the 911 Legislative Network. Your participation will help ensure the future of our specialty and our patients.

Embracing Challenges Championing Change

Emergency Medicine Residents' Association
Annual Report FY23



A message from **Jessica Adkins Murphy, MD** *EMRA President*

Walking into my emergency department in one of my last weeks of residency, my heart was pounding. My home away from home suddenly felt foreign to me: I was there not as a resident, certainly not as EMRA president, but as a patient. Like so many patients I had cared for over the previous three years, I sat in a hospital bed, my husband at my side, afraid I was miscarrying my early pregnancy. My co-resident took my hand in hers, said, "I'm sorry," and confirmed the ultrasound showed what we feared. I was devastated.

Amid waves of grief, unhelpful thoughts intruded. Something felt twisted about the fact that this was happening to me, not only because we physicians seem to think we're invulnerable, but also because I had spent the past two years writing miscarriage bereavement leave policies for EMRA and the AMA. An illogical part of me blamed that work for bringing this outcome upon my pregnancy. But maybe because of that policy work, maybe because of my supportive residency program's culture, and probably because of generations of female physicians before me, I felt empowered to request a few days off from residency to recover emotionally. Many women, especially in medicine, still do not have this option.

The experience of being human in medicine is not one that's inherently fair or compassionate. To me, advocacy has always seemed like the best way to make the unfair, ungovernable moments of life a bit more controllable. As young physicians who've inherited the harsh culture of medical training, a

profit-driven health care system, and doom-and-gloom online discourse, it's empowering to bring some compassion to the system through policy-making and solutions. And challenging the elements that don't seem fair has been my driving force as EMRA president.

This year, we've advocated for stronger residency standards to ensure the quality of our training remains high as programs grow. We've provided education on resident unionization to educate residents on collective bargaining as a strategy to improve their working conditions, wages, and resources. We supported EM-bound medical students by revamping student resources like our Student Advising Guide and providing free EMRA membership to students under-represented in medicine selected to the ABEM Haley Academy. And we passed new EMRA policies to support our patients, including policies on firearm restrictions in EDs, opioid harm reduction, rural medicine, racial equity, and more.

As I conclude my year as EMRA president, I'm overwhelmed with gratitude to each and every one of you for trusting me to represent your voice. It has been an immense honor to lead this organization of 20,400 remarkable residents, fellows, medical students, and alumni, and I'm thrilled to witness all we will accomplish together in the years to come. Here's to EMRA, and building a future of compassion, justice, and excellence in emergency medicine.

Jessica Adkins Murphy

Advocacy

> \$3.1M annually invested into members

This year EM faced an **unprecedented Match cycle** in which more than 500 residency spots went unfilled prior to the SOAP. Knowing this phenomenon was likely due to the rapid growth of EM residency programs, the ranking practices of programs, and a decrease in applicants to EM, we reached out to our members. In a town hall at our 2023 spring meeting of the EMRA Representative Council, we heard your concerns about profit motives in residency program growth, quality of training amid rapid growth, and whether

future job markets would be able to sustain the exploding workforce.

In response, we released **EMRA's statement on the 2023 EM Match** outlining strategies that residents, program directors, students, and organizations can employ to keep our specialty strong. We advocated directly to the ACGME to fortify EM residency requirements through evidence-based increases in procedure numbers and training experiences. And we amplified your voices through national news media, podcasts, social media, and more.

We've strengthened our approach to advocacy all around. This year, EMRA leaders have provided educational content on **unionization** including panels of resident organizers, EMRA*Cast episodes, and Instagram Live discussions. We addressed **ED boarding** and its impact on patients, physicians, and training in our first annual **Advocacy Week**. Live-streamed discussions on these topics and more are posted on our Instagram @emresidents, where we've been exploring new ways to connect with you, our members.

12



Resolutions proposed and debated by EMRA members and the Representative Council

- » Firearms in emergency departments
- » Opioid harm reduction
- » Position on excited delirium
- » Funding for rural emergency medicine
- » Improving overall wellness among emergency medicine residents
- » Racially equitable language and media in medical education
- » Supporting populations experiencing homelessness
- » Mitigation of competition for procedures between EM resident physicians
- » Reproductive rights and emergency contraception
- » Expanding resident experience to rural and critical access hospitals
- » Improving care for patients who are incarcerated
- » Standardizing away rotation applications

Protecting our training

EMRA is dedicated to ensuring residents receive high-quality training and do not compete with PAs and NPs for procedures in the ED.

In every room where a decision affecting EM physicians-in-training is being made, the EMRA voice is sought out, respected, and heard loud and clear. In 2023, EMRA advocated on your behalf:

- » At ACEP Council, where EMRA brought forward a resolution on protecting residents' choice of three-year and four-year programs, and a resolution on prioritizing residents (over non-physician trainees) when delegating procedures in EDs.
- » At the ACEP Leadership and Advocacy Conference in Washington, D.C., where EMRA residents and students joined ACEP to meet with legislators on Capitol Hill.
- » At the ACGME Emergency Medicine Stakeholder Summit on residency program standards.
- » At the Council of Residency Directors in Emergency Medicine Academic Assembly.

- » On the All EM Organizations' Diversity, Equity, and Inclusion Task Force.
- » On the Coalition on Psychiatric Emergencies.

EMRA released our own statement on the 2023 EM Match and the following statements with our partner organizations:

- » Joint Statement from Emergency Medicine Organizations on Efforts to Diversify Health Care Professionals in the United States
- » Response to Improving Income-Driven Repayment for the William D. Ford Federal Direct Loan Program
- » Easy Bystander AED Use, a tutorial video from EMRA and ACEP
- » Multi-Organizational Letter Regarding AHRQ Report on Diagnostic Errors in the Emergency Department

EMRA also personally reached out to residents displaced by program closures and to residents at EDs affiliated with Envision and American Physician Partners after these corporations restructured and closed in 2023.

12+ Partnerships
Advanced Analgesia in the Emergency Department, AEROS, ACEP, ALiEM, AMA, Coalition on Psychiatric Emergencies, EDPMA, EMF, EMPI, NEMPAC, CORD, Essentials of EM, PolicyRx, and others.

Education

Membership **20,400** >**95%** of EM residents are EMRA members

Our EMRA/ACEP **new member kits** that welcome students, residents, fellows, and alumni to each new EMRA family category, have gotten an upgrade. For years, the kits have equipped trainees to excel on-shift, exemplifying EMRA's dedication to directly supporting our 20,400 members in your daily lives. Now, in addition to our most popular printed guides like EMRA Antibiotic Guide, PressorDex, and more, we are proud to announce the first edition of the **EMRA and AAED Nerve Blocks and Procedural Pain Management Guide**. This new guide, created in partnership with Advanced Analgesia in the Emergency Department, focuses on

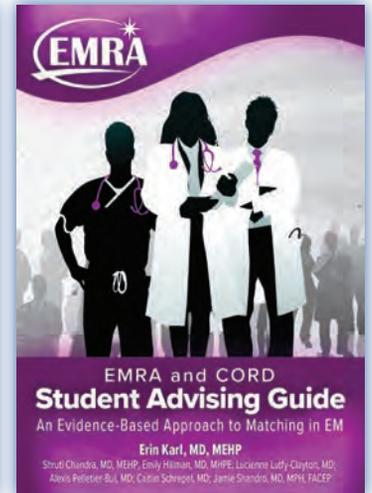
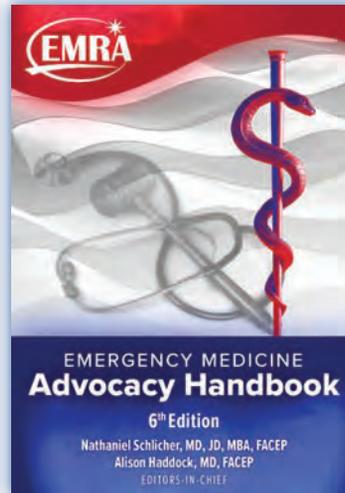
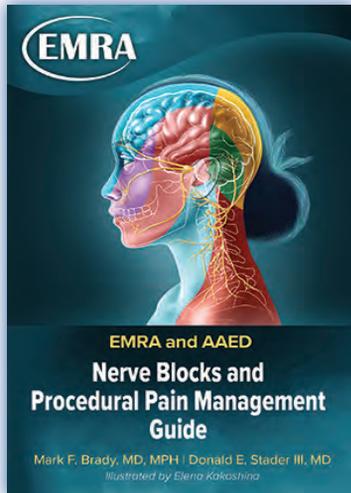
procedural analgesia and dovetails with the already-established EMRA Pain Management Guide to offer thorough alternatives to opioids for pain control.

EM Resident continues to produce stellar content and we just couldn't be prouder. **"Plus One: Care of the Pregnant Trauma Patient"** is being used by a maternal-fetal medicine specialist at Emory University to develop guidelines for EMS management of pregnant trauma patients. In addition, we took steps to highlight our digital content and lessened our environmental impact by transitioning our printed issues from bimonthly to quarterly publication.

EMRA's growing member benefits make the best educational products more accessible to residents than ever before. In addition to EMRA members' free access to EM:RAP, and discounts for Hippo EM, PEERprep, and Rosh Review, we recently secured member discounts for the **EMCrit Podcast**. Furthermore, recognizing the stress that residents and medical students face, EMRA is now exploring wellness-focused benefits. Through a pilot partnership with the app **Headspace**, 300 EMRA members have accessed guided meditation sessions in the past year. We plan to roll out even more new benefits in the months ahead.

36 On-shift guides and original EMRA resources

4 New or newly-revised EMRA guides, references, and apps in 2023



5,000+ Downloads per month

4

Student focused national Hangouts sessions

24 New episodes per year

60,000+ Average monthly online views

>210,000 Searches of EMRA Match for:

18,000 Print distribution

- Residents
- Clerkships
- Fellowships
- Jobs

Leadership

245 programs with 100% membership



EMRA is a launchpad to career-long leadership, and we equip residents and medical students with the opportunities and preparation necessary to shape the future of the specialty.

EMRA committees engage 5,342 of our members in meaningful opportunities to lead and learn. This year, our Education Committee engaged hundreds of residents in Quiz Show, a simulation and trivia competition during the EMRA spring meeting in Las Vegas. The Critical Care Committee joined forces with the Government Services Committee to share fascinating experiences in military medicine in Afghanistan. The Health Policy Committee was instrumental in planning and executing the Health Policy Primer at the Leadership and Advocacy Conference in Washington, D.C. And at ACEP Scientific Assembly, the annual adventure race MedWAR challenged attendees' physical capabilities and medical skills in a heated competition led by the Wilderness Committee.

EMRA's partnership with ACEP unlocks unique leadership opportunities and mentorship that can skyrocket a resident

or medical student's career. More than 60 resident liaisons represented EMRA to ACEP committees, sections, and task forces. The EMRA and ACEP Leadership Academy professional development program graduated 11 Leadership Academy Fellows in 2023. These fellows completed a year-long curriculum followed by a capstone project.

This year, EMRA found new ways to support diverse leaders in EM by engaging students who are under-represented in medicine. We provided complimentary EMRA memberships to medical student scholars of the American Board of Emergency Medicine Dr. Leon L. Haley, Jr., Bridge to the Future of Emergency Medicine Academy. Scholars will have full access to member benefits including our New Member Kit on-shift guides, EMRA committees, and leadership opportunities for the duration of their medical school journey.

These are just a few of the initiatives that EMRA leaders have undertaken to advance our specialty, support fellow trainees, and propel their careers through leadership.

20 Committees

285+ Meetings, webinars, publications

5,342 Members of EMRA's Committees

- Medical students
- Residents
- Fellows

140 Funded national leadership opportunities for members

EMRA and ACEP Leadership Academy
135 Leadership Academy fellows

101 graduates and 34 currently in the program

32 Categories of awards, scholarships, and grants

- Scholarships
- Leaderships roles
- Professional excellence

The Emergency Medicine Residents' Association

is proud to remain the voice of emergency medicine physicians-in-training and the future of our specialty.



Memorandum

To: 2023 Council

From: James L. Shoemaker, Jr., MD, FACEP
Secretary-Treasurer

Date: October 3, 2023

Subj: FY 2022-23 Financial Report

This report of the FY 2022-23 encompasses the College's activities from July 1, 2022, through June 30, 2023. Additional details can be found in the June 30, 2023, Financial Statements.

Year End 2023 Operating Results

- FY23 Operating Budget (excluding Strategic Project Initiatives or SPI funding) was initially approved with a (\$1.670M) loss to support the investment in ACEP's new strategic plan and key technology initiatives. Budget modifications through the year due to grants received and additional technology expenses reduced the budgeted net loss to (\$937K).
- YE23 Revenues were \$37.932M vs budget of \$40.665M, under budget by \$2.733M. Notable variances include meeting revenues under by (\$3.655M), (27%) and membership dues under by (\$1.334M), (9%). Grant revenue was over budget by \$461K and an unanticipated ERTC refund of \$2.166M.
- YE23 Total Expenses were \$39,822M vs budget of \$41,602M, under budget by \$1,780M. Notable variances include salaries under by (\$575K), (3%); benefits under by (\$295K), (6%); member travel under by (\$330K), (31%); and staff travel under by (\$159K), (22%). Facility/meal costs were over by \$432K, 8% and bank/investment fees were over by \$129K, 20%.
- YE23 NI from Operations was (\$1.890M) vs the modified budget of (\$937K), behind budget by (\$953K)
- To date, \$1.464M of the approved \$3.4M 3-year SPI investment has been spent for upgrading CEDR/EMDI. YE23 revenues for EMDI were \$3.047M vs budget of \$3.8M and expenses were \$3.561m vs budget of \$6.200M.
- YE23 Member's Equity was \$13.853M, excluding \$2.048M in Restricted Member's Equity
- YE unrealized losses on investments were (\$135)

Liquid Reserve

Liquid reserve represents the amount of cash on hand minus the amount due to chapters and deferred revenue,

Fiscal Year Ending 2023

| | |
|--------------------------|---------------------------------------|
| Cash equivalents | \$21,114,215 |
| Due to chapters | \$2,611,427 |
| Deferred revenue | \$12,599,507 |
| Restricted Contributions | \$2,048,402 |
| Liquid reserve | \$3,854,879 (10% of operating budget) |

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ACEP's policy is to have at least 15% of the operating budget in liquid reserves. The FY 2022-23 operating budget was \$40,665,064 and 15% would equal \$6,099,760. Therefore, we have a deficit in liquid reserves of (\$2,244,881).

Equity

Total member's equity is \$15,901,251, of which \$13,852,849 is unrestricted and \$2,048,402 is restricted. The total unrestricted use of equity this fiscal year was \$5,047,720.

| | |
|-------------|--------------|
| Assets | \$40,604,222 |
| Liabilities | \$24,702,971 |
| Equity | \$15,901,251 |

Investment Portfolio

The current distribution is approximately 39.87% in equities, 45.22% in fixed income and preferreds, 1.97% in alternatives, and 12.94% in cash.

Membership

Total membership decreased by 1,156 to a total of 37,630 (-2.98%). Regular membership decreased by 645 to 22,078 (-2.85). Candidate membership decreased by 559 to 14,250 (-3.77%). International membership increased by 50 to 1,252 (4.16%). Honorary membership increased by 1 to 50 (4.16%).