COUNCIL MEETING

October 25-26, 2019

Hyatt Regency Hotel at the Colorado Convention Center
Denver, CO

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved June 2013

Antitrust

Reaffirmed by the ACEP Board of Directors June 2013, October 2007

Revised and approved by the ACEP Board of Directors October 2001

Revised and approved by the ACEP Board of Directors June 1996

Approved by the ACEP Board of Directors 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:

Copyright © 2013 American College of Emergency Physicians. All rights reserved.

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

Copyright © 2013 American College of Emergency Physicians. All rights reserved.

- 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.

Copyright © 2013 American College of Emergency Physicians. All rights reserved.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved January 2017

Conflict of Interest

Revised by the ACEP Board of Directors January 2017, June 2011, June 2008

Reaffirmed by the ACEP Board of Directors October 2001

Revised by the ACEP Board of Directors September 1997

Approved by the ACEP Board of Directors January 1996

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

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

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

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

Direct conflicts of interest arise, for example, when an individual engages in a personal transaction with the College or holds a material interest or position of responsibility in an organization involved in a specific transaction with the College or that may have interests at variance or in competition with the College. The appropriate and necessary course of action in such cases is to disclose the conflict and recuse oneself, during the deliberations and the vote on the issue.

Copyright © 2017 American College of Emergency Physicians. All rights reserved.

In rare circumstances, an individual may have such a serious, ongoing, and irreconcilable conflict, where the relationship to an outside organization so seriously impedes one's ability to carry out the fiduciary responsibility to the College, that resignation from the position with the College or the conflicting entity is appropriate.

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

A. General

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

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

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

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

5. Officers, Board Members, the Executive Director, and the General Counsel shall annually pledge to clarify their position when speaking on their own behalf as opposed to speaking on behalf of the

Copyright © 2017 American College of Emergency Physicians. All rights reserved.

membership as a whole, or as an officer or member of the Board of Directors or senior staff member.

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

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

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

B. Disclosure Form

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

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

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

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

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

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

      iii. That provides goods or services in support of the practice of emergency medicine (e.g. physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company).

Copyright © 2017 American College of Emergency Physicians. All rights reserved.

d. Industry-sponsored research support within the preceding twenty-four (24) months.

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

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

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

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

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

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

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

C. Additional Rules of Conduct

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

Copyright © 2017 American College of Emergency Physicians. All rights reserved.

a. The individual;

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

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

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

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

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

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

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

Copyright © 2017 American College of Emergency Physicians. All rights reserved.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Meeting Schedule of Events

Hyatt Regency at Colorado Convention Center
October 24-26, 2019
Denver, CO

Thursday, October 24

3:00 pm – 8:00 pm	Councillor Credentialing – *Centennial Ballroom Foyer, 3rd Floor*
4:30 pm – 6:00 pm	Candidate Forum Subcommittee – *Capitol Ballroom 3, 3rd Floor*
6:00 pm – 7:00 pm	Steering Committee Meeting – *Capitol Ballroom 5-7,* 4th *Floor*
7:00 pm – 8:00 pm	Tellers, Credentials, & Elections Committee – *Capitol Ballroom 3, 3rd Floor*
7:00 pm – 8:00 pm	Reference Committee Briefing – *Mineral Hall A, 3rd Floor*
8:00 pm – 9:00 pm	Councillor Orientation – *Capitol Ballroom 5-7, 4th Floor*

Friday, October 25

7:30 am – 5:30 pm	Councillor Credentialing – *Centennial Ballroom Foyer, 3rd Floor*
7:30 am – 8:00 am	Council Continental Breakfast – *Centennial Ballroom Foyer, 3rd Floor*
8:00 am – 9:15 am	Council Meeting – *Centennial Ballroom A-F, 3rd Floor*
9:30 am – 12:30 pm	Reference Committee A – *Capitol Ballroom* 4*, 4th Floor*
*9:*30 am – 12:30 pm	Reference Committee B – *Capitol Ballroom* 5-7*, 4th Floor*
9:30 am – 12:30 pm	Reference Committee C – *Capitol Ballroom 1-3, 4th Floor*
11:00 am – 12:30 pm	Reference Committee Boxed Luncheon – *Capitol Ballroom Foyer, 4th Floor*
12:30 pm – 2:30 pm	Reference Committee Executive Sessions A – Capitol Ballroom 4*, 4th Floor* B – Capitol Ballroom 5-7*, 4th Floor* C – Capitol Ballroom 1-3*, 4th Floor*
12:45 pm – 1:45 pm	Town Hall Meeting – *Centennial Ballroom A-F, 3rd Floor*
2:00 pm – 2:30 pm	Candidate Forum for President-Elect Candidates – *Centennial Ballroom A-F, 3rd Floor*
2:45 pm – 4:30 pm	Candidate Forum for Board of Directors and Council Officer Candidates – Capitol Ballrooms 1-7*, 4th Floor*
4:45 pm – 6:00 pm	Council Reconvenes – *Centennial Ballroom A-F, 3rd Floor*
6:15 pm – 7:15 pm	Candidate Reception – *Capitol Ballroom 2-3, 4th Floor*

Saturday, October 26

7:00 am – 8:30 am	Keypad Distribution – *Centennial Ballroom Foyer, 3rd Floor*
7:00 am – 5:30 pm	Councillor Credentialing – *Centennial Ballroom Foyer, 3rd Floor*
7:30 am – 8:00 am	Council Continental Breakfast – *Centennial Ballroom Foyer, 3rd Floor*
8:00 am – 12:00 pm	Council Meeting – *Centennial Ballroom A-F, 3rd Floor*
12:00 pm – 1:30 pm	Council Awards Luncheon – *Capitol Ballroom 1-7, 4th Floor*
1:45 pm – 5:45 pm	Council Reconvenes – *Centennial Ballroom A-F, 3rd Floor*
5:10 pm – 5:40 pm	Elections – *Centennial Ballroom A-F, 3rd Floor*

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Council Meeting

October 25-26, 2019
Pre-Meeting Events Occur Thursday, Evening, October 24, 2019, Hyatt Regency at Colorado Convention Center
Centennial Ballroom, 3rd Floor
Denver, CO

TIMED AGENDA

Friday, October 25, 2019

Continental Breakfast – Centennial Ballroom, 3rd Floor		***7:30 am***
1. Call to Order A. Meeting Dedication B. Pledge of Allegiance C. National Anthem	Dr. McManus	8:00 am
2. Introductions	Dr. McManus	8:10 am
3. Welcome from CO Chapter President	Dr. Stader	8:12 am
4. Tellers, Credentials, & Election Committee A. Credentials Report B. Meeting Etiquette	Dr. Costello	8:14 am
5. Changes to the Agenda	Dr. McManus	8:16 am
6. Council Meeting Website	Mr. Joy	8:16 am
7. EMF Challenge	Dr. Wilcox	8:21 am
8. NEMPAC Challenge	Dr. Jacoby	8:23 am
9. Review and Acceptance of Minutes A. Council Meeting – September 29-30, 2018	Dr. McManus	8:25 am
10. Approval of Steering Committee Actions A. Steering Committee Meeting – January 29, 2019 B. Steering Committee Meeting – May 5, 2019	Dr. McManus	
11. Call for and Presentation of Emergency Resolutions	Dr. McManus	
12. Steering Committee's Report on Late Resolutions A. Reference Committee Assignments of Allowed Late Resolutions B. Disallowed Late Resolutions	Dr. McManus	
13. Nominating Committee Report A. Speaker 1. Slate of Candidates 2. Call for Floor Nominations B. Vice Speaker 1. Slate of Candidates 2. Call for Floor Nominations C. Board of Directors 1. Slate of Candidates 2. Call for Floor Nominations D. President-Elect 1. Slate of Candidates 2. Call for Floor Nominations	Dr. McManus	8:30 am

Friday, October 25, 2019 (*Continued*)

14. Candidate Opening Statements	Dr. McManus	
A Speaker Candidates (2 minutes each)		8:35 am
B. Vice Speaker Candidates (2 minutes each)		8:37 am
C. Board of Directors Candidates (2 minutes each)		8:43 am
D. President-Elect Candidates (5 minutes each)		9:00 am
15. Reference Committee Assignments	Dr. McManus	9:10 am
BREAK		***9:10 am – 9:30 am***
16. Reference Committee Hearings –		9:30 am – 12:30 pm
A – Governance & Membership – *Capitol Ballroom 4, 4th Floor*		
B – Advocacy & Public Policy – *Capitol Ballroom 5-7, 4th Floor*		
C – Emergency Medicine Practice – *Capitol Ballroom 1-3, 4thFloor*		
Lunch Available – List Location		***11:00 am – 12:30 pm***
17. Reference Committee Executive Sessions		12:30 pm – 2:30 pm
A – *Capitol Ballroom 4, 4th Floor*		
B – *Capitol Ballroom 5-7, 4th Floor*		
C – *Capitol Ballroom 1-3, 4th Floor*		
BREAK – Return to main Council meeting room – Centennial Ballroom, 3rd Floor.		***12:30 pm – 12:45 pm***
18. Town Hall Meeting – *Centennial Ballroom, 3rd Floor*	Dr. Katz	12:45 pm – 1:45 pm
A. Growth of the ACEP Council		
19. Candidate Forum for the President-Elect Candidates – *Centennial Ballroom 3rd Floor*		2:00 pm – 2:30 pm
BREAK – Return to Reference Committee meeting rooms – Capitol Ballrooms 1-7, 4th Floor		***2:30 pm – 2:45 pm***
20. Candidate Forum for Board and Council Officer Candidates – *Capitol Ballrooms 1-7, 4th Floor*		2:45 pm – 4:30 pm
Candidates rotate through Reference Committee meeting rooms.		
BREAK – Return to main Council meeting room – Centennial Ballroom, 3rd Floor		***4:30 pm – 4:45 pm***
21. Speaker's Report	Dr. McManus	4:45 pm
A. Leadership Development Advisory Committee		
B. Board Actions on 2018 Resolutions		
C. Introduction of Honored Guests		
D. Introduction of Council Steering Committee		
E. Introduction of Board of Directors		
22. In Memoriam	Dr. McManus	5:00 pm
A. Reading and Presentation of Memorial Resolutions	Dr. Katz	5:00 pm
Adopt by observing a moment of silence.		
23. ABEM Report	Dr. Baren	5:10 pm
24. AOBEM Report	Dr. Zabbo	5:15 pm
25. Secretary-Treasurer's Report	Dr. Rosenberg	5:20 pm
26. EMRA Report	Dr. Maniya	5:25 pm
27. EMF Report	Dr. Anderson	5:30 pm
28. NEMPAC Report	Dr. Jacoby	5:35 pm
29. President's Address	Dr. Friedman	5:40 pm

Candidate Reception ● 6:15 pm – 7:15 pm ● *Capitol Ballroom 2-3, 4th Floor*

Saturday, October 26, 2019

Keypad Distribution – Centennial Ballroom Foyer, 3rd Floor		***7:00 am***
Continental Breakfast – Centennial Ballroom, 3rd Floor		***7:30 am***
1. Call to Order	Dr. McManus	8:00 am
2. Tellers, Credentials, & Elections Committee Report	Dr. Costello	8:00 am
3. Electronic Voting A. Keypad Testing/Demographic Data Collection	Dr. Costello	8:05 am
4. Executive Directors Report	Mr. Wilkerson	8:30 am
5. Video – How to Submit Amendments Electronically		8:55 am
6. Reference Committee Reports A. Reference Committee _____ B. Reference Committee _____		9:00 am
7. Awards Luncheon – *Capitol Ballroom 1-7, 4th Floor*		*12:00 pm*
A. Welcome	Dr. McManus	12:45 pm
1. Recognition of Past Speakers and Past Presidents		
2. Recognition of Chapter Executives		
B. ACEP Awards Announcements	Dr. Friedman	12:55 pm
C. Reading and Presentation of Commendation Resolutions	Dr. McManus/Dr. Katz	
D. Council Award Presentations	Dr. McManus/Dr. Katz	
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 Award in Diversity & Inclusion		
5. Council Curmudgeon Award		
6. Council Meritorious Service Award		
8. Luncheon Adjourns – ***Return to main Council meeting room – Centennial Ballroom, 3rd Floor***		***1:30 pm***
9. Council Survey on Firearms	Dr. Richardson	1:45 pm
10. Reference Committee Reports Continue C. Reference Committee ___		2:15 pm
11. President-Elect's Address	Dr. Jaquis	4:45 pm
12. Installation of President	Dr. Friedman/Dr. Jaquis	5:05 pm
13. Elections A. Speaker B. Vice Speaker C. Board of Directors D. President-Elect	Dr. Costello	5:10 pm
14. Announcements	Dr. McManus	5:40 pm
15. Adjourn	Dr. McManus	5:45 pm

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Council Meeting Materials

Table of Contents

TAB

01 2019 Council Steering Committee Members

02 Procedures for Councillor and Alternate Seating

03 Councillor Seating Chart

04 Councillor Roster

05 Councillor Handbook

06 Council Standing Rules

07 Bylaws

08 College Manual

09 Minutes
- a. Council Meeting Minutes – September 29-30, 2018
- b. Steering Committee Meeting Minutes – January 29, 2019
- c. Steering Committee Meeting Minutes – May 5, 2019

10 Definition of Council Actions

11 Reference Committee Assignments

12 2019 Resolutions

13 Reports from the Board of Directors
- Compensation Committee Report
- Position and Votes on Amended Resolution 11(15)
- Resolution 16(18) No More Emergency Physician Suicides

14 Town Hall Meeting
- Growth of the ACEP Council

15 Board Action on 2018 Council Resolutions

16 Board Action on 2017 Council Resolutions

17 Board Action on 2016 Council Resolutions

18 President-Elect Candidates
- Jon Mark Hirshon, MD, PhD, MPH, FACEP
- Mark S. Rosenberg, DO, MBA, FACEP

19 Council Speaker Candidate
- Gary R. Katz, MD, MBA, FACEP

Council Vice Speaker Candidates
- Kelly Gray-Eurom, MD, MMM, FACEP
- Andrea L. Green, MD, FACEP
- Howard K. Mell, MD, MPH, CPE, FACEP

20 Board of Directors Candidates
- Michael J. Baker, MD FACEP
- Jeffrey M. Goodloe, MD, FACEP
- Rachelle A. Greenman, MD, FACEP
- Gabor D. Kelen, MD, FRCP(C), FACEP
- Pamela A. Ross, MD, FAAP, FACEP
- Gillian R. Schmitz, MD, FACEP
- Ryan A. Stanton, MD, FACEP
- Thomas J. Sugarman, MD, FACEP

21 2019 Award Recipients

22 2018-19 Annual Committee Reports

23 2019-20 Committee Structure and Objectives

24 Strategic Plan FY 2019-22

25 Emergency Medicine Foundation Report

26 National Emergency Medicine Political Action Committee Report

27 American Board of Emergency Medicine Report

28 Emergency Medicine Residents' Association Report

29 Secretary-Treasurer's Report

30 June 30, 2019 Financial Audit

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Council Steering Committee

Updated August 2019

John G. McManus, Jr., MD, MBA, FACEP - Speaker

Evans, GA

Gary R. Katz, MD, MBA, FACEP
Vice Speaker

Dublin, OH

Michael J. Baker, MD, FACEP

Ann Arbor, MI

Melissa W. Costello, MD, FACEP

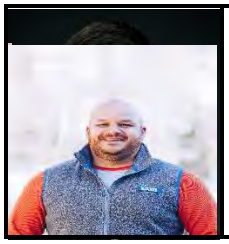
Mobile, AL

Justin W. Fairless, DO, FACEP

Colleyville, TX

Daniel Freess, MD, FACEP

West Hartford, CT



Muhammad N. Husainy, DO, FACEP

Florence, AL

Tiffany Jackson, MD

Fort Mill, SC

Gabor (Gabe) D. Kelen, MD, FACEP

Baltimore, MD

Chadd K. Kraus, DO, DrPH, MPH, FACEP

Lewisburg, PA

Gregg A. Miller, MD, FACEP

Edmonds, WA

Aimee K. Moulin, MD, FACEP

Sacramento, CA

Matthew Rudy, MD, FACEP

Evans, GA

Sullivan K. Smith, MD, FACEP

Cookeville, TN

Susanne J. Spano, MD, FACEP

Fresno, CA

Arvind Venkat, MD, FACEP

Wexford, PA

Nathan P. Vafaie, MD, MBA (EMRA REP to Steering Committee)

Dallas, TX

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Procedures for Councillor and Alternate Seating

Councillor Credentialing

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

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

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

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

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

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

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

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

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

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

Seating of Past Presidents, Past Council Speakers, and 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 Keypads

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

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

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

Seating Exchange Between Credentialed Councillors and Alternates

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

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

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

2019 Councillor Seating Chart

SECRETARY PARLIAMENTARIAN SPEAKER VICE SPEAKER

PROJECTION STAFF

433 Councillors + 37 past leaders = 470 seats

WI=6 WY=1 YPS=1 Wilderness=1	TX=10 UT=4 VT=1	WA=9 WV=4
PA=4 TN=5 Trauma=1	TX=15	VA=13 Undersea=1 Wellness=1
PA=15	OH=4 PR=2 SC=6 SD=1 Toxicology=1	NY=6 OR=5 RI=3 SAEM-1
NC=12 ND=1 Tactical=1	OH=15	Telehealth=1 NY=10 OK=4
NJ=11 Social EM=1 Sports Med=1	MI=10 NM=4	NY=15
MA=10 NE=2 NH=2	MI=13 Peds=1 QPS=1	MN=8 MO=7
Observation=1 Med Humanities=1 Med Director=1 HI=2 ID=2 GS-7	IN=8 IA=3 KS=3 Pain Mgmt=1	Rural=1 NV=3 MS=3 MD=7
FL=8 GS=7	IL=15	Palliative=1 ME=3 MT=1 KY=4 LA=6
FL=15	GA=10 Informatics=1 Locums=1 EMPCHP=1 EM Research=1 US=1	EMS=1 Event Med=1 Freestanding=1 Geriatric=1 Int'l=1 EM Workforce=1 CA=7
Disaster=1 D&I=1 Dual Training=1 DC=3 EMRA=8 Democratic=1	Cruise Ship=1 CT=8 Careers=1 Critical Care=1 DE=2	CA=15
AL=4 AK= 2 AZ=9	AACEM=1 AR=2 Air Med=1 AAWEP=1 CO=9 CORD=1	CA=15
	Board of Directors = 7	
	Board of Directors = 7	

A	B	C
Alternate Councillors	Reserved Staff	Reserved Chapter Staff
Open Seating	Open Seating	Open Seating

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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 2019 councillor seating chart includes the following:

Arizona	8 councillors + 1 past leader attending not serving as councillor = 9 seats
California	33 councillors + 4 past leaders attending not serving as councillors = 37 seats
Colorado	7 councillors + 2 past leader attending not serving as a councillor =9 seats
Connecticut	6 councillors + 2 past leader attending not serving as a councillors = 8 seats
Florida	21 councillors + 2 past leader attending not serving as a councillors = 23 seats
Georgia	9 councillors + 1 past leader attending not serving as a councillors = 10 seats
Government Services	13 councillors + 1 past leader attending not serving as councillor = 14 seats
Illinois	14 councillors + 1 past leader attending not serving as councillor = 15 seats
Indiana	7 councillors + 1 past leader attending not serving as councillor = 8 seats
Louisiana	5 councillors + 1 past leader attending not serving as councillor = 6 seats
Michigan	20 councillors + 3 past leaders attending not serving as councillors = 23 seats
New Jersey	10 councillors +1 past leader attending and not serving as councilor = 11 seats
New Mexico	2 councillors + 2 past leader attending and not serving as councillor = 4 seats
New York	29 councillors + 2 past leader attending not serving as a councillor = 31 seats
North Carolina	11 councillors + 1 past leaders attending not serving as councillors = 12 seats
Ohio	16 councillors + 3 past leaders attending not serving as councillors = 19 seats
Pennsylvania	18 councillors + 1 past leader attending not serving as a councillor = 19 seats
Texas	22 councillors + 3 past leader attending not serving as a councillor = 25 seats
Virginia	10 councillors + 3 past leader not serving as a councillor = 13 seats
Washington	8 councillors + 1 past leader attending not serving as a councillor = 9 seats
West Virginia	3 councillors + 1 past leader attending not serving as a councillor = 4 seats

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

Chapter/Section	Position	Name
ALABAMA CHAPTER	Councillor	Melissa Wysong Costello, MD, FACEP
	Councillor	Muhammad N Husainy, DO, FACEP
	Councillor	Bobby R Lewis, MD, FACEP
	Councillor	Annalise Sorrentino, MD, FACEP
ALASKA CHAPTER	Councillor	David James Scordino, MD
	Councillor	Anne Zink, MD, FACEP
	Alternate	Nathan Phillip Peimann, MD, FACEP
ARIZONA CHAPTER	Councillor	Patricia A Bayless, MD, FACEP
	Councillor	Bradley A Dreifuss, MD, FACEP
	Councillor	Olga Gokova, MD
	Councillor	Paul Andrew Kozak, MD, FACEP
	Councillor	J Scott Lowry, MD, FACEP
	Councillor	Wendy Ann Lucid, MD, FACEP
	Councillor	Willard R Van Nostrand, MD
	Councillor	Dale P Woolridge, MD, PhD, FACEP
	Alternate	Nicole R Hodgson, MD
ARKANSAS CHAPTER	Councillor	J Shane Hardin, MD, PhD, FACEP
	Councillor	Robert Thomas VanHook, MD, FACEP
	Alternate	Brian L Hohertz, MD, FACEP
ASSOC OF ACAD CHAIRS OF EM	Councillor	Gabor David Kelen, MD, FACEP
CALIFORNIA CHAPTER	Councillor	Harrison Alter, MD, FACEP
	Councillor	Zahir I Basrai, MD
	Councillor	Rodney W Borger, MD, FACEP
	Councillor	Andrea M Brault, MD, FACEP
	Councillor	Reb JH Close, MD, FACEP
	Councillor	John Dirk Coburn, MD, FACEP
	Councillor	Carrieann E Drenten, MD, FACEP
	Councillor	Irv E Edwards, MD, FACEP
	Councillor	Andrew N Fenton, MD, FACEP
	Councillor	Jorge A Fernandez, MD
	Councillor	William E Franklin, DO, FACEP
	Councillor	Marc Allan Futernick, MD, FACEP
	Councillor	Michael Gertz, MD, FACEP
	Councillor	Douglas Everett Gibson, MD, FACEP
	Councillor	Vikant Gulati, MD, FACEP
	Councillor	William K Mallon, MD, FACEP
	Councillor	Sujal S Mandavia, MD, FACEP
	Councillor	Aimee K Moulin, MD, FACEP
	Councillor	Leslie Mukau, MD, FACEP
	Councillor	Taylor S Nichols
	Councillor	Hunter M Pattison, MD
	Councillor	Chi Lee Perlroth, MD, FACEP
	Councillor	Vivian Reyes, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Peter Erik Sokolove, MD, FACEP
	Councillor	Susanne J Spano, MD, FACEP
	Councillor	Melanie T Stanzer, DO
	Councillor	Lawrence M Stock, MD, FACEP
	Councillor	Thomas Jerome Sugarman, MD, FACEP
	Councillor	David Terca, MD
	Councillor	Patrick Um, MD, FACEP
	Councillor	Andrea M Wagner, MD, FACEP
	Councillor	Lori D Winston, MD, FACEP
	Councillor	Anna L Yap, MD
	Alternate	Fred Dennis, MD, MBA, FACEP
	Alternate	Roneet Lev, MD, FACEP
	Alternate	Valerie C Norton, MD, FACEP
	Alternate	Bing S Pao, MD, FACEP
	Alternate	Gary William Tamkin, MD, FACEP
	Alternate	Anna L Webster, MD, FACEP
	Alternate	Bradley Alan Zlotnick, MD, FACEP
COLORADO CHAPTER	Councillor	Ramnik S Dhaliwal, MD, JD
	Councillor	Nathaniel T Hibbs, DO, FACEP
	Councillor	Douglas M Hill, DO, FACEP
	Councillor	Christopher David Johnston, MD, FACEP
	Councillor	Carla Elizabeth Murphy, DO, FACEP
	Councillor	Eric B Olsen, MD, FACEP
	Councillor	Donald E Stader, MD, FACEP
	Alternate	Matthew E Mendes, MD
	Alternate	James D Thompson, MD, FACEP
	Alternate	Allison Marie Trop, MD
	Alternate	Pramod Vangeti, MD, FACEP
	Alternate	Erik Janis Verzemnieks, MD
CONNECTICUT CHAPTER	Councillor	Thomas A Brunell, MD, FACEP
	Councillor	Daniel Freess, MD, FACEP
	Councillor	B Bryan Jordan, DO
	Councillor	Elizabeth Schiller, MD, FACEP
	Councillor	Gregory L Shangold, MD, FACEP
	Councillor	David E Wilcox, MD, FACEP
	Alternate	Michael L Carius, MD, FACEP
	Alternate	Peter J Jacoby, MD, FACEP
COUNCIL OF EMERGENCY MEDICINE RESIDENCY DIRECTORS (CORD)	Councillor	Maria E Moreira, MD, FACEP
DELAWARE CHAPTER	Councillor	Emily M Granitto, MD
	Councillor	John T Powell, MD, MHCDS, FACEP
	Alternate	Lauren Ashley Briskie, MD
	Alternate	Kathryn Groner, MD, FACEP
	Alternate	Michael Shaw Murphey, Jr, MD

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

DISTRICT OF COLUMBIA CHAPTER	Councillor	Jessica Galarraga, MD, MPH
	Councillor	Rita A Manfredi-Shutler, MD, FACEP
	Councillor	Natasha N Powell, MD, MPH, FACEP
	Alternate	Natalie L Kirilichin, MD
DIVERSITY & INCLUSION SECTION	Councillor	Ugo A Ezenkwele, MD, FACEP
	Alternate	Adetolu Olufunmilayo Oyewo, MD, FACEP
EMERGENCY MEDICINE LOCUM TENENS SECTION	Councillor	Angela F Mattke, MD, FACEP
EMERGENCY MEDICINE RESIDENTS' ASSOCIATION	Councillor	Erik Blutinger, MD
	Councillor	Hannah R Hughes, MD
	Councillor	Zachary Joseph Jarou, MD
	Councillor	Omar Z Maniya, MD, MBA
	Councillor	Scott H Pasichow, MD, MPH
	Councillor	Nicholas R Salerno, MD
	Councillor	Karina Sanchez, MD
	Councillor	Nathan P Vafaie, MD, MBA
	Alternate	Angela Cai, MD, MBA
	Alternate	Christopher T Clifford, MD
	Alternate	Brian Eby, MD
	Alternate	Samantha A Hay, MD
	Alternate	Breanne M Jaqua, DO
	Alternate	Tracy Marko, MD
	Alternate	Eric McDonald, MD
	Alternate	Eric McDonald, MD
	Alternate	Jeniffer Okungbowa-Ikponmwosa, MD, MPH
	Alternate	Onyeka Otugo
	Alternate	Venkat Subramanyam, MD
	Alternate	Gregory H Tanquary, DO
FLORIDA CHAPTER	Councillor	Andrew I Bern, MD, FACEP
	Councillor	Ashley Booth-Norse, MD, FACEP
	Councillor	Damian E Caraballo, MD, FACEP
	Councillor	Jordan GR Celeste, MD, FACEP
	Councillor	Andrzej T Dmowski, MD, FACEP
	Councillor	Kelly Gray-Eurom, MD, MMM, FACEP
	Councillor	Shayne M Gue, MD
	Councillor	Steven B Kailes, MD, FACEP
	Councillor	Mike Lozano, Jr., MD, MSHI, FACEP
	Councillor	Rene S Mack, MD, FACEP
	Councillor	Kristin McCabe-Kline, MD, FACEP
	Councillor	Ryan T McKenna, DO, FACEP
	Councillor	Ryan D Nesselroade, MD
	Councillor	David J Orban, MD, FACEP
	Councillor	Sanjay Pattani, MD, FACEP
	Councillor	Russell D Radtke, MD

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Danyelle Redden, MD, MPH, FACEP
	Councillor	Todd L Slesinger, MD, FACEP
	Councillor	Joseph Adrian Tyndall, MD, FACEP
	Councillor	L Kendall Webb, MD, FACEP
	Councillor	Aaron Anthony Wohl, MD, FACEP
	Alternate	Rajiv Bahl, MD, MBA, MS
	Alternate	Clifford Findeiss, MD
	Alternate	Gary W Gillette, MD, FACEP
	Alternate	D Eliot Goldner, MD, FACEP
	Alternate	Tracy G Sanson, MD, FACEP
	Alternate	David Charles Seaberg, MD, CPE, FACEP
	Alternate	John Caleist Soud, DO
	Alternate	Christian C Zuver, MD, FACEP
GEORGIA CHAPTER	Councillor	Brett H Cannon, MD, FACEP
	Councillor	James Joseph Dugal, MD, FACEP(E)
	Councillor	Matthew Taylor Keadey, MD, FACEP
	Councillor	Jeffrey F Linzer, Sr, MD, FACEP
	Councillor	Matthew Lyon, MD, FACEP
	Councillor	DW "Chip" Pettigrew, III, MD, FACEP
	Councillor	Stephen A Shiver, MD, FACEP
	Councillor	James L Smith, Jr, MD, FACEP
	Councillor	Matthew J Watson, MD, FACEP
	Alternate	Matthew R Astin, MD, FACEP
	Alternate	Shamie Das, MD
	Alternate	Mark A Griffiths, MD, FACEP
	Alternate	Earl A Grubbs, MD, FACEP
	Alternate	Benjamin Lefkove, MD, FACEP
	Alternate	Matthew Rudy, MD, FACEP
	Alternate	Richard B Schwartz, MD, FACEP
	Alternate	John L Wood, MD, FACEP
GOVT SERVICES CHAPTER	Councillor	Andrea Austin, MD, FACEP
	Councillor	James David Barry, MD, FACEP
	Councillor	Kyle E Couperus, MD
	Councillor	Tyler Davis, MD
	Councillor	Gerald Delk, MD, FACEP
	Councillor	Melissa L Givens, MD, FACEP
	Councillor	Lindsay Grubish, DO
	Councillor	Alan Jeffrey Hirshberg, MD, MPH, FACEP
	Councillor	Julio Rafael Lairet, DO, FACEP
	Councillor	David S McClellan, MD, FACEP
	Councillor	Torree M McGowan, MD, FACEP
	Councillor	Paul James Diggins Roszko, MD, FACEP
	Councillor	Laura Tilley, MD, FACEP
HAWAII CHAPTER	Councillor	Mark Baker, MD, FACEP
	Councillor	Daniel Cheng, MD

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

IDAHO CHAPTER	Councillor	Nathan R Andrew, MD, FACEP
	Councillor	Ken John Gramyk, MD, FACEP
	Alternate	Heather S Hammerstedt, MD, FACEP
	Alternate	Travis Aaron Newby, DO, FACEP
ILLINOIS CHAPTER	Councillor	Amit D Arwindekar, MD, FACEP
	Councillor	Christine Babcock, MD, FACEP
	Councillor	Cai Glushak, MD, FACEP
	Councillor	Scott A Heinrich, MD, FACEP
	Councillor	George Z Hevesy, MD, FACEP
	Councillor	Jason A Kegg, MD, FACEP
	Councillor	Napoleon B Knight, MD, FACEP
	Councillor	Janet Lin, MD, FACEP
	Councillor	Christopher M McDowell, MD, FACEP
	Councillor	Henry Pitzele, MD, FACEP
	Councillor	Yanina Purim-Shem-Tov, MD, FACEP
	Councillor	Willard W Sharp, MD, FACEP
	Councillor	Ernest Enjen Wang, MD, FACEP
	Councillor	Deborah E Weber, MD, FACEP
	Alternate	Shu Boung Chan, MD, FACEP
	Alternate	John W Hafner, MD, FACEP
	Alternate	Michael P Logan, MD
	Alternate	Kurtis A Mayz, JD, MD, MBA
	Alternate	Laura D Napier, MD, FACEP
	Alternate	Rebecca B Parker, MD, FACEP
INDIANA CHAPTER	Councillor	Michael D Bishop, MD, FACEP(E)
	Councillor	Bart S Brown, MD, FACEP
	Councillor	Sara Ann Brown, MD, FACEP
	Councillor	Timothy A Burrell, MD, MBA, FACEP
	Councillor	James L Shoemaker, Jr, MD, FACEP
	Councillor	Lauren Stanley, MD, FACEP
	Councillor	Lindsay M Weaver, MD, FACEP
	Alternate	John Agee, DO, FACOEP, FACEP
	Alternate	Christopher B Cannon, MD, FACEP
	Alternate	Daniel W Elliott, MD
	Alternate	Gina Teresa Huhnke, MD, FACEP
	Alternate	Christian Ross, MD, FACEP
	Alternate	Christopher S Weaver, MD, FACEP
IOWA CHAPTER	Councillor	Thomas E Benzoni, DO, FACEP
	Councillor	Sarah Hoper, MD, JD, FACEP
	Councillor	Rachael Sokol, DO, FACEP
	Alternate	Kathryn K Dierks, DO, FACEP
KANSAS CHAPTER	Councillor	Dennis Michael Allin, MD, FACEP
	Councillor	John F McMaster, MD, FACEP
	Councillor	Jeffrey G Norvell, MD, MBA, FACEP
	Alternate	Chad Michael Cannon, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	John M Gallagher, MD, FACEP
KENTUCKY CHAPTER	Councillor	David Wesley Brewer, MD, FACEP
	Councillor	Melissa Platt, MD, FACEP
	Councillor	Hugh W Shoff, MD, FACEP
	Councillor	Ryan Stanton, MD, FACEP
	Alternate	Christopher W Pergrem, MD, FACEP
	Alternate	Steven Joseph Stack, MD, MBA, FACEP
LOUISIANA CHAPTER	Councillor	James B Aiken, MD, FACEP
	Councillor	Phillip Luke LeBas, MD, FACEP
	Councillor	Mark Rice, MD, FACEP
	Councillor	Michael D Smith, MD MBA CPE, FACEP
	Councillor	Roland S Waguespack, III, MD, FACEP
	Alternate	Angela Pettit Cornelius, MD, FACEP
	Alternate	Jon Michael Cuba, FACEP
	Alternate	Julius (Jay) A Kaplan, MD, FACEP
	Alternate	Randy L Pilgrim, MD, FACEP
MAINE CHAPTER	Councillor	Thomas C Dancoes, DO, FACEP
	Councillor	Garreth C Debiegun, MD, FACEP
	Councillor	Charles F Pattavina, MD, FACEP
	Alternate	Nathan G Donaldson, DO, FACEP
	Alternate	James B Mullen, III, MD, FACEP
	Alternate	Marcus E Riccioni, MD, FACEP
MARYLAND CHAPTER	Councillor	Michael C Bond, MD, FAAEM, FACEP
	Councillor	Arjun S Chanmugam, MD, FACEP
	Councillor	Richard J Ferraro, MD, FACEP
	Councillor	Kyle Fischer, MD
	Councillor	Kathleen D Keeffe, MD, FACEP
	Councillor	Michelle Pyka, MD, FACEP
	Councillor	Theresa E Tassey, MD
	Alternate	Kerry Forrestal, MD, FACEP
	Alternate	David A Hexter, MD, FACEP
	Alternate	Michael P Murphy, MD, FACEP
MASSACHUSETTS CHAPTER	Councillor	Brien Alfred Barnewolt, MD, FACEP
	Councillor	Stephen K Epstein, MD, MPP, MPP, FACEP
	Councillor	Laura Janneck, MD, FACEP
	Councillor	Kathleen Kerrigan, MD, FACEP
	Councillor	Matthew B Mostofi, DO, FACEP
	Councillor	Mark D Pearlmutter, MD, FACEP
	Councillor	Jesse Rideout, MD, FACEP
	Councillor	Brian Sutton, MD, FACEP
	Councillor	Joseph C Tennyson, MD, FACEP
	Councillor	Scott G Weiner, MD, FACEP
	Alternate	Kathleen Cara Coan, MD
	Alternate	Farah Dadabhoy, MD

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	Joseph William Kopp, MD
	Alternate	Lucinda Lai, MD
	Alternate	Ira R Nemeth, MD, FACEP
	Alternate	Heikki E Nikkanen, MD, FACEP
	Alternate	Mark Notash, MD, FACEP
MICHIGAN CHAPTER	Councillor	Michael J Baker, MD, FACEP
	Councillor	Sara S Chakel, MD, FACEP
	Councillor	Nicholas Dyc, MD, FACEP
	Councillor	Gregory Gafni-Pappas, DO, FACEP
	Councillor	Rami R Khoury, MD, FACEP
	Councillor	Warren F Lanphear, MD, FACEP
	Councillor	Robert T Malinowski, MD, FACEP
	Councillor	Jacob Manteuffel, MD, FACEP
	Councillor	Emily M Mills, MD, FACEP
	Councillor	James C Mitchiner, MD, MPH, FACEP
	Councillor	Kevin Monfette, MD, FACEP
	Councillor	Diana Nordlund, DO, JD, FACEP
	Councillor	David T Overton, MD, FACEP
	Councillor	Paul R Pomeroy, Jr, MD, FACEP
	Councillor	Larisa May Traill, MD, FACEP
	Councillor	Bradley J Uren, MD, FACEP
	Councillor	Gregory Link Walker, MD, FACEP
	Councillor	Bradford L Walters, MD, FACEP
	Councillor	Mildred J Willy, MD, FACEP
	Councillor	James Michael Ziadeh, MD, FACEP
	Alternate	Nikeata Bell, DO
	Alternate	Carrie Hoogerhyde Clark, DO
	Alternate	Olga G Dewald, MD
	Alternate	Corey Fellows, DO
	Alternate	Therese G Mead, DO, FACEP
	Alternate	Luke Christopher Saski, MD, FACEP
	Alternate	Charles Sierzant, MD
	Alternate	Jacob Sinkoff, DO
	Alternate	Jennifer B Stevenson, DO, FACEP
	Alternate	Andrew Taylor, DO
MINNESOTA CHAPTER	Councillor	Heather Ann Heaton, MD, FACEP
	Councillor	William G Heegaard, MD, FACEP
	Councillor	Timothy James Johnson, MD, FACEP
	Councillor	David A Milbrandt, MD, FACEP
	Councillor	David Nestler, MD, MS, FACEP
	Councillor	Lane Patten, MD, FACEP
	Councillor	Thomas E Wyatt, MD, FACEP
	Councillor	Andrew R Zinkel, MD, MBA, FACEP
	Alternate	Kurt M Isenberger, MD, FACEP
	Alternate	Donald L Lum, MD, FACEP
MISSISSIPPI CHAPTER	Councillor	Jonathan S Jones, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Fred E Kency, Jr, MD
	Councillor	William E Walker, MD, FACEP
MISSOURI CHAPTER	Councillor	Sabina A Braithwaite, MD, FACEP
	Councillor	Douglas Mark Char, MD, FACEP
	Councillor	Jonathan Heidt, MD, MHA, FACEP
	Councillor	Louis D Jamtgaard, MD
	Councillor	Thomas B Pinson, MD, FACEP
	Councillor	Robert Francis Poirier, Jr., MD, MBA, FACEP
	Councillor	Evan Schwarz, MD, FACEP
	Alternate	Dennis E Hughes, DO, FACEP
	Alternate	Sebastian A Rueckert, MD, MBA, FACEP
MONTANA CHAPTER	Councillor	Nathan Allen, MD, FACEP
	Alternate	Harry Eugene Sibold, MD, FACEP
NEBRASKA CHAPTER	Councillor	Renee Engler, MD, FACEP
	Councillor	Benjamin L Fago, MD, FACEP
NEVADA CHAPTER	Councillor	John Dietrich Anderson, MD, FACEP
	Councillor	Graham Stephen Ingalsbe, MD
	Councillor	Gregory Alan Juhl, MD, FACEP
	Alternate	Jason W David, MD
NEW HAMPSHIRE CHAPTER	Councillor	Reed Brozen, MD, FACEP
	Councillor	Sarah Garlan Johansen, MD, FACEP
NEW JERSEY CHAPTER	Councillor	Victor M Almeida, DO, FACEP
	Councillor	Thomas A Brabson, DO, FACEP
	Councillor	William Basil Felegi, FACEP, FACEP
	Councillor	Rachelle Ann Greenman, MD, FACEP
	Councillor	Steven M Hochman, MD, FACEP
	Councillor	Marjory E Langer, MD, FACEP
	Councillor	Jessica M Maye, DO
	Councillor	Amy Ondeyka, MD, FACEP
	Councillor	Nilesh Patel, DO, FACOEP, FAAEM, FACEP
	Councillor	Michael Ruzek, DO
	Alternate	Jenice Baker, MD, FACEP
	Alternate	Joseph J Calabro, DO, FACEP
	Alternate	David C Castillo, DO, FACEP
	Alternate	Gregory Scott Corcoran, MD
	Alternate	William Colwell Dalsey, MD, FACEP
	Alternate	Robert M Eisenstein, MD, FACEP
	Alternate	Barnet Eskin, MD, FACEP
	Alternate	Patrick Blaine Hinfey, FACEP
	Alternate	Marianna Karounos, DO, MS, FACEP
	Alternate	J Mark Meredith, MD, FACEP
	Alternate	Tiffany Murano, MD, FACEP
NEW MEXICO CHAPTER	Councillor	Eric Michael Ketcham, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Tatsuya Norii, MD, FACEP
NEW YORK CHAPTER	Councillor	Brahim Ardolic, MD, FACEP
	Councillor	Joseph Basile, MD, FACEP
	Councillor	Nicole Berwald, MD, FACEP
	Councillor	Robert M Bramante, MD, FACEP
	Councillor	Mark Curato, DO, FACEP
	Councillor	Jeremy T Cushman, MD, FACEP
	Councillor	Mathew Foley, MD, FACEP
	Councillor	Sanjey Gupta, MD, FACEP
	Councillor	Abbas Husain, MD, FACEP
	Councillor	Marc P Kanter, MD, FACEP
	Councillor	Stuart Gary Kessler, MD, FACEP
	Councillor	Penelope Chun Lema, MD, FACEP
	Councillor	Angelo Mascia, DO
	Councillor	Robert McCormack, MD, FACEP
	Councillor	Laura D Melville, MD
	Councillor	Joshua B Moskovitz, MD, MBA, MPH, FACEP
	Councillor	Nestor B Nestor, MD, FACEP
	Councillor	William F Paolo, MD, FACEP
	Councillor	Louise A Prince, MD, FACEP
	Councillor	Jennifer Pugh, MD, FACEP
	Councillor	Jeffrey S Rabrich, DO, FACEP
	Councillor	Christopher C Raio, MD, FACEP
	Councillor	James Gerard Ryan, MD, FACEP
	Councillor	Livia M Santiago-Rosado, MD, FACEP
	Councillor	Virgil W Smaltz, MD, MPA, FACEP
	Councillor	Jessica M Thomas, MD
	Councillor	Asa "Peter" Viccellio, MD, FACEP
	Councillor	Luis Carlos Zapata, MD, FACEP
	Councillor	Joseph A Zito, MD, FACEP
	Alternate	Neel Andharia, DO
	Alternate	Jerel Chacko, MD
	Alternate	Bernard P. Chang, MD, PhD
	Alternate	Mary E McLean, MD
	Alternate	Shivani M Mody, DO
	Alternate	David L Ng, MD, FACEP
	Alternate	Jeffrey J Thompson, MD, FACEP
NORTH CAROLINA CHAPTER	Councillor	Scott W Brown, MD, FACEP
	Councillor	Gregory J Cannon, MD, FACEP
	Councillor	Jennifer Casaletto, MD, FACEP
	Councillor	Charles W Henrichs, III, MD, FACEP
	Councillor	Thomas Lee Mason, MD, FACEP
	Councillor	Eric E Maur, MD, FACEP
	Councillor	Abhishek Mehrotra, MD, MBA, FACEP
	Councillor	Bret Nicks, MD, MHA, FACEP
	Councillor	Sankalp Puri, MD, FACEP
	Councillor	Stephen A Small, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	David Matthew Sullivan, MD, FACEP
NORTH DAKOTA CHAPTER	Councillor	K J Temple, MD, FACEP
OHIO CHAPTER	Councillor	Eileen F Baker, MD, PhD, FACEP
	Councillor	Dan Charles Breece, DO, FACEP
	Councillor	Christina Campana, DO, FACEP
	Councillor	Purva Grover, MD, FACEP
	Councillor	Erika Charlotte Kube, MD, FACEP
	Councillor	Thomas W Lukens, MD, PhD, FACEP
	Councillor	Catherine Anna Marco, MD, FACEP
	Councillor	Daniel R Martin, MD, FACEP
	Councillor	Michael McCrea, MD, FACEP
	Councillor	John R Queen, MD, FACEP
	Councillor	Bradley D Raetzke, MD, FACEP
	Councillor	Zachary Dennis Rasmussen, MD
	Councillor	Matthew J Sanders, DO, FACEP
	Councillor	Ryan Squier, MD, FACEP
	Councillor	Travis Ulmer, MD, FACEP
	Councillor	Nicole Ann Veitinger, DO, FACEP
	Alternate	Andrew Aten, MD
	Alternate	Teresa Bigley, DO
	Alternate	John Casey, DO, MA, FACEP
	Alternate	Tyler Hill, DO
	Alternate	John L Lyman, MD, FACEP
	Alternate	Richard N Nelson, MD, FACEP
	Alternate	Yojan Patel, MD
	Alternate	Dacia Russell Goman
	Alternate	Imran Shaikh, MD
	Alternate	Ryan Stegenga, MD
OKLAHOMA CHAPTER	Councillor	Jeffrey Michael Goodloe, MD, FACEP
	Councillor	Cecilia Guthrie, MD, FACEP
	Councillor	Jeffrey Johnson, MD, FACEP
	Councillor	James Raymond Kennedye, MD, MPH, FACEP
OREGON CHAPTER	Councillor	Meaghan Francis Dehning, MD
	Councillor	Joshua Lupton, MD
	Councillor	Michael F McCaskill, MD, FACEP
	Councillor	John C Moorhead, MD, FACEP
	Councillor	Michelle R Shaw, MD, FACEP
PENNSYLVANIA CHAPTER	Councillor	Smeet R Bhimani, DO
	Councillor	Ankur A Doshi, MD, FACEP
	Councillor	Marcus Eubanks, MD, FACEP
	Councillor	Ronald V Hall, MD, FACEP
	Councillor	Richard Hamilton, MD, FACEP
	Councillor	F Richard Heath, MD, FACEP
	Councillor	Annahieta Kalantari, DO, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Gary Khammahavong, MD
	Councillor	Chadd K Kraus, DO, DrPH, MPH, FACEP
	Councillor	Priyanka Lauber, DO
	Councillor	Michael J Lynch, MD
	Councillor	Dhimitri Nikolla, DO
	Councillor	Vishnu M Patel, MD
	Councillor	Shawn M Quinn, DO, FACEP
	Councillor	Jennifer L Savino, DO, FACEP
	Councillor	Robert J Strony, DO, FACEP
	Councillor	Michael A Turturro, MD, FACEP
	Councillor	Arvind Venkat, MD, FACEP
	Alternate	Michelle Appel, MD
	Alternate	Kevin Thomas Argentieri
	Alternate	William Gene Bell, MD
	Alternate	Dean Dobkin, MD, FACEP
	Alternate	Eleanor Dunham, MD, FACEP
	Alternate	Todd Fijewski, MD, FACEP
	Alternate	Kevin Connolly King, MD, FACEP
	Alternate	Gerald F O'Malley, DO, FACEP
	Alternate	Meaghan L Reid, MD
	Alternate	Thomas Douglas Sallade, DO
	Alternate	Daniel Tannenholtz, DO
PUERTO RICO CHAPTER	Councillor	Miguel F. Agrait Gonzalez, MD
	Councillor	Fernando L Soto Torres, MD, FACEP
	Alternate	Jesus M Perez, MD
RHODE ISLAND CHAPTER	Councillor	Nadine T Himelfarb, MD, FACEP
	Councillor	Achyut B Kamat, MD, FACEP
	Councillor	Jessica Smith, MD, FACEP
SOCIETY OF ACADEMIC EMERGENCY MEDICINE	Councillor	Kathleen J Clem, MD, FACEP
SOUTH CAROLINA CHAPTER	Councillor	Matthew D Bitner, MD, FACEP
	Councillor	Stephen A D Grant, MD, FACEP
	Councillor	Allison Leigh Harvey, MD, FACEP
	Councillor	Tiffany Jackson, MD
	Councillor	Kelly Johnson, MD
	Councillor	Christina Millhouse, MD, FACEP
	Alternate	Stewart Oliver Sanford, MD
SOUTH DAKOTA CHAPTER	Councillor	Donald Neilson, MD
TENNESSEE CHAPTER	Councillor	Sanford H Herman, MD, FACEP
	Councillor	Sudave D Mendiratta, MD, FACEP
	Councillor	Thomas R Mitchell, MD, FACEP
	Councillor	John H Proctor, MD, MBA, FACEP
	Councillor	Sullivan K Smith, MD, FACEP
	Alternate	Anneliese Cuttle, MD

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	Kenneth L Holbert, MD, FACEP
	Alternate	Nicole Streiff McCoin, MD
	Alternate	Matthew Neal, MD
TEXAS CHAPTER	Councillor	Sara Andrabi, MD
	Councillor	Carrie de Moor, MD, FACEP
	Councillor	Justin W Fairless, DO, FACEP
	Councillor	Diana L Fite, MD, FACEP
	Councillor	Juan Francisco Fitz, MD, FACEP
	Councillor	Andrea L Green, MD, FACEP
	Councillor	Robert D Greenberg, MD, FACEP
	Councillor	Robert Hancock, Jr, DO, FACEP
	Councillor	Doug Jeffrey, MD, FACEP
	Councillor	Heidi C Knowles, MD, FACEP
	Councillor	Laura N Medford-Davis, MD
	Councillor	Sterling Evan Overstreet, MD, FACEP
	Councillor	Heather S Owen, MD, FACEP
	Councillor	Daniel Eugene Peckenpaugh, MD, FACEP
	Councillor	R Lynn Rea, MD, FACP
	Councillor	Angela Siler Fisher, FACEP
	Councillor	Nicholas P Steinour, MD, FACEP
	Councillor	Theresa Tran, MD
	Councillor	Gerad A Troutman, MD, FACEP
	Councillor	Hemant H Vankawala, MD, FACEP
	Councillor	James M Williams, DO, FACEP
	Councillor	Sandra Williams, DO, MPH, FACEP
	Alternate	Steven B Baker, MD
	Alternate	Rebecca A Briggs, MD
	Alternate	Darrell Y Calderon, MD
	Alternate	Nora Demchur, MD
	Alternate	Katherine A Dowdell, MD
	Alternate	Whitney Faulconer, 5945973, DO
	Alternate	Angela F Gardner, MD, FACEP
	Alternate	Mohamed Hagahmed, MD
	Alternate	Laura E Haselden, MD
	Alternate	Renee C Johnson, MD
	Alternate	Alexander J Kirk, MD, FACEP
	Alternate	Edward Kuo, MD
	Alternate	Jason A Lesnick, MD
	Alternate	Anisha Malhotra, MD
	Alternate	Craig Meek, MD, FACEP
	Alternate	Anant Patel, DO, FACEP
	Alternate	Jonathan Rogg, MD
	Alternate	Michael Richard Rozum, MD
	Alternate	Chance L Sims, DO
	Alternate	Marcus Lynn Sims, II, DO, FACEP
	Alternate	Angela L Straface, MD, FACEP
	Alternate	Katie White, MD

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	Chaethana Yalamanchili, MD
UTAH CHAPTER	Councillor	Jim V Antinori, MD, FACEP
	Councillor	Stephen Carl Hartsell, MD, FACEP
	Councillor	Kathleen Marie Lawliss, MD, FACEP
	Councillor	David Brent Mabey, MD
	Alternate	Alison L Smith, MD, MPH
VERMONT CHAPTER	Councillor	Alexandra Nicole Thran, MD, FACEP
VIRGINIA CHAPTER	Councillor	Kenneth Hickey, MD, FACEP
	Councillor	David Matthew Kruse, MD, FACEP
	Councillor	Bruce M Lo, MD, MBA, RDMS, FACEP
	Councillor	Joseph Mason, MD
	Councillor	Cameron K Olderog, MD, FACEP
	Councillor	Todd Parker, MD, FACEP
	Councillor	Joran Sequeira, MD
	Councillor	Mark Robert Sochor, MD, FACEP
	Councillor	Jesse Duane Spangler, MD
	Councillor	Sara F Sutherland, MD, MBA, FACEP
	Alternate	Pamela Andrea Ross, MD, FACEP
WASHINGTON CHAPTER	Councillor	Cameron Ross Buck, MD, FACEP
	Councillor	Herbert Duber, MD, MPH, FACEP
	Councillor	C Ryan Keay, MD, FACEP
	Councillor	Gregg A Miller, MD, FACEP
	Councillor	Karolyn K Moody, DO, MPH, FACEP
	Councillor	Jennifer L'Hommedieu Stankus, MD, FACEP
	Councillor	Susan Amy Stern, MD
	Councillor	Liam Yore, MD, FACEP
	Alternate	Callan Fockele, MD
WEST VIRGINIA CHAPTER	Councillor	Adam Thomas Crawford, DO
	Councillor	Christopher S Goode, MD, FACEP
	Councillor	Thomas Marshall, MD, FACEP
	Alternate	Frederick C Blum, MD, FACEP
	Alternate	Erica B Shaver, MD, FACEP
WISCONSIN CHAPTER	Councillor	Bradley Burmeister, MD
	Councillor	William D Falco, MD, MS, FACEP
	Councillor	Jeffrey J Pothof, MD, FACEP
	Councillor	Robert Sands Redwood, MD, MPH, FACEP
	Councillor	Michael Dean Repplinger, MD, PhD, FACEP
	Councillor	Brian Sharp, MD, FACEP
	Alternate	Lisa J Maurer, MD, FACEP
	Alternate	Jamie Schneider, MD
WYOMING CHAPTER	Councillor	Jessica Kisicki, MD, FACEP
	Alternate	Carol Lea Wright Becker, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

AIR MEDICAL TRANSPORT SECTION	Councillor	Henderson D McGinnis, MD, FACEP
AMERICAN ASSOCIATION OF WOMEN EMERGENCY PHYSICIANS SECTION	Councillor	E Lea Walters, MD, FACEP
	Alternate	Elizebeth Dubey, MD, FACEP
CAREERS IN EMERGENCY MEDICINE SECTION	Councillor	John J Rogers, MD, FACEP
	Alternate	Constance J Doyle, MD, FACEP
CRITICAL CARE MEDICINE SECTION	Councillor	Nicholas M Mohr, MD, FACEP
	Alternate	Ayan Sen, MD, FACEP
CRUISE SHIP MEDICINE SECTION	Councillor	Sydney W Schneidman, MD, FACEP
	Alternate	Ruben Dario Parejo, MD
DEMOCRATIC GROUP PRACTICE SECTION	Councillor	David F Tulsiak, MD, FACEP
	Alternate	Craig Savoy Brummer, MD, FACEP
DISASTER MEDICINE SECTION	Councillor	David Wayne Callaway, MD, FACEP
DUAL TRAINING SECTION	Councillor	De Benjamin Winter, III, MD
	Alternate	Vinay Mikkilineni, MD
EMERGENCY MEDICAL INFORMATICS SECTION	Councillor	John D Manning, MD
	Alternate	Jeffrey A Nielson, MD, FACEP
EMERGENCY MEDICAL SERVICES-PREHOSPITAL CARE SECTION	Councillor	Maia Dorsett, MD
	Alternate	Michael O'Brien, MD
EMERGENCY MEDICINE PRACTICE MANAGEMENT AND HEALTH POLICY SECTION	Councillor	Richard Lee Austin, Jr, MD
EMERGENCY MEDICINE RESEARCH SECTION	Councillor	James Ross Miner, MD, FACEP
	Alternate	Richard Gentry Wilkerson, MD, FACEP
EMERGENCY MEDICINE WORKFORCE SECTION	Councillor	Donald L Lum, MD, FACEP
EMERGENCY ULTRASOUND SECTION	Councillor	Chris Bryczkowski, MD, FACEP
	Alternate	Lisa M Bundy, MD, FACEP
EVENT MEDICINE SECTION	Councillor	Claire E Melin, MD
	Alternate	Melissa D Kohn, MD, FACEP
	Alternate	Paul E Pepe, MD, FAEMS, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

FREESTANDING EMEGENCY CENTERS	Councillor	Edward A Shaheen, MD, FACEP
	Alternate	Lonnie R Schwirtlich, MD, FACEP
GERIATRIC EMERGENCY MEDICINE SECTION	Councillor	Maura Kennedy, MD
	Alternate	Shan W Liu, MD, FACEP
INTERNATIONAL EMERGENCY MEDICINE SECTION	Councillor	Camilo E Gutierrez, MD, FACEP
	Alternate	Jeffrey A Nielson, MD, FACEP
MEDICAL DIRECTORS SECTION	Councillor	Johnny L Sy, DO, FACEP
	Alternate	C Ryan Keay, MD, FACEP
MEDICAL HUMANITIES SECTION	Councillor	Zayir Malik
	Alternate	Robert C Solomon, MD, FACEP
OBSERVATION SERVICES SECTION	Councillor	Kristy Ziontz, DO, FACEP
	Alternate	Alexei Wagner, MD
PAIN MANAGEMENT SECTION	Councillor	Alexis M LaPietra, DO, FACEP
	Alternate	Adelaide Viguri, DO
PALLIATIVE MEDICINE SECTION	Councillor	Eric D Isaacs, MD, FACEP
PEDIATRIC EMERGENCY MEDICINE SECTION	Councillor	Eric R Schmitt, MD, MPH, FACEP
QUALITY IMPROVEMENT AND PATIENT SAFETY SECTION	Councillor	Susan Marie Nedza, MD, MBA, FACEP
	Alternate	Venkatesh R. Bellamkonda, MD
	Alternate	Shashank Ravi, MD MBA
	Alternate	Robert Sands Redwood, MD, MPH, FACEP
	Alternate	Brian Sharp, MD, FACEP
RURAL EMERGENCY MEDICINE SECTION	Councillor	Darrell L Carter, MD, FACEP
SOCIAL EMERGENCY MEDICINE SECTION	Councillor	Aislinn D Black, DO, FACEP
	Alternate	Breena R Taira, MD, MPH, FACEP
SPORTS MEDICINE SECTION	Councillor	WILLIAM DENQ
	Alternate	Calvin E Hwang, MD, FACEP
TACTICAL EMERGENCY MEDICINE SECTION	Councillor	Howard K Mell, MD, MPH, CPE, FACEP
	Alternate	Amado Alejandro Baez, MD, FACEP
	Alternate	Ameen Mohammad Jamali, FACEP
TELEHEALTH SECTION	Councillor	Alexander Chiu, MD, FACEP
	Alternate	David C Ernst, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	Emily M Hayden
	Alternate	Edward A Shaheen, MD, FACEP
TOXICOLOGY SECTION	Councillor	Jennifer Hannum, MD, FACEP
	Alternate	Eric J Lavonas, MD, FACEP
TRAUMA & INJURY PREVENTION SECTION	Councillor	Gregory Luke Larkin, MD, FACEP
	Alternate	Mark Robert Sochor, MD, FACEP
UNDERSEA & HYPERBARIC MEDICINE SECTION	Councillor	Robert W Sanders, MD, FACEP
	Alternate	Stephen Hendriksen, MD, FACEP
WELLNESS SECTION	Councillor	Susan T Haney, MD, FACEP
	Alternate	Angelica N McPartlin, MD
	Alternate	Kristen Nordenholz, MD, FACEP
	Alternate	Matthew L Wong, MD, FACEP
WILDERNESS MEDICINE SECTION	Councillor	Brendan Harry Milliner, MD
YOUNG PHYSICIANS SECTION	Councillor	John R Corker, MD
	Alternate	Jessica Ann Best, MD
	Alternate	Benjamin Karfunkle, MD

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Councillor Handbook

Councillor Handbook

Table of Contents

I. COMPOSITION OF THE COUNCIL 3
Introduction 3
What is the Council? 3
What Does the Council Do? 3

II. COUNCILLOR PREPARATION 3
How Does a Councillor Prepare for the Annual Meeting? 3
How Does the Council Conduct its Business? 4
What is a Resolution? 4
Amendments to Resolutions 5
Emergency Resolutions 5
Late Resolutions 5
What if I Have Questions About the Council? 5
What is the Steering Committee? 6
Council Steering Committee 6

III. COUNCIL REFERENCE COMMITTEE PROCEEDINGS AND REPORTS 6
Procedures 6
Proceedings 7
Reports 7

IV. GUIDELINES AND DEFINITIONS OF COUNCIL ACTIONS TO ASSIST THE COUNCIL IN CONSIDERING REPORTS OF REFERENCE COMMITTEES. 9
Adopt 9
Adopt as Amended 9
Refer 9
Not adopt 9

V. PRINCIPLE RULES GOVERNING MOTIONS 10

VI. INCIDENTAL MOTIONS 11

VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS 12
Submission and Deadline 12
Questions 12
Format 12
Whereas Statements 12
Bylaws Amendments 13
General Resolutions 13
Council Actions on Resolutions 13
Board Actions on Resolutions 13
Sample Resolutions 14

VIII. PARLIAMENTARY MOTIONS GUIDE ..... .16

I. COMPOSITION OF THE COUNCIL

Introduction

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

What is the Council?

The Council is a body composed of emergency physicians who directly represent the 53 chartered chapters of the American College of Emergency Physicians, the Emergency Medicine Residents' Association (EMRA), the Association of Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors (CORD), the Society for Academic Emergency Medicine (SAEM), the American College of Osteopathic Emergency Physicians (ACOEP), 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, CORD, SAEM, and ACOEP, are each allocated one voting councillor; and each section of membership is allocated one voting councillor.

What Does the Council Do?

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

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

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

II. COUNCILLOR PREPARATION

How Does a Councillor Prepare for the Annual Meeting?

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

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

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

be open to receiving additional information at the meeting and then make the best decision on behalf of the College.

How Does the Council Conduct its Business?

Business attire is appropriate for the Council meeting.

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

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

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

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

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

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

What is a Resolution?

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

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

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

Amendments to Resolutions

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

Late Resolutions

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

Emergency Resolutions

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

What if I Have Questions About the Council?

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

How are Nominations and Elections Conducted?

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

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

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

Each year a Candidate Forum is held. This year the Candidate Forum 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.

2019 Council Steering Committee

John G. McManus, Jr., MD, FACEP, Chair
Gary R. Katz, MD, MBA, FACEP, Vice Chair
Michael J. Baker, MD, FACEP (MI)
Melissa W. Costello, MD, FACEP (AL)
Justin W. Fairless, DO, FACEP (TX)
Daniel Freess, MD, FACEP (CT)
Muhammad N. Husainy, DO, FACEP (AL)
Tiffany Jackson, MD (SC)
Gabor D. Kelen, MD, FACEP (AACEM)
Chadd K. Kraus, DO, DrPH, MPH, FACEP (PA)
Heather A. Marshall, MD, FACEP (NM)
Gregg A. Miller, MD, FACEP (WA)
Aimee K. Moulin, MD, FACEP (CA)
Matthew Rudy, MD, FACEP (GA)
Sullivan K. Smith, MD, FACEP (TN)
Susanne J. Spano, MD, FACEP (Wilderness)
Arvind Venkat, MD, FACEP (PA)

III. COUNCIL REFERENCE COMMITTEE PROCEEDINGS AND REPORTS

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

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

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

Procedures

Reference Committee hearings are open to all members of the College, its committees, and invited guests of the Reference Committee. Members of the College, its committees, and/or invited guests are privileged to present written testimony or to speak to the committee on the resolution under consideration. Upon recognition by the chair, non-members may be permitted to speak. The chair is privileged to call upon anyone

attending the hearing if, in his/her opinion, the individual called upon may have information that would be helpful to the committee.

The Reference Committee hearings are scheduled from 9:30 am until 12:30 pm on Friday, October 25. Reference Committees may take brief breaks if the chair determines that time is available. The Reference Committee chair is requested to designate a member of the committee to keep track of all pro and con comments pertaining to each resolution.

Proceedings

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

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

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

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

Reports

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

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

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

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

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

Examples of our common variants employing the procedure are:

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

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

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

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

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

Summary of Council Actions on Reference Committee Reports

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

Definition of Council Action

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

ADOPT
Approve resolution as recommendation implemented through the Board of Directors

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

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

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

V. PRINCIPLE RULES GOVERNING MOTIONS

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

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

VI. INCIDENTAL MOTIONS

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

* Per the Council Standing Rules.

VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS

Definition

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

Submission and Deadline

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

All resolutions should be submitted to:

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

E-mail: smontgomery@acep.org

Phone: 800-798-1822 x3202

Fax: 972-580-2816

Bylaws and regular resolutions are due 90 days before the annual Council meeting. The 2019 Council meeting will be held on Friday, October 25 and Saturday, October 26, in Denver. Therefore, the deadline for resolutions for the 2019 Council meeting is July 27, 2019.

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

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

Questions

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

Format

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

Whereas Statements

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

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

Resolved Statements

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

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

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

Bylaws Amendments

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

General Resolutions

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

Council Actions on Resolutions

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

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

Board Actions on Resolutions

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

shall address all other matters referred to the Board within such time and manner as the Council may determine.

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

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

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

Sample Resolutions

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

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

RESOLUTION 9(06)

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

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

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

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

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

ARTICLE XI – COMMITTEES
Section 2 – Executive Committee

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

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

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

RESOLUTION 23(06)

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

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

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

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

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

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

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

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

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

RESOLUTION 16(99)

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

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

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

WHEREAS, The fault for boating fatalities 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

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

[1] As modified by the ACEP Council Standing Rules

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

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

Council Standing Rules

Revised October 2018

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Standing Rules

Revised October 2018

Preamble

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

Alternate Councillors

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

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

Amendments to Council Standing Rules

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

Announcements

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

Appeals of Decisions from the Chair

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

Board of Directors Seating

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

Campaign Rules

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

Conflict of Interest Disclosure

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

Councillor Allocation for Sections of Membership

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

Councillor Seating

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

Credentialing and Proper Identification

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

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

Debate

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

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

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

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

Distribution of Printed or Other Material During the Annual Meeting

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

Election Procedures

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

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

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

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

**NOTE: If at any time, the total number of invalid individual ballots added to any candidate's total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be*

elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.

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

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

Electronic Devices

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

Leadership Development Advisory Committee

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

Limiting Debate

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

Nominating Committee

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

Nominations

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

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

Parliamentary Procedure

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

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

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

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

Policy Review

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

Reference Committees

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

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

A Reference Committee may recommend that a resolution:

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

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

Reports

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

Resolutions

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

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

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

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

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

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

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

- ***Bylaws Resolutions***

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

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

- ***Late Resolutions***

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

- ***Emergency Resolutions***

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

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

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

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

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

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

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, or defeat for each resolution listed. A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the

Reference Committee report. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Voting Immediately

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

Voting on Resolutions and Motions

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

BYLAWS

Revised October 2018

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Bylaws

Table of Contents

ARTICLE I — NAME 1

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES 1
- Section 1 — Mission 1
- Section 2 — Purposes and Objectives 1

ARTICLE III — COLLEGE MEETINGS 1

ARTICLE IV — MEMBERSHIP 1
- Section 1 — Eligibility 1
- Section 2 — Classes of Membership 2
- Section 2.1 — Regular Members 2
- Section 2.2 — Honorary Members 2
- Section 2.3 — Candidate Members 2
- Section 2.4 — International Members 3
- Section 3 — Agreement 3
- Section 4 — Voting & Holding Office 3
- Section 5 — Disciplinary Action 3
- Section 6 — Dues, Fees, and Assessments 3
- Section 7 — Official Publications 4

ARTICLE V — ACEP FELLOWS 4
- Section 1 — Eligibility 4
- Section 2 — Fellow Status 4

ARTICLE VI — CHAPTERS 4
- Section 1 — Charters 4
- Section 2 — Chapter Bylaws 5
- Section 3 — Qualifications 5
- Section 4 — Component Branches 5
- Section 5 — Charter Suspension - Revocation 5
- Section 6 — Ultimate Authority by College 5

ARTICLE VII — SECTIONS 6

ARTICLE VIII — COUNCIL 6
- Section 1 — Composition of the Council 6
- Section 2 — Powers of the Council 7
- Section 3 — Meetings 7
- Section 4 — Quorum 7
- Section 5 — Voting Rights 8
- Section 6 — Resolutions 8
- Section 7 — Nominating Committee 8
- Section 8 — Board of Directors Actions on Resolutions 8

ARTICLE IX — BOARD OF DIRECTORS 9
Section 1 — Authority 9
Section 2 — Composition and Election 9
Section 3 — Meetings 9
Section 4 — Removal 9
Section 5 — Vacancy 10

ARTICLE X —OFFICERS/EXECUTIVE DIRECTOR 10
Section 1 — Officers 10
Section 2 — Election of Officers 10
Section 3 — Removal 10
Section 4 — Vacancy 10
Section 4.1 — President 10
Section 4.2 — President-Elect 11
Section 4.3 — Chair, Vice President & Secretary-Treasurer 11
Section 4.4 — Council Officers 11
Section 4.5 — Vacancy by Removal of a Board Officer 11
Section 4.6 — Vacancy by Removal of a Council Officer 11
Section 5 — President 11
Section 6 — Chair 11
Section 7 — Vice President 12
Section 8 — President-Elect 12
Section 9 — Secretary-Treasurer 12
Section 10 — Immediate Past President 12
Section 11 — Speaker 12
Section 12 — Vice Speaker 13
Section 13 — Executive Director 13
Section 14 — Assistant Secretary-Treasurer 13

ARTICLE XI — COMMITTEES 13
Section 1 — General Committees 13
Section 2 — Executive Committee 13
Section 3 — Steering Committee 14
Section 4 — Bylaws Interpretation Committee 14
Section 5 — Finance Committee 14
Section 6 — Bylaws Committee 14
Section 7 — Compensation Committee 15

ARTICLE XII — ETHICS 15

ARTICLE XIII — AMENDMENTS 15
Section 1 — Submission 15
Section 2 — Notice 15
Section 3 — Amendment Under Initial Consideration 15
Section 4 — Contested Amendment 15

ARTICLE XIV — MISCELLANEOUS 16
Section 1 — Inspection of Records 16
Section 2 — Annual Report 16
Section 3 — Parliamentary Authority 16
Section 4 — College Manual 16

ARTICLE XV – MANDATORY INDEMNIFICATION 16
Section 1 — Policy of Indemnification and Advancement of Expenses 16
Section 2 — Definitions 17
Section 3 — Non-Exclusive; Continuation 17
Section 4 — Insurance or Other Arrangement 17
Section 5 — Exclusion of Certain Acts from Indemnification 17

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

BYLAWS

Revised October 2018

ARTICLE I — NAME

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

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES

Section 1 — Mission

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

Section 2 — Purposes and Objectives

The purposes and objectives of the College are:

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

ARTICLE III — COLLEGE MEETINGS

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

ARTICLE IV — MEMBERSHIP

Section 1 — Eligibility

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

Section 2 — Classes of Membership

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

Section 2.1 — Regular Members

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

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

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

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

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

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

Section 2.2 — Honorary Members

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

Section 2.3 — Candidate Members

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

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

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

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

Section 2.4 — International Members

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

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

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

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

Section 3 — Agreement

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

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

Section 4 — Disciplinary Action

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

Section 5 — Dues, Fees, and Assessments

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

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

nonpayment of dues and assessments.

Section 6 — Official Publications

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

ARTICLE V — ACEP FELLOWS

Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

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

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

Section 2 — Fellow Status

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

ARTICLE VI — CHAPTERS

Section 1 — Charters

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

Section 2 — Chapter Bylaws

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

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

Section 3 — Qualifications

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

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

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

Section 4 — Component Branches

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

Section 5 — Charter Suspension – Revocation

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

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

Section 6 — Ultimate Authority by College

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

ARTICLE VII — SECTIONS

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

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

ARTICLE VIII — COUNCIL

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

Section 1 — Composition of the Council

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

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

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

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

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

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

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

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

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

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

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

Section 2 — Powers of the Council

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

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

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

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

Section 3 — Meetings

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

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

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

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

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

Section 4 — Quorum

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

Section 5 — Voting Rights

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

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

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

Section 6 — Resolutions

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

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

Section 7 — Nominating Committee

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

Section 8 — Board of Directors Action on Resolutions

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

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

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

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

ARTICLE IX — BOARD OF DIRECTORS

Section 1 — Authority

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

Section 2 — Composition and Election

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

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

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

Section 3 — Meetings

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

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

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

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

Section 4 — Removal

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

Section 5 — Vacancy

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

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

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

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

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

Section 2 — Election of Officers

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

Section 3 — Removal

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

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

Section 4 — Vacancy

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

Section 4.1 — President

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

Section 4.2 — President-Elect

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

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

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

Section 4.4 — Council Officers

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

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

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

Section 4.5 — Vacancy by Removal of a Board Officer

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

Section 4.6 — Vacancy by Removal of a Council Officer

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

Section 5 — President

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

Section 6 — Chair

The chair shall be a member of and shall chair the Board of Directors. Any director shall be eligible for election to the position of chair and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The chair's term of office shall begin at the conclusion of the meeting at which the election as

chair occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. No director may serve more than one term as chair.

Section 7 — Vice President

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

Section 8 — President-Elect

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

Section 9 — Secretary-Treasurer

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

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

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

Section 10 — Immediate Past President

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

Section 11 — Speaker

The term of office of the speaker of the Council shall be two years. The speaker shall attend meetings of the Board of Directors and may address any matter under discussion. The speaker shall preside at all meetings of the Council, except that the vice speaker may preside at the discretion of the speaker. The speaker shall prepare, or cause

to be prepared, the agendas for the Council. The speaker may appoint committees of the Council and shall inform the councillors of the activities of the College. The speaker's term of office shall begin immediately following the conclusion of the annual meeting at which the election occurred and shall conclude at such time as a successor takes office. The speaker shall not have the right to vote in the Council except in the event of a tie vote of the councillors. During the term of office, the speaker is ineligible to accept nomination to the Board of Directors of the College. No speaker may serve consecutive terms.

Section 12 — Vice Speaker

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

Section 13 — Executive Director

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

Section 14 — Assistant Secretary-Treasurer

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

ARTICLE XI — COMMITTEES

Section 1 — General Committees

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

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

Section 2 — Executive Committee

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

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

Section 3 — Steering Committee

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

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

Section 4 — Bylaws Interpretation Committee

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

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

Section 5 — Finance Committee

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

Section 6 — Bylaws Committee

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

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.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

COLLEGE MANUAL

Revised October 2014

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

College Manual

Table of Contents

I. Applications for Membership 1

II. Procedures for Addressing Charges of Ethical Violations and Other Misconduct 1
- A. Complaint Received 1
- B. Executive Director 1
- C. Bylaws Committee 2
- D. Ethics Committee 3
- E. Board of Directors 3
- F. Ad Hoc Committee 4
- G. Right of Respondent to Request a Hearing 4
- H. Hearing Procedures 4
- I. Disciplinary Action: Censure, Suspension, or Expulsion 5
- J. Disclosure 6
- K. Ground Rules 6

III. Chartering Chapters 7

IV. Charter Suspension-Revocation 8

V. Filling Board Vacancies Created by Other Than Removal 8

VI. Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council 9

VII. Amendments 9

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

College Manual

Revised October 2014

I. Applications for Membership

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

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

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

A. Complaint Received

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

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

B. Executive Director

1. Sends a written acknowledgement to the complainant confirming the complainant's intent to file a complaint and identifying the elements that must be addressed in an ethics complaint.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct ("Procedures")."
3. Notifies the ACEP President and the chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
4. a. Determines, in consultation with the ACEP President and the chair of the Ethics and/or Bylaws Committee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the *Code of Ethics for Emergency Physicians* or of ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or

b. Determines, in consultation with the Ethics Committee chair, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics for Emergency Physicians*, and if so, forwards the complaint and the response together, as soon as both are received, to each member of the Ethics Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose, or
c. Determines, in consultation with the Bylaws Committee chair, that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, as soon as both are received, to each member of the Bylaws Committee, or at the discretion of the chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or
d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, the complaint will not be considered. The Board of Directors will review the President's action at the next regularly scheduled Board meeting. The President's action can be overturned by a majority vote of the Board, or
e. Determines that the alleged violation is not the subject of a pending ACEP Standard of Care Review. If the alleged violation is the subject of a pending Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.

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

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

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Current ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of current ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Proceeds to develop its recommendation based solely on the written record.
6. Develops a report regarding the complaint and recommendation for action; minority reports may also be presented.

7. The Bylaws Committee will deliver its report and minority reports, if any to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors:
   a. Dismiss the complaint; or
   b. Take disciplinary action, the specifics of which shall be included in the committee's report.
8. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a subcommittee of five or more members of the Bylaws Committee. The Bylaws Committee chair shall appoint this subcommittee and designate one of its members to chair the-subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.

D. Ethics Committee [within sixty (60) days of the forwarding of the complaint/response specified in Section B.4.b. above]

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

E. Board of Directors

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

6. If the respondent chooses the option described in Section E.4.b., that is, a Board decision based solely on the written record, the Board will implement its decision to impose disciplinary action based on the written record.

F. Ad Hoc Committee

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

G. Right of Respondent to Request a Hearing

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

H. Hearing Procedures

1. If the respondent requests a hearing , the complainant and respondent will be notified in writing by certified U.S. mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board, its subcommittee pursuant to Section H.6. below, or an Ad Hoc Committee pursuant to Section F., intends to call in the hearing.
2. The Executive Director will send a notification of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing by certified U.S. mail.

3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel or any other person of their choice. Each party will bear the expense of his or her own counsel.
5. The parties have the right to have a record made of the proceedings by transcript, audiotape, or videotape at the expense of the requesting party.
6. The hearing may be conducted by the entire Board, by a subcommittee of three to five members of the Board of Directors, at the discretion of and as appointed by the chair of the Board of Directors or, if required pursuant to Section F., by an Ad Hoc Committee described in Section F. If the hearing is conducted by a subcommittee or by an Ad Hoc Committee that includes one or more Board members as described in Section F., the presiding officer of the hearing will be a Board member designated by the chair of the Board. The chair of the Board of Directors will act as the presiding officer throughout the hearing conducted by the full Board unless the chair is unable to serve or is disqualified from serving, in which case the ACEP President will designate a member of the Board of Directors to chair the hearing. If all Board members have recused themselves, the Ad Hoc Committee members shall choose an individual from among themselves to chair the hearing. If a subcommittee of the Board or an Ad Hoc Committee conducts the hearing, such hearing must take place with all of the parties and all the members of the subcommittee or ad hoc committee present in person. If the full Board conducts the hearing, all of the parties, and a quorum of the Board, must be present in person. Hearings may not take place by telephone conference call.
7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.
8. The Board, its appointed subcommittee, or an Ad Hoc Committee will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the filing of any written briefs, conclude the hearing.
9. In the event that the hearing is conducted by a subcommittee of the Board or an Ad Hoc Committee, such subcommittee or Ad Hoc Committee will, within one hundred twenty (120) days after the hearing concludes, submit the written record of the hearing, along with the subcommittee's recommendation or the Ad Hoc Committee's decision, to the Board of Directors. If the hearing is conducted by a subcommittee of the Board, within thirty (30) days after receiving a subcommittee report and recommendation, or, if the full Board conducts the hearing, within thirty (30) days after the hearing concludes, the Board shall render a decision. The affirmative vote of two-thirds of the Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws, shall be required to take disciplinary action against the respondent. If the Board does not achieve a two-thirds vote of entitled Directors with a quorum present, the respondent shall be exonerated. Directors shall be entitled to vote if they have not recused themselves or been recused, and, in the case of a hearing conducted by the full Board, if they have attended the entire hearing. If the hearing is conducted by an Ad Hoc Committee pursuant to Section F., the decision of such Ad Hoc Committee will be final and will be implemented by the Board.
10. The decision of the Board or Ad Hoc Committee will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the Board's or Ad Hoc Committee's decision will be sent by certified U.S. mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board's or Ad Hoc Committee's decision and a statement of the basis for that decision.

I. Disciplinary Action: Censure, Suspension, or Expulsion

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

b. Public Censure: a public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards set forth in Section A.2. above.

2. Suspension from ACEP membership shall be for a period of twelve months; the dates of commencement and completion of the suspension shall be determined by the Board of Directors. At the end of the twelve-month period of suspension, the suspended member shall be offered reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues).
3. Expulsion from ACEP membership shall be for a period of five years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors.

J. Disclosure

1. Nature of Disciplinary Action
   a. Private censure: the content of a private letter of censure shall not be disclosed, but the fact that such a letter has been issued shall be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed.
   b. Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.
   c. Suspension: the dates of suspension, including whether or not the member was reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which may result in a report of such action to the National Practitioner Data Bank.
   d. Expulsion: the date of expulsion, along with a statement of the basis for the expulsion, shall be disclosed. If the five-year period has elapsed, the disclosure shall indicate whether the former member petitioned for reinstatement and, if so, the Board's decision on such petition. ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.
2. Scope and Manner of Disclosure
   a. Disclosure to ACEP members: Any ACEP member may transmit to the Executive Director a request for information regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section J.1.
   b. Public Disclosure: The Board of Directors shall publicize in an appropriate ACEP publication the names of members receiving public censure, suspension, or expulsion. This published announcement shall also state which ACEP bylaw or policy was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. If any person makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication.

K. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the Board of Directors or an Ad Hoc Committee pursuant to Section F., at which time the decision will be available upon request by ACEP members, to the extent specified in Section J. Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics Committee, the Bylaws Committee, the Board of Directors, their appointed subcommittees, as appropriate, or an Ad Hoc Committee, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the committee's, Board's,

subcommittee's, or Ad Hoc Committee's overall time to complete its task. However, such requests and the responses thereto shall not extend the time to deliver a recommendation or a decision to the Board beyond ninety (90) days from the date the complaint is forwarded to the appropriate committee, subcommittee, or Ad Hoc Committee.

4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
5. If a participant in this process (such as a member of the Ethics Committee, the Bylaws Committee, or Board of Directors) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic competition with the respondent, that person shall recuse himself or herself from the process except as a complaining party or respondent. Any committee member who recuses himself or herself shall report this recusal promptly to the committee chair, and any Board member who recuses himself or herself shall report this recusal promptly to the chair of the Board.
6. Once the Board has made a decision or implemented a decision of an Ad Hoc Committee pursuant to Section F. on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
7. The Board's decision or the decision of an Ad Hoc Committee pursuant to Section F. to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.
8. If a respondent fails to respond to a complaint, to notice of the right to request a hearing, or to a request for information, the Board or an Ad Hoc Committee pursuant to Section F. may make a decision on the complaint solely on the basis of the information it has received.
9. If a complaint alleges a violation that is the subject of a pending ACEP Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.
10. If a respondent seeks to voluntarily resign his/her ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

III. Chartering Chapters

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

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

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

IV. Charter Suspension-Revocation

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

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

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

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

V. Filling Board Vacancies Created by Other Than Removal

General Provisions

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

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

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

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

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

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

Election by the Council (when applicable in accordance with the Bylaws):

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

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

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

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

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

VII. Amendments

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Meeting
October 29-30, 2018
Manchester Grand Hyatt Hotel
San Diego, CA

Minutes

The 47th annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:00 am, Saturday, September 29, 2018, by Speaker John G. McManus, Jr., MD, MBA, FACEP.

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

Dr. McManus provided a meeting dedication and announced the Navy Medical Center San Diego to present colors. Dr. McManus then led the Council in reciting the Pledge of Allegiance and singing the National Anthem.

Peter Fahrney, MD, FACEP, Council Speaker 1974-75, addressed the Council.

Dr. McManus introduced ACEP's Parliamentarian Jim Slaughter, JD, CPP, and ACEP's Executive Director Dean Wilkerson, JD, MBA, CAE. He then welcomed new councillors, new alternate councillors, first time attendees, and guests.

Chi Perlroth, MD, FACEP, president of the California Chapter, welcomed councillors and other meeting attendees.

Chad Kessler, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 380 councillors of the 421 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 Web site and other technology enhancements.

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

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

The following members were credentialed by the Tellers, Credentials, & Elections Committee for seating at the 2018 Council meeting:

ALABAMA CHAPTER	Melissa Wysong Costello, MD, FACEP Muhammad N Husainy, DO, FACEP Annalise Sorrentino, MD, FACEP
ALASKA CHAPTER	Nathan P. Peimann, MD, FACEP
ARIZONA CHAPTER	Patricia A Bayless, MD, FACEP Bradley A Dreifuss, MD, FACEP Paul A. Kozak, MD, FACEP J. Scott Lowry, MD, FACEP Wendy A Lucid, MD, FACEP Michael E Sheehy, DO, FACEP

	Casey R Solem, MD, FACEP Nicholas F Vasquez, MD, FACEP
ARKANSAS CHAPTER	J Shane Hardin, MD, PhD Brian L. Hohertz, MD, FACEP
AACEM	Gabor David Kelen, MD, FACEP
CALIFORNIA CHAPTER	Rodney W Borger, MD, FACEP Andrea M. Brault, MD, FACEP Adam P. Dougherty, MD Carrieann E Drenten, MD, FACEP Irv E Edwards, MD, FACEP Jorge A Fernandez, MD, Marc Allan Futernick, MD, FACEP Michael Gertz, MD, FACEP Douglas Everett Gibson, MD, FACEP Vikant Gulati, MD, FACEP Samantha Jeppsen, MD Kevin M Jones, DO, FACEP John Thomas Ludlow, MD, FACEP William K Mallon, MD, FACEP Aimee K Moulin, MD, FACEP Leslie Mukau, MD, FACEP Karen Murrell, MD, MBA, FACEP Valerie C Norton, MD, FACEP Luke J. Palmisano, MD, MBA, FACEP Bing S. Pao, MD, FACEP Mitesh Patel, MD Chi Lee Perlroth, MD, FACEP Vivian Reyes, MD, FACEP Peter Erik Sokolove, MD, FACEP Melanie T. Stanzer, DO Lawrence M Stock, MD, FACEP Thomas Jerome Sugarman, MD, FACEP Patrick Um, MD, FACEP Andrea M Wagner, MD, FACEP Lori D Winston, MD, FACEP
COLORADO CHAPTER	Nathaniel T Hibbs, DO, FACEP Douglas M Hill, DO, FACEP Christopher David Johnston, MD Kevin W McGarvey, MD Carla Elizabeth Murphy, DO, FACEP Eric B Olsen, MD, FACEP Donald E Stader, MD, FACEP Erik J Verzemnieks, MD
CONNECTICUT CHAPTER	Thomas A Brunell, MD, FACEP Spencer J Cross, MD, Daniel Freess, MD, FACEP Elizabeth Schiller, MD, FACEP Gregory L Shangold, MD, FACEP David E Wilcox, MD, FACEP
CORD	Saadia Akhtar, MD, FACEP

DELAWARE CHAPTER	Kathryn Groner, MD, FACEP John T Powell, MD, MHCDS, FACEP
DISTRICT OF COLUMBIA CHAPTER	Jessica Galarraga, MD, MPH Danya Khoujah, MBBS, FACEP Rita A Manfredi-Shutler, MD, FACEP Natasha N Powell, MD, MPH, FACEP
EMRA	Nida F Degesys, MD Zachary Joseph Jarou, MD Alicia Mikolaycik Kurtz, MD Omar Z Maniya, MD, MBA Eric McDonald, MD Shehni Nadeem, MD Scott H Pasichow, MD, MPH Rachel Solnick, MD
FLORIDA CHAPTER	Andrew I Bern, MD, FACEP Damian E. Carabello, MD, FACEP Jordan GR Celeste, MD, FACEP Amy Ruben Conley, MD, FACEP Jay L Falk, MD, FACEP Kelly Gray-Eurom, MD, MMM, FACEP Larry Allen Hobbs, MD, FACEP Steven B Kailes, MD, FACEP Michael Lozano, MD, FACEP Rene S. Mack, MD, FACEP Kristin McCabe-Kline, MD, FACEP Ryan T McKenna, DO, FACEP Ashley Booth Norse, MD, FACEP Ernest Page, II, MD, FACEP Sanjay Pattani, MD, FACEP Russell D Radtke, MD Danyelle Redden, MD, MPH, FACEP Todd L Slesinger, MD, FACEP Joseph Adrian Tyndall, MD, FACEP L Kendall Webb, MD, FACEP
GEORGIA CHAPTER	Matthew R Astin, MD, FACEP James Joseph Dugal, MD, FACEP(E) Matthew Taylor Keadey, MD, FACEP Jeffrey F Linzer, Sr, MD, FACEP Matthew Lyon, MD, FACEP D. W. Chip Pettigrew, III, MD, FACEP Stephen A Shiver, MD, FACEP James L Smith, Jr, MD, FACEP Matthew J Watson, MD, FACEP
GOVT SERVICES CHAPTER	James David Barry, MD, FACEP Adam O Burgess, MD Marco Coppola, DO, FACEP Kyle E Couperus, MD Alan Thomas Flanigan, MD Roderick Fontenette, MD, FACEP Melissa L Givens, MD, FACEP Antonia Helbling, MD Alan Jeffrey Hirshberg, MD, MPH, FACEP Chad Kessler, MD, MHPE, FACEP

	Julio Rafael Lairet, DO, FACEP Linda L Lawrence, MD, FACEP David S McClellan, MD, FACEP Torree M McGowan, MD, FACEP Nadia M Pearson, DO, FACEP
HAWAII CHAPTER	Carolyn Annerud, MD, FACEP Mark Baker, MD, FACEP
IDAHO CHAPTER	Nathan R Andrew, MD, FACEP Ken John Gramyk, MD, FACEP
ILLINOIS CHAPTER	Amit D Arwindekar, MD, FACEP Christine Babcock, MD, FACEP Cai Glushak, MD, FACEP John W Hafner, MD, FACEP George Z Hevesy, MD, FACEP Jason A Kegg, MD, FACEP Janet Lin, MD, FACEP Valerie Jean Phillips, MD, FACEP Henry Pitzele, MD, FACEP Yanina Purim-Shem-Tov, MD, FACEP William P Sullivan, DO, FACEP Ernest Enjen Wang, MD, FACEP Deborah E Weber, MD, FACEP
INDIANA CHAPTER	Michael D Bishop, MD, FACEP(E) Timothy A Burrell, MD, MBA, FACEP John T Finnell, II, MD, FACEP Gina Teresa Huhnke, MD, FACEP Christian Ross, MD, FACEP James L Shoemaker, Jr, MD, FACEP Lindsay M. Weaver, MD, FACEP
IOWA CHAPTER	Chris Buresh, MD, FACEP Ryan M Dowden, MD, FACEP Hans Roberts House, MD, FACEP
KANSAS CHAPTER	Dennis Michael Allin, MD, FACEP John F McMaster, MD, FACEP Jeffrey G Norvell, MD MBA, FACEP
KENTUCKY CHAPTER	David Wesley Brewer, MD, FACEP Melissa Platt, MD, FACEP Hugh W. Shoff, MD, FACEP Ryan Stanton, MD, FACEP
LOUISIANA CHAPTER	James B Aiken, MD, MHA, FACEP Jon Michael Cuba, MD, FACEP Phillip Luke LeBas, MD, FACEP Mark Rice, MD, FACEP Michael D Smith, MD, MBA, CPE, FACEP
MAINE CHAPTER	Thomas C Dancoes, DO, FACEP Garreth C Debiegun, MD, FACEP Charles F Pattavina, MD, FACEP

MARYLAND CHAPTER	Arjun S Chanmugam, MD, FACEP Richard J Ferraro, MD, FACEP Kyle Fischer, MD Kerry Forrestal, MD, FACEP David A Hexter, MD, FACEP Kathleen D Keeffe, MD, FACEP Michael Adam Silverman, MD, FACEP Theresa E Tassey, MD
MASSACHUSETTS CHAPTER	Brien Alfred Barnewolt, MD, FACEP Kate Burke, MD, FACEP Stephen K Epstein, MD, MPP, FACEP Kathleen Kerrigan, MD, FACEP Melisa W Lai-Becker, MD, FACEP Matthew B Mostofi, DO, FACEP Mark D Pearlmutter, MD, FACEP Brian Sutton, MD Joseph C Tennyson, MD, FACEP Scott G Weiner, MD, FACEP
MICHIGAN CHAPTER	Michael J Baker, MD, FACEP Nicholas Dyc, MD, FACEP Gregory Gafni-Pappas, DO, FACEP Rami R Khoury, MD, FACEP Warren F Lanphear, MD, FACEP Robert T Malinowski, MD, FACEP Jacob Manteuffel, MD, FACEP Emily M Mills, MD, FACEP James C Mitchiner, MD, MPH, FACEP Kevin Monfette, MD, FACEP Diana Nordlund, DO, JD, FACEP, FACEP David T Overton, MD, FACEP Paul R Pomeroy, Jr, MD, FACEP Luke Christopher Saski, MD, FACEP Larisa May Traill, MD, FACEP Bradley J Uren, MD, FACEP Gregory Link Walker, MD, FACEP Bradford L Walters, MD, FACEP Mildred J Willy, MD, FACEP James Michael Ziadeh, MD, FACEP
MINNESOTA CHAPTER	William G Heegaard, MD, FACEP David A Milbrandt, MD, FACEP David Nestler, MD, MS, FACEP Lane Patten, MD, FACEP Gary C Starr, MD, FACEP Thomas E Wyatt, MD, FACEP Andrew R Zinkel, MD, FACEP
MISSISSIPPI CHAPTER	Jonathan S Jones, MD, FACEP Sherry D Turner, DO
MISSOURI CHAPTER	Sabina A Braithwaite, MD, FACEP Douglas Mark Char, MD, FACEP Jonathan Heidt, MD, MHA, FACEP Louis D Jamtgaard, MD Robert F Poirier, Jr., MD, MBA, FACEP Evan Schwarz, MD, FACEP

MONTANA CHAPTER	Harry Eugene Sibold, MD, FACEP
NEBRASKA CHAPTER	Renee Engler, MD, FACEP Benjamin L Fago, MD, FACEP
NEVADA CHAPTER	John Dietrich Anderson, MD, FACEP Jason R Grabert, MD, FACEP Gregory Alan Juhl, MD, FACEP
NEW HAMPSHIRE CHAPTER	Reed Brozen, MD, FACEP Sarah Garlan Johansen, MD, FACEP
NEW JERSEY CHAPTER	Jenice Baker, MD, FACEP Thomas A Brabson, DO, FACEP Robert M Eisenstein, MD, FACEP William Basil Felegi, DO, FACEP Rachelle Ann Greenman, MD, FACEP Steven M Hochman, MD, FACEP Marjory E Langer, MD, FACEP Nilesh Patel, DO Michael Ruzek, DO
NEW MEXICO CHAPTER	Heather Anne Marshall, MD, FACEP Tony B Salazar, MD, FACEP
NEW YORK CHAPTER	Theodore Albright, MD Brahim Ardolic, MD, FACEP Nicole Berwald, MD, FACEP Robert Bramante, MD, FACEP Jeremy T Cushman, MD, FACEP Michael W Dailey, MD, FACEP Jason Zemmel D'Amore, MD, FACEP Mathew Foley, MD, FACEP Abbas Husain, MD, FACEP Marc P Kanter, MD, FACEP Stuart Gary Kessler, MD, FACEP Penelope Chun Lema, MD, FACEP Mary E McLean, MD Laura D Melville, MD Joshua B Moskovitz, MD, MBA, MPH, FACEP Nestor B Nestor, MD, FACEP William F Paolo, MD, FACEP Mikhail Podlog, DO Louise A Prince, MD, FACEP Jennifer Pugh, MD, FACEP Jeffrey S Rabrich, DO, FACEP Christopher C Raio, MD, FACEP Gary S Rudolph, MD, FACEP Livia M Santiago-Rosado, MD, FACEP Virgil W Smaltz, MD, MPA, FACEP Asa "Peter" Viccellio, MD, FACEP Luis Carols Zapata, MD, FACEP Joseph A Zito, MD, FACEP
NORTH CAROLINA CHAPTER	Gregory J Cannon, MD, FACEP Jennifer Casaletto, MD, FACEP Charles W Henrichs, III, MD, FACEP Jeffrey Allen Klein, MD, FACEP

	Thomas Lee Mason, MD, FACEP Eric E Maur, MD, FACEP Abhishek Mehrotra, MD, MBA, FACEP Bret Nicks, MD, MHA, FACEP Sankalp Puri, MD, FACEP David Matthew Sullivan, MD, FACEP Michael J Utecht, MD, FACEP
NORTH DAKOTA CHAPTER	Kevin Scott Mickelson, MD, FACEP
OHIO CHAPTER	Eileen F Baker, MD, FACEP Dan Charles Breece, DO, FACEP John Casey, DO, MA, FACEP Purva Grover, MD, FACEP Erika Charlotte Kube, MD, FACEP Thomas W Lukens, MD, PhD, FACEP John L Lyman, MD, FACEP Catherine Anna Marco, MD, FACEP Daniel R Martin, MD, FACEP Michael McCrea, MD, FACEP Onyeka Otugo, MD John R Queen, MD, FACEP Ryan Squier, MD, FACEP Travis Ulmer, MD, FACEP Nicole Ann Veitinger, DO, FACEP
OKLAHOMA CHAPTER	Cecilia Guthrie, MD, FACEP Jeffrey Michael Goodloe, MD, FACEP James Raymond Kennedye, MD, MPH, FACEP W Craig Sanford, Jr., MD, FACEP
OREGON CHAPTER	Samuel H Kim, MD Joshua Lupton, MD John C Moorhead, MD, FACEP Carl Seger, MD, FACEP Michelle, R Shaw, MD, FACEP
PENNSYLVANIA CHAPTER	Smeet R Bhimani, DO Erik Blutinger, MD, MSc Merle Andrea Carter, MD, FACEP Ankur A Doshi, MD, FACEP Maria Koenig Guyette, MD, FACEP Ronald V Hall, MD Richard Hamilton, MD, FACEP Marilyn Joan Heine, MD, FACEP Scott Jason Korvek, MD, FACEP Chadd K Kraus, DO, DrPH, MPH, FACEP Jennifer R Marin, MD, MSc Dhimitri Nikolla, DO Shawn M Quinn, DO, FACEP Meaghan L Reid, MD Anna Schwartz, MD, FACEP Michael A Turturro, MD, FACEP Arvind Venkat, MD, FACEP
PUERTO RICO CHAPTER	Miguel F Agrait Gonzalez, MD Jesus M Perez, MD

RHODE ISLAND CHAPTER	L. Anthony Cirillo, MD, FACEP Achyut B Kamat, MD, FACEP Jessica Smith, MD, FACEP
SAEM	Kathleen J Clem, MD, FACEP
SOUTH CAROLINA CHAPTER	Matthew D Bitner, MD, FACEP Thomas H Coleman, MD, FACEP Stephen AD Grant MD, FACEP Allison Leigh Harvey, MD, FACEP Christina Millhouse, MD, FACEP
SOUTH DAKOTA CHAPTER	Scott Gregory VanKeulen, MD, FACEP
TENNESSEE CHAPTER	Sanford H Herman, MD, FACEP Kenneth L Holbert, MD, FACEP Thomas R Mitchell, MD, FACEP Matthew Neal, MD Sullivan K. Smith, MD, FACEP
TEXAS CHAPTER	Sara Andrabi, MD Carrie de Moor, MD, FACEP Justin W Fairless, DO, FACEP Angela Siler Fisher, MD, FACEP Diana L Fite, MD, FACEP Juan Francisco Fitz, MD, FACEP Andrea L Green, MD, FACEP Robert D Greenberg, MD, FACEP Robert Hancock, Jr, DO, FACEP Justin P Hensley, MD, FACEP Doug Jeffrey, MD, FACEP Heidi C Knowles, MD, FACEP Laura N Medford-Davis, MD Heather S Owen, MD, FACEP Daniel Eugene Peckenpaugh, MD, FACEP R Lynn Rea, MD, FACEP Richard Dean Robinson, MD, FACEP Nicholas P Steinour, MD, FACEP Gerad A Troutman, MD, FACEP Hemant H Vankawala, MD, FACEP James M Williams, DO, FACEP Sandra Williams, DO, FACEP
UTAH CHAPTER	Jim V Antinori, MD, FACEP Bennion D Buchanan, MD, FACEP Kathleen marie Lawliss, MD, FACEP David Brent Mabey, MD
VERMONT CHAPTER	Alexandra Nicole Thran, MD, FACEP
VIRGINIA CHAPTER	Catherine Agustiady-Becker, DO Trisha Danielle Anest, MD Irina Fox Brennan, MD, PhD Kenneth Hickey, MD, FACEP Sarah Klemencic, MD, FACEP David Matthew Kruse, MD, FACEP Bruce M Lo, MD, FACEP Todd Parker, MD, FACEP

	Joran Sequeira, MD Sara F Sutherland, MD, MBA, FACEP
WASHINGTON CHAPTER	Cameron Ross Buck, MD, FACEP Carlton E Heine, MD, PhD, FACEP Catharine R Keay, MD, FACEP Nathaniel R Schlicher, MD, JD, FACEP Patrick Solari, MD, FACEP Jennifer L Stankus, MD, JD, FACEP Susan Amy Stern, MD Liam Yore, MD, FACEP
WEST VIRGINIA CHAPTER	Frederick C Blum, MD, FACEP Adam Thomas Crawford, DO Christopher S Goode, MD, FACEP
WISCONSIN CHAPTER	William D Falco, MD, MS, FACEP William C Haselow, MD, FACEP Lisa J Maurer, MD, FACEP Jeffrey J Pothof, MD, FACEP Robert Sands Redwood, MD, FACEP Michael Dean Repplinger, MD, PhD, FACEP
WYOMING CHAPTER	Daniela S Gerard, MD, PhD, FACEP

Sections of Membership

AIR MEDICAL TRANSPORT	Henderson D McGinnis, MD, FACEP
AMER ASSOC OF WOMEN EMER PHYSICIANS	E Lea Walters, MD, FACEP
CAREERS IN EMERGENCY MEDICINE	Constance J Doyle, MD, FACEP
CRITICAL CARE MEDICINE	Ani Aydin, MD, FACEP
CRUISE SHIP MEDICINE	Sydney W Schneidman, MD, FACEP
DEMOCRATIC GROUP PRACTICE	David F Tulsiak, MD, FACEP
DISASTER MEDICINE	David Wayne Callaway, MD, FACEP
DUAL TRAINING	Carissa J Tyo, MD, FACEP
EMERGENCY MEDICAL INFORMATICS	Jeffrey A Nielson, MD, FACEP
EMS-PREHOSPITAL CARE	Maia Dorsett, MD
EMER MED PRAC MGMT & HEALTH POLICY	Heather Ann Heaton, MD, FACEP
EMERGENCY MEDICINE RESEARCH	James Ross Miner, MD, FACEP
EMERGENCY MEDICINE WORKFORCE	Donald L. Lum, MD, FACEP
EMERGENCY ULTRASOUND	Chris Bryczkowski, MD, FACEP
EVENT MEDICINE	Mark Robert Sochor, MD, FACEP
FREESTANDING EMEGENCY CENTERS	David C Ernst, MD, FACEP

GERIATRIC EMERGENCY MEDICINE	Teresita M Hogan, MD, FACEP
INTERNATIONAL EMERGENCY MEDICINE	Elizabeth L DeVos, MD, FACEP
MEDICAL DIRECTORS	Johnny L. Sy, DO, FACEP
MEDICAL HUMANITIES	Seth Collings Hawkins, MD, FACEP
OBSERVATION SERVICES	Sharon E Mace, MD, FACEP
PAIN MANAGEMENT	Alexis M LaPietra, DO, FACEP
PALLIATIVE MEDICINE	Eric D Isaacs, MD, FACEP
PEDIATRIC EMERGENCY MEDICINE	Eric R Schmitt, MD, MPH, FACEP
QUALITY IMPROVEMENT & PATIENT SAFETY	Brian Sharp, MD, FACEP
RURAL EMERGENCY MEDICINE	Darrell L Carter, MD, FACEP
SOCIAL EMERGENCY MEDICINE	Harrison Alter, MD, FACEP
SPORTS MEDICINE	Jolie C Holschen, MD, FACEP
TACTICAL EMERGENCY MEDICINE	James Phillips, MD
TELEMEDICINE	Edward A Shaheen, MD, FACEP
TOXICOLOGY	Jennifer Hannum, MD, FACEP
TRAUMA & INJURY PREVENTION	Gregory Luke Larkin, MD, MPH, FACEP
UNDERSEA & HYPERBARIC MEDICINE	Robert W Sanders, MD, FACEP
WELLNESS	Laura H McPeake, MD, FACEP
WILDERNESS MEDICINE	Susanne J Spano, MD, FACEP
YOUNG PHYSICIANS	Hilary E Fairbrother, MD, FACEP

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

Past Presidents

Robert K. Anzinger, MD, FACEP (NC)
Nancy J. Auer, MD, FACEP (WA)
Larry A. Bedard, MD, FACEP (CA)
Fredrick Blum, MD, FACEP (WV)
Brooks F. Bock, MD, FACEP (CO)
Michael L. Carius, MD, FACEP (CT)
Angela F. Gardner, MD, FACEP (TX)
Michael J. Gerardi, MD, FACEP (NJ)
Gregory L. Henry, MD, FACEP (MI)
J. Brian Hancock, MD, FACEP (MI)
Gregory L. Henry, MD, FACEP (MI)
Nicholas J. Jouriles, MD, FACEP (OH)
Jay A. Kaplan, MD, FACEP (LA)
Brian F. Keaton, MD, FACEP (OH)
Linda L. Lawrence, MD, FACEP (GS)
John B. McCabe, MD, FACEP (NY)
George Molzen, MD, FACEP (NM)
Michael T. Rapp, MD, FACEP (VA)
Alex M. Rosenau, DO, FACEP (PA)
Andrew Sama, MD, FACEP (NY)
Robert W. Schafermeyer MD, FACEP (NC)
Sandra M. Schneider, MD, FACEP (TX)
David C. Seaberg, MD, CPE, FACEP (OH)
Richard L. Stennes, MD, MBA, FACEP (CA)
Robert E. Suter, DO, MPH, FACEP (TX)

Past Speakers

Michael J. Bresler, MD, FACEP (CA)
James M. Cusick, MD, FACEP (CO)
Mark L. DeBard, MD, FACEP (OH)
Peter M. Fahrney, MD, FACEP (VA)
Peter J. Jacoby, MD, FACEP (CT)
Kevin M. Klauer, DO, FACEP (OH)
John R. Lumpkin, MD, FACEP (NJ)
Bruce MacLeod, MD, FACEP (PA)
Todd B. Taylor, MD, FACEP (TN)
Arlo F. Weltge, MD, MPH, FACEP (TX)
Dennis C. Whitehead, MD, FACEP (MI)

Past Chairs of the Board

John D. Bibb, MD, FACEP (CA)
Cherri D. Hobgood, MD, FACEP (IN)
Ramon W. Johnson, MD, FACEP (CA)
Robert E. O'Connor, MD, MPH, FACEP (VA)
John J. Rogers, MD, CPE, FACEP (GA)
David P. Sklar, MD, FACEP (NM)

****

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

Council Standing Rules

Preamble

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

Alternate Councillors

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

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

Amendments to Council Standing Rules

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

Announcements

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

Appeals of Decisions from the Chair

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

Board of Directors Seating

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

Campaign Rules

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

Cellular Phones, Pagers, and Computers

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

Councillor Allocation for Sections of Membership

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

Councillor Seating

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

Credentialing and Proper Identification

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

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

Debate

Councillors, members of the Board of Directors, past presidents, 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. Participants should refrain from speaking again on the same issue until all others wishing to speak have had the opportunity to do so.

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

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

Distribution of Printed or Other Material During the Annual Meeting

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

Election Procedures

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

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

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast

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

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

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

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

Limiting Debate

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

Nominating Committee

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

Nominations

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

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

Parliamentary Procedure

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

Past Presidents, 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 chapter delegations, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

Personal Privilege

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

Policy Review

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

Reference Committees

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

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

A Reference Committee may recommend that a resolution:

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

B) **Be Amended or Substituted:** In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.

C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee's motion to refer may go fully into the merits of the resolution. If the motion to refer is defeated, the speaker shall state the original resolution.

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

Reports

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

Resolutions

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

Resolutions must be submitted in writing by at least two members or by chapters, sections, committees, or the Board of Directors. A letter of endorsement from the sponsoring body is required if submitted by a chapter, section, or committee.

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

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

• Regular Non-Bylaws Resolutions

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

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

• Bylaws Resolutions

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

Bylaws resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting.

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

• Late Resolutions

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

• Emergency Resolutions

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

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

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

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

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

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

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

Voting Immediately

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

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

Voting on Resolutions and Motions

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

****

The councillors reviewed and accepted the minutes of the October 27-28, 2017, Council meeting and approved the actions of the Steering Committee taken at their February 6, 2018, and May 20, 2018, meetings.

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

Dr. McManus reported that five late resolutions were received and reviewed by the Steering Committee. Three memorial resolutions were accepted by the Steering Committee. Memorial resolutions are not assigned to a Reference Committee for testimony. The other two late resolutions were not accepted for submission to the Council. Dr. McManus stated the reason the late resolutions were rejected.

Dr. McManus reminded the Council that John Rogers, MD, FACEP, was elected last year as president-elect and he resigned from the position on June 26, 2018. The Board of Directors and the Council officers, in accordance with the Bylaws, elected Vidor Friedman, MD, FACEP, as president-elect for the remainder of the unexpired term from among the members of the Board, subject to ratification by the Council. There were no objections and Dr. Friedman's election was ratified.

Dr. McManus presented the Nominating Committee report. Two members were nominated for President-Elect: Jon Mark Hirshon, MD, PhD, MPH, FACEP, and William P. Jaquis, MD, FACEP. Dr. McManus called for floor nominations. There were no floor nominees. The nominations were then closed.

Nine members were nominated for four positions on the Board of Directors: L. Anthony Cirillo, MD, FACEP; Kathleen J. Clem, MD, FACEP; Francis L. Counselman, MD, FACEP, John T. (JT) Finnell, MD, FACEP; Jeffrey M. Goodloe, MD, FACEP; Christopher S. Kang, MD, FACEP; Michael McCrea, MD, FACEP; Mark S. Rosenberg, DO, FACEP; and Thomas J. Sugarman, MD, FACEP. Dr. McManus called for floor nominations. There were no floor nominees. The nominations were then closed.

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

The Council viewed a brief about the book "Bring 'em All," which was published to commemorate ACEP's 50th Anniversary. Dr. McManus informed the Council that the book is available for purchase in the Council meeting room foyer near councillor credentialing.

The Council recessed at 9:33 am for the Reference Committee hearings. The resolutions considered by the 2018 Council appear below as submitted.

2018 Council Resolutions

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians commends Hans R. House, MD, FACEP, for his service as an emergency physician, clinical investigator, educator, and leader in a life-long quest dedicated to the advancement of the specialty of emergency medicine.

RESOLUTION 2

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

RESOLUTION 3

RESOLVED, That the American College of Emergency Physicians bestows with gratitude this commendation to Les Kamens for his dedicated support and service.

RESOLUTION 4

RESOLVED, That the American College of Emergency Physicians commends Rebecca B. Parker, MD, FACEP, for her outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

RESOLUTION 5

RESOLVED, That the American College of Emergency Physicians bestows with gratitude this commendation to Eugene Richards for capturing the breathtaking moments that comprise the lives and careers of emergency physicians across the United States.

RESOLUTION 6

RESOLVED, that the American College of Emergency Physicians recognizes and commends John J. Rogers, MD, CPE, FACEP, for his lifetime of outstanding and selfless service, leadership, and commitment to the College, the specialty of emergency medicine, and the patients in the communities which we serve.

RESOLUTION 7

RESOLVED, That the American College of Emergency Physicians extends to his wife, Jeanette Linder, MD, his daughter, Kaylie, our condolences and gratitude for Dr. Linder's trailblazing leadership and service to the specialty of emergency medicine and to the patients and physicians of Maryland and the United States.

RESOLUTION 8

RESOLVED, That the American College of Emergency Physicians extends to the family of Kevin Rodgers, MD, FACEP, FAAEM, his friends, and his colleagues our condolences and our immense gratitude for his tireless service to his residents, his students, and the countless patients globally who will continue to benefit from his incredible life spent in service to others.

RESOLUTION 9

RESOLVED, That the ACEP Bylaws Article VIII – Council be amended to read:

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),** 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.

RESOLUTION 10

RESOLVED, That the ACEP College Manual, VI. Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council be amended to read:

Organizations that seek representation as a component body in the Council of the American College of Emergency Physicians (ACEP) must meet, and continue to meet, **at least eight (8) of** 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. **The organization supports major ACEP initiatives, such as the Emergency Medicine Action Fund.**
~~F.~~**G**. Established, stable, and in existence for at least 5 years prior to requesting representation in the ACEP Council.
~~G.~~**H**. 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.~~**I.** 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.

RESOLUTION 11

RESOLVED, That the Council Standing Rules be amended to include a new section titled "Leadership Development Advisory Group" to read:

"The Leadership Development Advisory Group (LDAG) shall be charged with identifying and mentoring diverse College members to serve in College leadership roles. The LDAG 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."

RESOLUTION 12

RESOLVED, That the "Nominating Committee" section of the Council Standing Rules be amended to read:

"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 practice institution, candidate diversity, and specific experiential needs of the organization** when considering the slate of candidates."

RESOLUITON 13

RESOLVED, That the Council direct the Council officers to appoint a task force of councillors to study the growth of the Council and determine whether a Bylaws amendment should be submitted to the 2019 Council limiting the size of the Council and the relative allocation of councillors.

RESOLUTION 14

RESOLVED, That ACEP strongly encourage its chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including candidate physician and young physician members.

RESOLUTION 15

RESOLVED, That ACEP, and any affiliated corporations, shall work in a timely and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and be it further

RESOLVED, That ACEP shall, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and be it further

RESOLVED, That ACEP shall support efforts of emergency physicians, state chapters, the Emergency Medicine Foundation, and other health professional associations to proceed with divestment, including to support continuing medical education, and to inform our patients, the public, legislators, and government policy makers about the health consequences of burning fossil fuels.

RESOLUTION 16

RESOLVED, That ACEP study the unique, specialty-specific factors leading to depression and suicide in emergency physicians; and be it further

RESOLVED, That ACEP formulate an action plan to address contributory factors leading to depression and suicide unique to our specialty and provide a report of these findings to the 2019 Council.

RESOLUTION 17

RESOLVED, That ACEP acknowledges the unique role that workplace factors, as well as departmental and institutional culture play in physician suicides, and that ACEP believes that physician suicides should be treated as sentinel events that should be investigated through internal and confidential review to better understand workplace systems, processes, and culture that can be changed to reduce the probability of future events; and be it further

RESOLVED, That ACEP work with partner organizations, including the American Medical Association, the American Hospital Association, and the National Academy of Medicine to advocate for the adoption of policies that consider physician suicides as sentinel events.

RESOLUTION 18

RESOLVED, That ACEP work with partner organizations to promote a culture where physician mental health issues can be addressed proactively, confidentially, and supportively, without fear of retribution; and be it further

RESOLVED, That ACEP work with the American Medical Association, Federation of State Medical Boards, and the American Psychiatric Association to petition state medical boards to end the practice of requesting a broad report of mental health information on licensure application forms unless there is a current diagnosis that causes physician impairment or poses a potential risk of harm to patients; and be it further

RESOLVED, That ACEP work with ACEP chapters to encourage state medical boards to amend their questions about both the physical and mental health of applicants to use the language recommended by the American Psychiatric Association: "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?"

RESOLUTION 19

RESOLVED, That ACEP reaffirms its position on the importance of scholarship and will advocate aggressively with the Accreditation Council for Graduate Medical Education to preserve core faculty teaching and academic time, including support of scientifically rigorous research and education that improves the patient care in emergency medicine; and be it further

RESOLVED, That ACEP develop model policy language on the importance of scholarship and the need for

core faculty teaching and academic time, which training programs can access and present to hospital systems as evidence for the need for financial support for scholarly activity; and be it further

RESOLVED, That ACEP explore additional ways to provide financial support to residency and training programs in carrying out scholarly activities; and be it further

RESOLVED, That ACEP work with the Council of Emergency Medicine Residency Directors and the Society for Academic Emergency Medicine to establish initiatives and processes to ensure all areas of scholarship are supported; and be it further

RESOLVED, That ACEP provide a statement to the Accreditation Council for Graduate Medical Education to request that accreditation requirements for scholarship be explicit to ensure institutional and program funding support is directed toward these activities.

RESOLUTION 20

RESOLVED, That ACEP work with stakeholders including the Federation of American Hospitals (FAH), American Hospital Association (AHA), and others as appropriate, to develop a standardized and streamlined application process for hospital credentialing; and be it further

RESOLVED, That ACEP support the development of a standardized verification of training form for hospital credentialing and be it further

RESOLVED, That ACEP support the development of a standardized peer reference form for hospital credentialing; and be it further

RESOLVED, That ACEP support the development of a standardized verification of employment form for hospital credentialing; and be it further

RESOLVED, That ACEP support the development of a standardized employment application for board eligible or board certified emergency physicians for hospital credentialing.

RESOLUTION 21

RESOLVED, That ACEP support advocacy to assure that adequate financial, community resources, and patient supports are included in proposed local, state, or federal policies dictating criteria for safe patient discharge from the emergency department.

RESOLUTION 22

RESOLVED, That ACEP issue a statement to inform members about the Medicaid Institutions for Mental Diseases Exclusion and its impact on ED psychiatric patients; and be it further

RESOLVED, That ACEP work through legislation or regulation to repeal the Medicaid Institutions for Mental Diseases Exclusion; and be it further

RESOLVED, That ACEP support Medicaid waiver demonstration applications that seek to receive federal financial participation for Institutions for Mental Diseases services provided to Medicaid beneficiaries.

RESOLUTION 23

RESOLVED, That ACEP request that any CMS policies effectively restricting the administration of rapid sequence intubation drugs by RNs or EMS providers be revised or revoked as soon as possible; and be it further

RESOLVED, That ACEP advocate for CMS to not promulgate policies, rules, or regulations that dictate or restrict emergency physicians, nurses, or EMS providers from providing quality emergency care to our patients.

RESOLUTION 24

RESOLVED, That ACEP opposes imposition of copays for Medicaid beneficiaries seeking care in the ED; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association House of Delegates to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED.

RESOLUTION 25

RESOLVED, That ACEP seek federal and state appropriation funding and/or grants for purposes of initiating buprenorphine-naloxone treatment programs in emergency departments with provided funding for start-up, training, and appropriate patient follow up.

RESOLUTION 26

RESOLVED, ACEP advocate for federal and state appropriations and/or federal and state grants for use in fully funding substance abuse intervention programs that are accessible seven days a week and 24 hours each day and will be initiated in emergency departments; and be it further

RESOLVED, That ACEP advocate for federal and state funding for substance abuse intervention programs that will be fully accessible and utilizable to their fully potential by all patients regardless of insurance status or ability to self-pay and that a pre-determined share of cost be covered by insurers to offset the cost to the government.

RESOLUTION 27

RESOLVED, That ACEP prepare a press release calling for repeal of the group purchasing organization (GPO) safe harbor.

RESOLUTION 28

RESOLVED, That ACEP add to its legislative agenda to advocate for an end to the prohibition and corresponding inclusion of Methadone in state and federal prescription databases.

RESOLUTION 29

RESOLVED, That ACEP add to its legislative and regulatory agenda to advocate for bills and policy changes that would require healthcare insurance companies to pay the professional fee directly to the provider and subsequently collect whatever patient responsibility remains according to the specific healthcare plan directly from the patient; and be it further

RESOLVED, That ACEP create an information paper and/or legislative toolkit to assist members in advocating for applicable changes to state insurance laws; and be it further

RESOLVED, That ACEP advocate for a federal law requiring healthcare insurance companies to pay the professional fee directly to the provider and subsequently the insurance company may collect whatever remaining patient responsibility is required according to the specific healthcare plan directly from the patient.

RESOLUTION 30

RESOLVED, That ACEP support state chapters in drafting and advocating for state legislation to recommend naloxone training in schools; and be it further

RESOLVED, That ACEP work with national advocacy and capacity-building organizations to advocate for increased naloxone training by laypersons.

RESOLUTION 31

RESOLVED, That ACEP advocate for mandated guidelines for insurance coverage of opioid sparing therapies, be they medications such as lidocaine patches and NSAID topical creams, and/or physical therapy without requiring preauthorization or outright denial of these prescribed therapies.

RESOLUTION 32

RESOLVED, That ACEP advocate and assist chapters for broad recognition of POLST; and be it further

RESOLVED, That ACEP support legislation where states recognize and honor POLST forms from other states; and be it further

RESOLVED, That ACEP encourage appropriate stakeholders (e.g., medical record systems, health information exchanges) to incorporate POLST into their products thus encouraging widespread national availability and adoption.

RESOLUTION 33

RESOLVED, That ACEP opposes the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and be it further

RESOLVED, That ACEP give priority to supporting families and protecting the health and well-being of the migrating children within those families where the children have been removed; and be it further

RESOLVED, That ACEP work with appropriate authorities to encourage and facilitate the reunification of separated migrating children with their caregivers immediately.

RESOLUTION 34

RESOLVED, That ACEP will recognize violence as a health issue addressable through both the medical model of disease and public health interventions; and be it further

RESOLVED, That ACEP will pursue policies, legislation, and funding for health and public-health-based approaches to reduce violence.

RESOLUTION 35

RESOLVED, That ACEP affirms the right for all patients to access and receive emergency care regardless of country of origin or immigration status; and be it further

RESOLVED, That ACEP encourages emergency departments to establish policies forbidding collaboration between hospital staff and immigration authorities, unless required by signed warrant; and be it further

RESOLVED, That ACEP opposes determination of "public charge" used in determining eligibility for legal entry into the United States or legal permanent residency that would include health benefits or coverage.

RESOLUTION 36

RESOLVED, That ACEP align with and adopt as ACEP policy the following relevant sections of the American Medical Association's Policy: "Cannabis and Cannabinoid Research H-95.952":

> (1) ACEP supports further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
> (2) ACEP supports that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.

RESOLUTION 37

RESOLVED, That ACEP align with and adopt as ACEP policy the following relevant section of the American Medical Association's Policy: "Cannabis and Cannabinoid Research H-95.952":

> ACEP urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use; and be it further

RESOLVED, That ACEP align with and adopt as ACEP policy the following relevant sections of the American Medical Association's Policy: "Cannabis Legalization for Recreational Use H-95.924":

> ACEP believes that the sale of cannabis for recreational use should not be legalized; and discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding.

RESOLUTION 38

RESOLVED, That ACEP issue a public statement on the public health implications of antimicrobial resistance and the importance of antimicrobial stewardship in the emergency department; and be it further

RESOLVED, That ACEP offer education aimed at emergency department providers on the hazards of antimicrobial overuse and strategies to prescribe antimicrobials appropriately; and be it further

RESOLVED, That ACEP disseminate an evidence-based resource and/or toolkit for emergency department providers to identify and implement provider-level and system-level opportunities for antimicrobial avoidance.

RESOLUTION 39

RESOLVED, That ACEP develop a toolkit to help physicians at the bedside address the following:

- patient handoff and frequency of evaluation while boarding;
- activities of daily living for the boarded patient; and
- initiation of mental health treatment while boarding.

RESOLUTION 40

RESOLVED, That ACEP work with relevant stakeholders to develop and disseminate educational materials for emergency physicians on the common conditions that cause individuals with Autism Spectrum Disorder to present to the emergency department, their assessment and management, and best practices in adapting the existing emergency department treatment environment to meet the needs of this population.

RESOLUTION 41

RESOLVED, That ACEP develop a policy statement addressing the emergency department and the emergency physician role and responsibility for the completion of death certificates for patients who have died in the emergency department under their care.

RESOLUTION 42

RESOLVED, That ACEP revise the "Expert Witness Guidelines for the Specialty of Emergency Medicine" policy statement to define an expert witness as a person actively engaged in the practice of medicine during the year prior to the initiation of litigation who has the same level or greater training in the same field as the subject of the tort for a majority of their professional time.

RESOLUTION 43

RESOLVED, That in order to help contain costs and improve the lives of the lowest paid health care workers, that ACEP study whether the income of the lowest paid health care workers is not to be below some pre-fixed fraction of the highest income for health care executives and physicians and to determine if such a policy would be beneficial to society and serve as an important example for other industries.

RESOLUTION 44

RESOLVED, That ACEP amend its firearm policy to emphasize the importance of research in firearm injury; clarify the range of firearm injuries that ought be subject to greater research; emphasize the role of suicide in the U.S. firearm injury landscape; and contain specific language clarifying that after-market modifications to firearms should qualify as subject to ACEP policy; and be it further

RESOLVED, That ACEP's policy statement "Firearm Safety and Injury Prevention" be amended to read:

The American College of Emergency Physicians abhors the current level of intentional and accidental firearm injuries ~~and finds that it poses a threat to the health and safety of the public.~~ **and deaths in the United States of America. We believe that firearm injuries are a public health concern, and one that is particularly relevant to us as the first physicians to treat its victims. This pertains not only to mass shootings, which often attract media attention, but also to the much larger number of persons who are injured or killed in daily incidents of interpersonal violence, and to suicidal patients who reach for a firearm. Above all, we support research into firearm violence and strive to promote policy that is evidence-based.**

ACEP supports legislative, regulatory, and public health efforts that:

- Encourage ~~the change of societal norms that glorify a culture of violence to one of social civility;~~ **research into the societal norms that contribute to violence, including media that glorify violence;**
- **Eliminate real and implied legal and financial barriers to research into firearm safety and violence prevention in the public and private arena. Encourage private funding for firearm safety and injury prevention research as a complement to public funding but not a replacement for it;**
- Investigate the effect ~~of socioeconomic and other cultural risk factors on firearm injury and provide public and private funding for firearm safety and injury prevention research;~~ **of the social determinants of health on patterns of firearm injury, such as the influence of poverty, the relationship between communities and law enforcement, and the role of firearms in intimate partner violence;**
- Create a confidential national firearm injury research registry while encouraging states to establish a uniform approach to tracking and recording **all U.S.** firearm related injuries, **regardless of the circumstances leading to the event, including personal defense, officer-involved, and line-of-duty injuries among law enforcement and EMS personnel;**
- Promote access to effective, affordable, and sustainable mental health services **for our patients, such that suicidal patients with access to firearms would have timely mental health intervention;**
- ~~Protect the duty of physicians and encourage health care provider discussions with patients on firearm safety;~~ **Recognizing that guns have the highest suicide case fatality rate, protect the duty of physicians to discuss firearm safety with patients, with particular emphasis on lethal means counseling in patients with suicidal ideation;**
- Promote **research in, and** the development of technology that increases firearm safety;
- Support universal background checks for firearm transactions **and transfers**;
- Require the enforcement of existing laws and support new legislation that prevents high risk and prohibited individuals from obtaining firearms by any means;

- Restrict the sale and ownership of weapons, munitions, and large capacity magazines that are designed for military or law enforcement use, **as well as after-market modifications that increase the lethality of otherwise legal weapons.**

RESOLUTION 45

RESOLVED, That ACEP amend its "Firearm Safety and Injury Prevention" policy statement to support extreme risk protection orders; and be it further

RESOLVED, That ACEP support extreme risk protection orders legislation at the national level; and be it further.

RESOLVED, That ACEP promote and assist state chapters in the passage of state legislation to enact extreme risk protection orders by creating a toolkit and other appropriate resources to disseminate to state chapters; and be it further

RESOLVED, That ACEP encourage and support research of the effectiveness and ramifications of extreme risk protection orders (ERPO) and Gun Violence Restraining Orders (GVRO).

RESOLUTION 46

RESOLVED, That ACEP revise the policy statement "Law Enforcement Information Gathering in the Emergency Department" to take into account the recent relevant court decisions regarding consent for searches with or without a warrant in investigations of driving under the influence to provide clarification and guidance to emergency physicians on their ethical and legal obligations on this issue.

RESOLUTION 47

RESOLVED, That ACEP promotes the use of medication for opioid use disorder, where clinically appropriate, for emergency department patients with opioid use disorder; and be it further

RESOLVED, That ACEP works with the Pain Management & Addiction Medicine section to develop a clinical policy on the initiation of medication for opioid use disorder for emergency department patients; and be it further

RESOLVED, That ACEP advocates for policy changes that lower the regulatory barriers to initiating medication for opioid use disorder in the emergency department; and be it further

RESOLVED, That until barriers to initiating medication for opioid use disorder in the emergency department are lowered, ACEP partners with the Substance Abuse and Mental Health Services Administration (SAMSHA) to create training that fulfills the existing requirement for 8-hour buprenorphine training while being more relevant to the emergency department context; and be it further

RESOLVED, That ACEP supports the expansion of outpatient opioid treatment programs and partnership with addiction medicine specialists to improve ED to outpatient care transitions.

RESOLUTION 48

RESOLVED, That ACEP explore implications, solutions, and education/training to address surreptitious (audio/video) recording in the emergency department; and be it further

RESOLVED, That ACEP work with other interested parties, such as the American Medical Association and American Hospital Association, to coordinate regulatory and legislative efforts to address the implications of surreptitious (audio/video) recording in the emergency department.

RESOLUTION 49 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians extends to the family of C. Christopher King MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine, and to the patients and physicians of Pennsylvania, New York, and the United States.

RESOLUTION 50 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by John Emory Campbell MD, FACEP, as one of the leaders in Emergency Medicine and a pioneer of prehospital trauma education; and be it further

RESOLVED, That the American College of Emergency Physicians extends its condolences to Dr. Campbell's family, friends, and colleagues for his tremendous service to Emergency Medicine and Emergency Medical Services.

RESOLUTION 51 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Adib Mechrefe, 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 his wife, Mary (Freij) Mechrefe, his family, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of Rhode Island and the United States.

****

Commendation and memorial resolutions were not assigned to reference committees.

Resolutions 9-20 were referred to Reference Committee A. J. David Barry, MD, FACEP, chaired Reference Committee A and other members were: Nida Degesys, MD; Andrea L. Green, MD, FACEP; Muhammad N. Husainy, DO, FACEP; James L. Shoemaker, Jr., MD, FACEP; Larisa M. Traill, MD, FACEP; Leslie Moore, JD; and Maude Surprenant Hancock.

Resolutions 21-35 were assigned to Reference Committee B. Kristin B. McCabe-Kline, MD, FACEP, chaired Reference Committee B and other members were: Justin W. Fairless, DO, FACEP; Chadd K. Kraus, DO, DrPH, MPH, FACEP; Diana Nordlund, DO, JD, FACEP; Livia M. Santiago-Rosado, MD, FACEP; Liam T. Yore, MD, FACEP; Ryan McBride, MPP; and Harry Monroe.

Resolutions 36-48 were referred to Reference Committee C. Michael D. Smith, MD, MBA, CPE, FACEP, chaired Reference Committee C and other members were: Melissa W. Costello, MD, FACEP; Carrie de Moor, MD, FACEP; William D. Falco, MD, MS, FACEP; Daniel Freess MD, FACEP; Nicole A. Veitinger, DO, FACEP; Margaret Montgomery, RN, MSN; Travis Schulz, MLS, AHIP; and Sam Shahid, MBBS, MPH.

At 12:45 pm a Town Hall Meeting was convened. The topic was "Single Payer: Has the Time Finally Arrived?" Michael J. Gerardi, MD, FACEP, served as the moderator and the discussants were James C. Mitchiner, MD, MPH, FACEP, and Todd B. Taylor, MD, FACEP.

The Candidate Forum for the president-elect candidates began at 2:00 pm with the president-elect candidates in the main Council meeting room. The Candidate Forum for the Board of Directors candidates began at 2:45 pm with candidates rotating through each of the Reference Committee meeting rooms.

At 4:45 pm the Council reconvened in the main Council meeting room to hear reports and the reading and presentation of the memorial resolutions.

Dr. McManus addressed the Council and then introduced the Steering Committee and the Board of Directors.

Dr. McManus reviewed the procedure for the adoption of the 2018 memorial resolution. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. McManus then presented framed memorial resolutions to the colleagues of John E. Campbell, MD, FACEP; C. Christopher King, MD, FACEP; Lawrence S. Linder, MD, FACEP; and Kevin Rodgers, MD, FACEP. The Council honored the memory of those who passed away since the last Council meeting 2018 and adopted the memorial resolutions by observing a moment of silence.

Dr. McManus announced that the commendation resolutions would be presented during the Council luncheon on Sunday, September 30, 2018.

Robert L. Muelleman, MD, FACEP, president of the American Board of Emergency Medicine, addressed the Council.

Stephen H. Anderson, MD, FACEP, presented the secretary-treasurer's report.

Zachary Jarou, MD, addressed the Council regarding the activities of the Emergency Medicine Residents' Association.

Jordan GR Celeste, MD, FACEP, addressed the Council regarding the activities of the Emergency Medicine Foundation.

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

Paul D. Kivela, MD, MBA, FACEP, president, addressed the Council. He reflected on his past year as ACEP president and highlighted the successes of the College.

The Council recessed at 6:30 pm pm for the candidate reception and reconvened at 8:02 am on Sunday, September 30, 2018.

Dr. Kessler reported that 414 councillors of the 421 eligible for seating had been credentialed. He then introduced the members of the Tellers, Credentials, & Elections Committee, reviewed the electronic voting procedures, and conducted a test of the keypads using demographic and survey questions.

Mr. Wilkerson, executive director and Council secretary, addressed the Council.

The Council viewed a video orientation on submitting resolution amendments electronically.

REFERENCE COMMITTEE B

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Amended Resolution 21, Amended Resolution 22, Amended Resolution 23, Resolution 24, Amended Resolution 25, Amended Resolution 26, Resolution 30, Amended Resolution 31, Amended Resolution 32, Amended Resolution 33, and Resolution 34.

For referral: Resolution 27, Resolution 28, and Resolution 35

Amended Resolution 21, Resolution 24, Amended Resolution 33, Resolution 27, Resolution 28, and Resolution 35 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 22

RESOLVED, THAT ACEP ~~ISSUE A STATEMENT TO~~ INFORM MEMBERS ABOUT THE MEDICAID INSTITUTIONS FOR MENTAL DISEASES EXCLUSION AND ITS IMPACT ON ED PSYCHIATRIC PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP **CONTINUE TO** WORK THROUGH LEGISLATION OR REGULATION TO REPEAL THE MEDICAID INSTITUTIONS FOR MENTAL DISEASES EXCLUSION; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT MEDICAID WAIVER DEMONSTRATION APPLICATIONS THAT SEEK TO RECEIVE FEDERAL FINANCIAL PARTICIPATION FOR INSTITUTIONS FOR MENTAL DISEASES SERVICES PROVIDED TO MEDICAID BENEFICIARIES.

AMENDED RESOLUTION 23

RESOLVED, THAT ACEP REQUEST THAT ANY CMS POLICIES ~~EFFECTIVELY~~ RESTRICTING THE ADMINISTRATION OF RAPID SEQUENCE INTUBATION DRUGS **IN THE EMERGENCY DEPARTMENT, UNDER THE DIRECTION OF EMERGENCY PHYSICIANS OR** BY ~~RNS OR~~ EMS ~~PROVIDERS~~ **PHYSICIANS** BE REVISED OR REVOKED AS SOON AS POSSIBLE; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~ADVOCATE FOR CMS TO NOT PROMULGATE POLICIES, RULES, OR REGULATIONS THAT DICTATE OR RESTRICT EMERGENCY PHYSICIANS, NURSES, OR EMS PROVIDERS FROM PROVIDING QUALITY EMERGENCY CARE TO OUR PATIENTS.~~ **REQUEST THAT CMS POLICY REFLECT THE CONSENSUS GUIDELINE ON UNSCHEDULED PROCEDURAL SEDATION OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS.**

AMENDED RESOLUTION 25

RESOLVED, THAT ACEP ~~SEEK~~ **PURSUES LEGISLATION FOR** FEDERAL AND STATE APPROPRIATION FUNDING AND/OR GRANTS FOR PURPOSES OF INITIATING ~~BUPRENORPHINE-NALOXONE~~ **AND SUSTAINING MEDICATION ASSISTED TREATMENT** PROGRAMS IN EMERGENCY DEPARTMENTS WITH PROVIDED FUNDING FOR START-UP, TRAINING, AND **ROBUST COMMUNITY RESOURCES FOR** APPROPRIATE PATIENT FOLLOW UP.

AMENDED RESOLUTION 26

RESOLVED, ACEP ADVOCATE FOR FEDERAL AND STATE APPROPRIATIONS AND/OR FEDERAL AND STATE GRANTS FOR USE IN FULLY FUNDING SUBSTANCE ABUSE INTERVENTION PROGRAMS THAT ARE ACCESSIBLE SEVEN DAYS A WEEK AND 24 HOURS EACH DAY AND WILL BE INITIATED IN EMERGENCY DEPARTMENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR FEDERAL AND STATE FUNDING FOR SUBSTANCE ABUSE INTERVENTION PROGRAMS THAT WILL BE FULLY ACCESSIBLE AND UTILIZABLE TO THEIR FULLY POTENTIAL BY ALL PATIENTS REGARDLESS OF INSURANCE STATUS OR ABILITY TO ~~SELF-PAY AND THAT A PRE-DETERMINED SHARE OF COST BE COVERED BY INSURERS TO OFFSET THE COST TO THE GOVERNMENT~~ **PAY**.

AMENDED RESOLUTION 31

RESOLVED, THAT ACEP ADVOCATES FOR ~~MANDATED GUIDELINES~~ INSURANCE COVERAGE OF OPIOID SPARING THERAPIES**,**~~; BE THEY MEDICATIONS SUCH AS LIDOCAINE PATCHES AND NSAID TOPICAL CREAMS, AND/OR PHYSICAL THERAPY~~ WITHOUT REQUIRING PREAUTHORIZATION OR OUTRIGHT DENIAL OF THESE PRESCRIBED THERAPIES.

AMENDED RESOLUTION 32

RESOLVED, THAT ACEP ADVOCATES AND ASSIST CHAPTERS FOR BROAD RECOGNITION OF POLST**, INCLUDING THE USE OF NATIONALLY-RECOGNIZED, STANDARDIZED POLST FORMS**; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORTS LEGISLATION WHERE STATES RECOGNIZE AND HONOR POLST FORMS FROM OTHER STATES; AND BE IT FURTHER

RESOLVED, THAT ACEP ENCOURAGES APPROPRIATE STAKEHOLDERS (E.G., MEDICAL RECORD SYSTEMS, HEALTH INFORMATION EXCHANGES) TO INCORPORATE POLST INTO THEIR PRODUCTS THUS ENCOURAGING WIDESPREAD NATIONAL AVAILABILITY AND ADOPTION.

The committee recommended that Amended Resolution 21 be adopted.

It was moved THAT AMENDED RESOLUTION 21 BE ADOPTED.

RESOLVED, THAT ACEP SUPPORTS ADVOCACY **AND ENGAGEMENT OF STAKEHOLDERS** TO ASSURE THAT ADEQUATE FINANCIAL **RESOURCES**, COMMUNITY RESOURCES, AND PATIENT SUPPORTS ARE INCLUDED IN PROPOSED LOCAL, STATE, OR FEDERAL POLICIES DICTATING CRITERIA FOR SAFE PATIENT DISCHARGE FROM THE EMERGENCY DEPARTMENT, **AND THAT THESE POLICIES TAKE INTO ACCOUNT SOCIAL DETERMINANTS OF HEALTH; AND BE IT FURTHER**

RESOLVED, THAT ACEP AFFIRMS THAT ANY SAFE DISCHARGE MANDATE THAT DOES NOT PROVIDE FOR THE NECESSARY FINANCIAL RESOURCES, COMMUNITY RESOURCES, AND PATIENT SUPPORTS RISKS UNINTENDED CONSEQUENCES THAT ADVERSELY IMPACT PATIENT SAFETY.

It was moved THAT THE FIRST RESOLVED BE AMENDED BY ADDITION OF THE WORDS “ANY EMERGENCY DEPARTMENT” BEFORE THE WORD “SAFE,” THAT THE WORD “PATIENT” BEFORE THE WORD “DISCHARGE” BE DELETED, THAT THE SECOND RESOLVED BE AMENDED BY ADDING THE WORD “MANDATED” BEFORE THE WORD “SAFE,” THE WORD “CONCEPT” BE ADDED AFTER THE WORD “DISCHARGE,” THE WORD “MANDATE” BE DELETED AFTER THE WORD “DISCHARGE,” AND THE WORD “SUPPORTS” BE CHANGED TO “SUPPORT.” The motion was adopted.

It was moved THAT THE RESOLUTION BE AMENDED TO READ:

RESOLVED, THAT ACEP SUPPORT ADVOCACY AND ENGAGEMENT OF STAKEHOLDERS TO ASSURE A ROBUST SAFETY NET WITH ADEQUATE FINANCIAL RESOURCES AND COMMUNITY RESOURCES TO SUPPORT PATIENTS ON DISCHARGE; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSE LOCAL, STATE, AND FEDERAL MANDATES ON DISCHARGE REQUIREMENTS. The motion was adopted.

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

RESOLVED, THAT ACEP OPPOSES ANDY "SAFE DISCHARGE" MANDATES AND BELIEVES THAT DISCHARGE FROM THE ED IS A CLINICAL DECISION OF THE EMERGENCY PHYSICIAN; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSE LOCAL, STATE, AND FEDERAL MANDATES ON DISCHARGE REQUIREMENTS.

It was MOVED THAT AMENDED RESOLUTION 21 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 Resolution 24 be adopted.

It was moved THAT RESOLUTION 24 BE ADOPTED.

It was moved THAT THE WORDS "IMPOSITION OF" IN THE FIRST RESOLVED BE REPLACED WITH THE WORD "PROHIBITIVE." The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Resolution 27 be referred to the Board of Directors.

It was moved THAT RESOLUTION 27 BE ADOPTED.

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

The committee recommended that Resolution 28 be referred to the Board of Directors.

It was moved THAT RESOLUTION 28 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 29 be adopted.

It was moved THAT RESOLUTION 29 BE ADOPTED.

There was no objection to replacing the "provider" with the word "clinician." The motion was then voted on and adopted.

The committee recommended that Amended Resolution 33 be adopted.

It was moved THAT AMENDED RESOLUTION 33 BE ADOPTED:

RESOLVED, THAT ACEP OPPOSES THE PRACTICE OF SEPARATING MIGRATING CHILDREN FROM THEIR CAREGIVERS IN THE ABSENCE OF IMMEDIATE PHYSICAL OR EMOTIONAL THREATS TO THE CHILD'S WELL-BEING.~~; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP GIVE PRIORITY TO SUPPORTING FAMILIES AND PROTECTING THE HEALTH AND WELL-BEING OF THE MIGRATING CHILDREN WITHIN THOSE FAMILIES WHERE THE CHILDREN HAVE BEEN REMOVED; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP WORK WITH APPROPRIATE AUTHORITIES TO ENCOURAGE AND FACILITATE THE REUNIFICATION OF SEPARATED MIGRATING CHILDREN WITH THEIR CAREGIVERS IMMEDIATELY.~~

It was moved THAT THE WORD "CAREGIVERS" BE REPLACED WITH THE WORD "PARENTS." The motion was not adopted.

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

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

RESOLVED, THAT ACEP SUPPORT EMERGENCY PHYSICIANS WHO PROTECT THE HEALTH AND WELL-BEING OF MIGRATING CHILDREN SEPARATED FROM THEIR FAMILIES. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Resolution 35 be referred to the Board of Directors.

It was moved THAT RESOLUTION 35 BE ADOPTED.

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

REFERENCE COMMITTEE C

Dr. Smith 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: Amended Resolution 38, Amended Resolution 39, Resolution 40, Amended Resolution 41, Substitute Resolution 44, Amended Resolution 45, Amended Resolution 46, Amended Resolution 47, and Amended Resolution 48.

Not for adoption: Resolution 43.

For referral: Resolution 42.

Amended Resolution 41 and Amended Resolution 47 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 38

RESOLVED, THAT ACEP ~~ISSUE A PUBLIC STATEMENT~~ **WORK WITH RELEVANT STAKEHOLDERS TO EDUCATE THE PUBLIC** ON THE ~~PUBLIC~~ HEALTH IMPLICATIONS OF ANTIMICROBIAL RESISTANCE AND THE IMPORTANCE OF ANTIMICROBIAL STEWARDSHIP IN THE EMERGENCY DEPARTMENT; AND BE IT FURTHER

RESOLVED, THAT ACEP OFFER EDUCATION AIMED AT EMERGENCY DEPARTMENT ~~PROVIDERS~~ **CLINICIANS** ON THE HAZARDS OF ANTIMICROBIAL OVERUSE AND STRATEGIES TO PRESCRIBE ANTIMICROBIALS APPROPRIATELY; AND BE IT FURTHER

RESOLVED, THAT ACEP DISSEMINATE AN EVIDENCE-BASED RESOURCE AND/OR TOOLKIT FOR EMERGENCY DEPARTMENT ~~PROVIDERS~~ **CLINICIANS** TO IDENTIFY AND IMPLEMENT CLINICIAN-LEVEL AND SYSTEM-LEVEL OPPORTUNITIES FOR ANTIMICROBIAL AVOIDANCE.

AMENDED RESOLUTION 39

RESOLVED, THAT ACEP DEVELOP A **PSYCHIATRIC BOARDING** TOOLKIT TO HELP ~~PHYSICIANS AT THE BEDSIDE~~ ADDRESS THE FOLLOWING:

- PATIENT HANDOFF AND FREQUENCY OF EVALUATION WHILE BOARDING;
- ACTIVITIES OF DAILY LIVING FOR THE BOARDED PATIENT; ~~AND~~
- INITIATION OF MENTAL HEALTH TREATMENT WHILE BOARDING; **AND**
- **DEVELOPMENT OF ED PSYCHIATRIC OBSERVATIONAL MEDICINE.**

SUBSTITUTE RESOLUTION 44

RESOLVED, THAT ACEP UPDATE THE FIREARM SAFETY AND INJURY PREVENTION POLICY TO REFLECT THE CURRENT STATE OF RESEARCH AND LEGISLATION.

AMENDED RESOLUTION 45

~~RESOLVED, THAT ACEP AMEND ITS "FIREARM SAFETY AND INJURY PREVENTION" POLICY STATEMENT TO SUPPORT EXTREME RISK PROTECTION ORDERS; AND BE IT FURTHER~~

RESOLVED, THAT ACEP SUPPORT EXTREME RISK PROTECTION ORDERS LEGISLATION AT THE NATIONAL LEVEL; AND BE IT FURTHER.

RESOLVED, THAT ACEP PROMOTE AND ASSIST STATE CHAPTERS IN THE PASSAGE OF STATE LEGISLATION TO ENACT EXTREME RISK PROTECTION ORDERS BY CREATING A TOOLKIT AND OTHER APPROPRIATE RESOURCES TO DISSEMINATE TO STATE CHAPTERS; AND BE IT FURTHER

RESOLVED, THAT ACEP ENCOURAGE AND SUPPORT **FURTHER** RESEARCH OF THE EFFECTIVENESS AND RAMIFICATIONS OF EXTREME RISK PROTECTION ORDERS (ERPO) AND GUN VIOLENCE RESTRAINING ORDERS (GVRO).

AMENDED RESOLUTION 46

RESOLVED, THAT ACEP REVISE THE POLICY STATEMENT "LAW ENFORCEMENT INFORMATION GATHERING IN THE EMERGENCY DEPARTMENT" TO ~~TAKE INTO ACCOUNT~~ **REFLECT** THE RECENT RELEVANT COURT DECISIONS REGARDING CONSENT FOR SEARCHES WITH OR WITHOUT A WARRANT ~~IN INVESTIGATIONS OF DRIVING UNDER THE INFLUENCE~~ TO PROVIDE CLARIFICATION AND GUIDANCE TO EMERGENCY PHYSICIANS ON THEIR ETHICAL AND LEGAL OBLIGATIONS ON THIS ISSUE.

AMENDED RESOLUTION 48 (with revised title ~~Surreptitious~~ Recording in the Emergency Department)

RESOLVED, THAT ACEP EXPLORE IMPLICATIONS, SOLUTIONS, AND EDUCATION/TRAINING TO ADDRESS ~~SURREPTITIOUS~~ (AUDIO/VIDEO) RECORDING IN THE EMERGENCY DEPARTMENT **TO INCLUDE SURREPTITIOUS RECORDING**; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH OTHER INTERESTED PARTIES, SUCH AS THE AMERICAN MEDICAL ASSOCIATION AND AMERICAN HOSPITAL ASSOCIATION, TO COORDINATE REGULATORY AND LEGISLATIVE EFFORTS TO ADDRESS THE IMPLICATIONS OF ~~SURREPTITIOUS~~ (AUDIO/VIDEO) RECORDING IN THE EMERGENCY DEPARTMENT.

The committee recommended that Amended Resolution 36 be adopted.

It was moved THAT AMENDED RESOLUTION 36 BE ADOPTED:

RESOLVED, ~~THAT ACEP ALIGN WITH AND ADOPT AS ACEP POLICY THE FOLLOWING RELEVANT SECTIONS OF THE AMERICAN MEDICAL ASSOCIATION'S POLICY: "CANNABIS AND CANNABINOID RESEARCH H-95.952":~~
~~(1) ACEP SUPPORTS FURTHER ADEQUATE AND~~ **THAT ACEP SUPPORTS** WELL-CONTROLLED STUDIES OF MARIJUANA AND RELATED CANNABINOIDS **FOR MEDICAL USE** IN PATIENTS WHO HAVE SERIOUS CONDITIONS FOR WHICH PRECLINICAL, ANECDOTAL, OR CONTROLLED EVIDENCE SUGGESTS POSSIBLE EFFICACY **OR HARM** AND THE APPLICATION OF SUCH RESULTS TO THE UNDERSTANDING AND TREATMENT OF DISEASE.

~~(2) ACEP SUPPORTS THAT MARIJUANA'S STATUS AS A FEDERAL SCHEDULE I CONTROLLED SUBSTANCE BE REVIEWED WITH THE GOAL OF FACILITATING THE CONDUCT OF CLINICAL RESEARCH AND DEVELOPMENT OF CANNABINOID-BASED MEDICINES, AND ALTERNATE DELIVERY METHODS. THIS SHOULD NOT BE VIEWED AS AN ENDORSEMENT OF STATE-BASED MEDICAL CANNABIS PROGRAMS, THE LEGALIZATION OF MARIJUANA, OR THAT SCIENTIFIC EVIDENCE ON THE THERAPEUTIC USE OF CANNABIS MEETS THE CURRENT STANDARDS FOR A PRESCRIPTION DRUG PRODUCT.~~

It was moved THAT THE RESOLUTION BE AMENDED BY ADDITION OF A LAST SENTENCE TO READ:

THIS SHOULD NOT BE VIEWED AS AN ENDORSEMENT OF STATE-BASED MEDICAL CANNABIS PROGRAMS, THE LEGALIZATION OF MARIJUANA, OR THAT SCIENTIFIC EVIDENCE ON THE THERAPEUTIC USE OF CANNABIS MEETS THE CURRENT STANDARDS FOR A PRESCRIPTION DRUG PRODUCT. The motion was not adopted.

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

RESOLVED, THAT ACEP SUPPORTS RESCHEDULING OF MARIJUANA TO FACILITATE WELL-CONTROLLED STUDIES OF MARIJUANA AND RELATED CANNABINOIDS FOR MEDICAL USE IN PATIENTS WHO HAVE SERIOUS CONDITIONS FOR WHICH PRECLINICAL, ANECDOTAL, OR CONTROLLED EVIDENCE SUGGESTS POSSIBLE EFFICACY OR HARM AND THE APPLICATION OF SUCH RESULTS TO THE UNDERSTANDING AND TREATMENT OF DISEASE.

It was moved THAT THE WORDS "OR HARM" BE DELETED. The motion was not adopted.

The motion was then voted on and adopted.

There was consensus to replace the word "marijuana" with the word "cannabis." The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 37 be adopted.

It was moved THAT AMENDED RESOLUTION 37 BE ADOPTED:

RESOLVED, ~~THAT ACEP ALIGN WITH AND ADOPT AS ACEP POLICY THE FOLLOWING RELEVANT SECTION OF THE AMERICAN MEDICAL ASSOCIATION'S POLICY: "CANNABIS AND CANNABINOID RESEARCH H-95.952":~~

ACEP URGES LEGISLATURES TO DELAY ~~INITIATING THE~~ **NEW** LEGALIZATION OF CANNABIS FOR RECREATIONAL USE UNTIL ~~FURTHER~~ RESEARCH IS ~~COMPLETED~~ **AVAILABLE** ON THE PUBLIC HEALTH, MEDICAL, ECONOMIC, AND SOCIAL CONSEQUENCES OF ITS USE; AND BE IT FURTHER

RESOLVED, ~~THAT ACEP ALIGN WITH AND ADOPT AS ACEP POLICY THE FOLLOWING RELEVANT SECTIONS OF THE AMERICAN MEDICAL ASSOCIATION'S POLICY: "CANNABIS LEGALIZATION FOR RECREATIONAL USE H-95.924":~~

ACEP ~~BELIEVES THAT THE SALE OF CANNABIS FOR RECREATIONAL USE SHOULD NOT BE LEGALIZED; AND~~ DISCOURAGES CANNABIS USE~~, ESPECIALLY BY PERSONS VULNERABLE TO THE DRUG'S EFFECTS AND~~ IN HIGH-RISK POPULATIONS SUCH AS YOUTH, PREGNANT WOMEN, AND WOMEN WHO ARE BREASTFEEDING.

It was moved THE RESOLUTION BE AMENDED BY SUBSTITUTION TO READ:

ACEP DISCOURAGES RECREATIONAL CANNABIS USE AND URGES THE PUBLIC AND LEGISLATURES TO DELAY LEGALIATION OR DECRIMINALIZATION OF CANNABIS FOR RECREATIONAL USE UNTIL RESEARCH IS AVAILABLE ON THE PUBLIC HEALTH, MEDICAL, ECONOMIC, AND SOCIAL CONSEQUENCES OF ITS USE. The motion was not adopted.

It was moved THAT THE WORD "FURTHER" BE RETAINED. The motion was not adopted.

It was moved THAT EACH RESOLVED BE VOTED ON SEPARATELY. The motion was not adopted.

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

The Council recessed at 12:00 pm for the awards luncheon and reconvened at 1:45 pm on Sunday, September 30, 2018.

The committee recommended that Amended Resolution 41 be adopted.

It was moved THAT AMENDED RESOLTUION 41 BE ADOPTED.

RESOLVED, THAT ACEP DEVELOP A ~~POLICY STATEMENT~~ **TOOLKIT TO** ADDRESS~~ING THE EMERGENCY DEPARTMENT AND~~ THE EMERGENCY PHYSICIAN**'S** ROLE AND RESPONSIBILITY FOR THE COMPLETION OF DEATH CERTIFICATES FOR PATIENTS WHO HAVE DIED IN THE EMERGENCY DEPARTMENT UNDER THEIR CARE.

It was moved THAT THE RESOLUTION BE AMENDED BY SUBSTITUTION OF THE ORIGINAL RESOLUTION. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 47 be adopted.

It was moved THAT AMENDED RESOLUTION BE ADOPTED:

~~RESOLVED, THAT ACEP PROMOTES THE USE OF MEDICATION FOR OPIOID USE DISORDER, WHERE CLINICALLY APPROPRIATE, FOR EMERGENCY DEPARTMENT PATIENTS WITH OPIOID USE DISORDER; AND BE IT FURTHER~~

RESOLVED, THAT ACEP WORKS WITH THE PAIN MANAGEMENT & ADDICTION MEDICINE SECTION TO DEVELOP A ~~CLINICAL POLICY~~ **GUIDELINE** ON THE INITIATION OF MEDICATION FOR OPIOID USE DISORDER FOR **APPROPRIATE** EMERGENCY DEPARTMENT PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATES FOR POLICY CHANGES THAT LOWER THE REGULATORY BARRIERS TO INITIATING MEDICATION FOR OPIOID USE DISORDER IN THE EMERGENCY DEPARTMENT; AND BE IT FURTHER

~~RESOLVED, THAT UNTIL BARRIERS TO INITIATING MEDICATION FOR OPIOID USE DISORDER IN THE EMERGENCY DEPARTMENT ARE LOWERED, ACEP PARTNERS WITH THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMSHA) TO CREATE TRAINING THAT FULFILLS THE EXISTING REQUIREMENT FOR 8 HOUR BUPRENORPHINE TRAINING WHILE BEING MORE RELEVANT TO THE EMERGENCY DEPARTMENT CONTEXT; AND BE IT FURTHER~~

RESOLVED, THAT ACEP SUPPORTS THE EXPANSION OF OUTPATIENT OPIOID TREATMENT PROGRAMS AND PARTNERSHIP WITH ADDICTION MEDICINE SPECIALISTS TO IMPROVE ED TO OUTPATIENT CARE TRANSITIONS.

It was moved THAT THE WORDS "AND INPATIENT" BE ADDED BEFORE THE WORD "OPIOID" IN THE THIRD RESOLVED. The motion was adopted.

The amended main motion was then voted on and adopted.

REFERENCE COMMITTEE A

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Amended Resolution 11, Resolution 12, Amended Resolution 13, Amended Resolution 14,

Resolution 16, and Resolution 20.

Not for adoption: Resolution 10.

Amended Resolution 13 was extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDEED RESOLUTION 11

RESOLVED, THAT THE COUNCIL STANDING RULES BE AMENDED TO INCLUDE A NEW SECTION TITLED "LEADERSHIP DEVELOPMENT ADVISORY GROUP" TO READ:

"**THE LEADERSHIP DEVELOPMENT ADVISORY ~~GROUP~~ COMMITTEE (LDA~~G~~C) ~~SHALL BE~~ IS A COUNCIL COMMITTEE CHARGED WITH IDENTIFYING AND MENTORING DIVERSE COLLEGE MEMBERS TO SERVE IN COLLEGE LEADERSHIP ROLES. THE LDA~~G~~C 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."**

AMENDED RESOLUTION 14

RESOLVED, THAT ACEP STRONGLY ENCOURAGE ITS CHAPTERS TO APPOINT AND MENTOR COUNCILLORS AND ALTERNATE COUNCILLORS THAT REPRESENT THE DIVERSITY OF THEIR MEMBERSHIP, INCLUDING ~~CANDIDATE PHYSICIAN~~**, BUT NOT LIMITED TO RESIDENTS, FELLOWS,** AND YOUNG PHYSICIAN MEMBERS.

The committee recommended that Resolution 9 be adopted.

It was moved THAT RESOLUTION 9 BE ADOPTED:

RESOLVED, That the ACEP Bylaws Article VIII – Council be amended to read:

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),** 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. The motion was adopted.

The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 13 BE ADOPTED:

RESOLVED, THAT THE COUNCIL DIRECT THE COUNCIL OFFICERS TO APPOINT A TASK FORCE OF COUNCILLORS TO STUDY THE GROWTH OF THE COUNCIL AND DETERMINE WHETHER A BYLAWS AMENDMENT SHOULD BE SUBMITTED TO THE 2019 COUNCIL ~~LIMITING~~ **ADDRESSING** THE SIZE OF THE COUNCIL AND THE RELATIVE ALLOCATION OF COUNCILLORS. The motion was adopted.

The committee recommended that Resolution 15 not be adopted.

It was moved THAT RESOLUTION 15 BE ADOPTED.

It was moved THAT RESOLUTION 15 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The main motion was then voted on and was not 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 REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

It was moved THAT THE WORDS “SENTINEL EVENTS” BE REPLACED WITH THE WORDS “A ROOT CAUSE ANALYSIS (RCA).”

It was moved THAT THE WORDS “BY MEDICAL STAFF WELLNESS COMMITTEE” BE INSERTED AFTER “(RCA).” The motion was not adopted.

The main motion was then voted on and adopted.

It was moved THAT THE RESOLUTION BE AMENDED TO READ:

RESOLVED, THAT ACEP ACKNOWLEDGES THE UNIQUE ROLE THAT WORKPLACE FACTORS, AS WELL AS DEPARTMENTAL AND INSTITUTIONAL CULTURE PLAY IN PHYSICIAN SUICIDES, AND THAT ACEP BELIEVES THAT PHYSICIAN SUICIDES SHOULD ~~BE TREATED AS SENTINEL EVENTS THAT SHOULD BE~~ INVESTIGATED THROUGH INTERNAL AND CONFIDENTIAL REVIEW **LIMITED** TO ~~BETTER UNDERSTAND~~ WORKPLACE SYSTEMS, PROCESSES, AND CULTURE THAT CAN BE CHANGED TO REDUCE THE PROBABILITY OF FUTURE EVENTS~~; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP WORK WITH PARTNER ORGANIZATIONS, INCLUDING THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN HOSPITAL ASSOCIATION, AND THE NATIONAL ACADEMY OF MEDICINE TO ADVOCATE FOR THE ADOPTION OF POLICIES THAT CONSIDER PHYSICIAN SUICIDES AS SENTINEL EVENTS~~. The motion was not adopted.

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

The committee recommended that Resolution 18 be adopted.

It was moved THAT RESOLUTION 18 BE ADOPTED.

It was moved THAT THE RESOLUION BE AMENDED TO READ:

RESOLVED, THAT ACEP WORK WITH PARTNER ORGANIZATIONS TO PROMOTE A CULTURE WHERE PHYSICIAN MENTAL HEALTH ISSUES CAN BE ADDRESSED PROACTIVELY, CONFIDENTIALLY, AND SUPPORTIVELY, WITHOUT FEAR OF RETRIBUTION; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE AMERICAN MEDICAL ASSOCIATION, FEDERATION OF STATE MEDICAL BOARDS, AND THE AMERICAN PSYCHIATRIC ASSOCIATION TO ~~PETITION~~ **ENCOURAGE THOSE** STATE MEDICAL BOARDS ~~TO END THE PRACTICE OF~~ REQUESTING **THAT REQUEST** A BROAD REPORT OF MENTAL HEALTH INFORMATION ON LICENSURE APPLICATION FORMS **TO END THIS PRACTICE** UNLESS THERE IS A CURRENT DIAGNOSIS THAT CAUSES PHYSICIAN IMPAIRMENT OR POSES A POTENTIAL RISK OF HARM TO PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH ACEP CHAPTERS TO ENCOURAGE **THOSE** STATE MEDICAL BOARDS ~~TO AMEND THEIR QUESTIONS~~ **THAT INQUIRE** ABOUT BOTH THE PHYSICAL AND MENTAL HEALTH OF APPLICANTS TO USE THE LANGUAGE RECOMMENDED BY THE ~~AMERICAN PSYCHIATRIC ASSOCIATION~~ **FEDERATION OF STATE MEDICAL BOARDS**: "ARE YOU CURRENTLY SUFFERING FROM ANY CONDITION FOR WHICH YOU ARE NOT BEING APPROPRIATELY TREATED THAT IMPAIRS YOUR JUDGMENT OR THAT WOULD OTHERWISE ADVERSELY AFFECT YOUR ABILITY TO PRACTICE MEDICINE IN A COMPETENT, ETHICAL AND PROFESSIONAL MANNER?" The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 19 be adopted.

It was moved THAT AMENDED RESOLUTION 19 BE ADOPTED:

RESOLVED, THAT ACEP REAFFIRMS ITS POSITION ON THE IMPORTANCE OF SCHOLARSHIP **AS WELL AS PROTECTED CLINICAL HOURS FOR OUR CORE FACULTY TO TEACH OUR RESIDENTS** AND WILL ADVOCATE ~~AGGRESSIVELY~~ WITH THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION TO PRESERVE CORE FACULTY TEACHING AND ACADEMIC TIME, INCLUDING SUPPORT OF SCIENTIFICALLY RIGOROUS RESEARCH AND EDUCATION THAT IMPROVES THE PATIENT CARE IN EMERGENCY MEDICINE; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP MODEL POLICY LANGUAGE ON THE IMPORTANCE OF SCHOLARSHIP AND THE NEED FOR **SUPPORTED** CORE FACULTY TEACHING AND ACADEMIC TIME, WHICH TRAINING PROGRAMS CAN ACCESS AND PRESENT TO HOSPITAL SYSTEMS AS EVIDENCE FOR THE NEED FOR FINANCIAL SUPPORT FOR SCHOLARLY ACTIVITY **AND PROTECTED TEACHING ACADEMIC TIME;** AND BE IT FURTHER

RESOLVED, THAT ACEP EXPLORE ADDITIONAL WAYS TO PROVIDE FINANCIAL SUPPORT TO RESIDENCY AND TRAINING PROGRAMS **TO PROTECT CORE FACULTY** IN CARRYING OUT SCHOLARLY ACTIVITIES; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE COUNCIL OF EMERGENCY MEDICINE RESIDENCY DIRECTORS AND THE SOCIETY FOR ACADEMIC EMERGENCY MEDICINE TO ESTABLISH INITIATIVES AND PROCESSES TO ENSURE ALL AREAS OF SCHOLARSHIP **TEACHING TIME AND ACADEMIC TIME** ARE SUPPORTED; AND BE IT FURTHER

RESOLVED, THAT ACEP PROVIDE A STATEMENT TO THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION TO REQUEST THAT ACCREDITATION REQUIREMENTS FOR SCHOLARSHIP **AND PROTECTED CLINICAL TIME FOR TEACHING** BE EXPLICIT TO ENSURE INSTITUTIONAL AND PROGRAM FUNDING SUPPORT IS DIRECTED TOWARD THESE ACTIVITIES.

It was moved THAT THE TITLE OF THE RESOLUTION BE AMENDED TO READ: SUPPORT FOR ACGME FACULTY SCHOLARLY ACTIVITY. The motion was not adopted.

It was moved THAT THE FIRST AND SECOND RESOLVEDS BE AMENDED TO READ:

RESOLVED, THAT ACEP REAFFIRMS ~~ITS POSITION ON THE IMPORTANCE OF SCHOLARSHIP~~ ~~**AS WELL AS PROTECTED CLINICAL HOURS FOR**~~ **THE IMPORTANCE OF SCHOLARSHIP AND EDUCATION AS WELL AS SUPPORTED TIME FOR OUR CORE FACULTY FOR THESE ACTIVITIES** ~~**TO TEACH OUR RESIDENTS**~~ AND WILL ADVOCATE ~~AGGRESSIVELY~~ WITH THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION TO PRESERVE CORE FACULTY TEACHING AND ACADEMIC TIME, INCLUDING SUPPORT OF SCIENTIFICALLY RIGOROUS RESEARCH AND EDUCATION THAT IMPROVES THE PATIENT CARE IN EMERGENCY MEDICINE; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP MODEL POLICY LANGUAGE ON THE IMPORTANCE OF SCHOLARSHIP AND THE NEED FOR **SUPPORTED** CORE FACULTY TEACHING AND ACADEMIC TIME, WHICH TRAINING PROGRAMS CAN ACCESS AND PRESENT TO HOSPITAL SYSTEMS AS EVIDENCE FOR THE NEED FOR FINANCIAL SUPPORT FOR SCHOLARLY **AND EDUCATIONAL** ACTIVIT~~Y~~**IES** ~~**AND PROTECTED TEACHING ACADEMIC TIME**~~**;** AND BE IT FURTHER

The motion was not adopted.

The main motion was then voted on and adopted.

****

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

Dr. Kessler reported that 420 of the 421 councillors eligible for seating had been credentialed.

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

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

There being no further business, Dr. McManus adjourned the 2018 Council meeting at 4:54 pm on Sunday, September 30, 2018. The next meeting of the ACEP Council is scheduled for September 28-29, 2018, at the Hyatt Regency Denver at Colorado Convention Center in Denver, CO.

Respectfully submitted,

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

Approved by,

John G. McManus, Jr., MD, FACEP
Council Speaker

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Meeting
January 29, 2019
ACEP Headquarters
Irving, TX

Minutes

Speaker John McManus, MD, FACEP, called to order a regular meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:04 am Central time on Monday, Tuesday, January 29, 2019 at the ACEP headquarters in Irving, TX.

Steering Committee members present for all or portions of the meeting were: Michael Baker, MD, FACEP; Melissa Costello, MD, FACEP; Justin Fairless, DO, FACEP; Dan Freess, MD, FACEP; Muhammad Husainy, DO, FACEP; Gary Katz, MD, FACEP, vice speaker; Gabor Kelen, MD, FACEP; Chadd Kraus, DO, FACEP; Gregg Miller, MD, FACEP; Aimee Moulin, MD, FACEP; John McManus, MD, FACEP, speaker; Matthew Rudy, MD, FACEP; Sullivan Smith, MD, FACEP (phone); Susanne Spano, MD, FACEP; Arvind Venkat, MD, FACEP; and Nathan Vafaie, MD.

Other members and guests present for all or portions of the meeting were: Stephen Anderson, MD, FACEP; Erik Blutinger, MD; L. Anthony Cirillo, MD, FACEP; J.T. Finnell, MD, FACEP; Vidor Friedman, MD, FACEP, president; Jon Mark Hirshon, MD, FACEP; William Jaquis, MD, FACEP, president-elect; Christopher Kang, MD, FACEP; Paul Kivela, MD, FACEP, immediate past president; Michael McCrea, MD, FACEP; and Mark Rosenberg, DO, FACEP, secretary-treasurer.

Staff present for all or portions of the meeting were: Nancy Calaway, CAE; Tanya Downing; Mary Ellen Fletcher, CPC, CEDC; Maude Suprenant Hancock; Robert Heard, MBA, CAE; David McKenzie, CAE; Harry Monroe; Jana Nelson; Margaret Montgomery, RN; Sonja Montgomery, CAE; Leslie Moore, JD; Layla Powers; Shari Purpura; Loren Rives, MNA; Sam Shahid, MBBS, MPH; Dean Wilkerson, JD, MBA, CAE; Julie Wassom; Carole Wollard; and Laura Wooster, MPH.

Officer and Staff Reports
Speaker

Dr. McManus welcomed everyone and discussed preparations for the meeting.

Vice Speaker

Dr. Katz thanked everyone for their participation and commitment to the College.

President

Dr. Friedman discussed ACEP's federal strategy to address out-of-network balance billing.

President-Elect

Dr. Jaquis reported on the work of the Governance Task Force that he chaired and the changes that have been implemented regarding the Board of Directors roles and responsibilities.

Executive Director

Mr. Wilkerson distributed a copy of ACEP's annual report and provided an update on several ACEP initiatives: *ACEP18*, Clinical Emergency Data Registry, the recent staff reorganization, and the upcoming BalancED wellness conference.

Steering Committee Expectations

Dr. McManus reminded the Steering Committee of their expectation to attend the May 5, 2019, Steering Committee meeting in Washington, DC and the entire Leadership & Advocacy Conference May 5-8. The Steering Committee will also meet at 6:00 pm on Thursday, October 24, 2019, in Denver, the evening prior to the Council meeting. Steering Committee members were also reminded that supporting NEMPAC and EMF is strongly encouraged as part of their leadership role.

Councillor Allocation

Dr. McManus reported that councillor allocation for 2019 is 434, which is an increase of 13 councillors than were allocated for the 2018 meeting. AL, AK, FL, IL, MN, MS, MO, NJ, NY, OH, PA and SC each gained one councillor and CA gained three councillors. CO, DC, and MD each lost one councillor and Government Services lost two councillors. The Diversity, Inclusion, & Health Equity Section and the Locum Tenens Emergency Medicine met the met the minimum requirements of 100 members by December 31, 2018, adding two new councillors for 2019. The Forensic Medicine Section had 98 members and will not have a councillor at the 2019 meeting. The other 35 sections met the minimum requirement of 100 members and will have a councillor for the 2019 Council meeting.

One councillor was also allocated for the American College of Osteopathic Emergency Physicians (ACOEP). Staff are in the process of verifying that a majority of ACOEP members are also members of ACEP.

Growth of the Council Task Force

Dr. McCrea reported on the work of the task force to date. One conference call has been held. The task force expects to complete their work and recommendations by the May 5 Steering Committee meeting. It was suggested that the task force develop multiple options for the Council to consider and that the options be discussed as the Town Hall meeting topic.

ACEP Social Media

Ms. Calaway provided an overview of ACEP's social media action team.

Tellers, Credentials, & Elections Committee Report

Dr. Katz, on behalf of Dr. Kessler, presented a report from the Tellers, Credentials, & Elections Committee from the 2018 Council meeting, including the results of the demographic data questions. There were 421 councillors allocated for the 2018 meeting and 420 were credentialed. It was suggested that a survey be distributed to the Council following the 2019 meeting to obtain comments about the meeting.

2018 Council Meeting Minutes

The Steering Committee reviewed the draft 2018 Council meeting minutes. The minutes will be provided to the 2019 Council for approval at the annual meeting.

2018 Council Meeting

Dr. McManus and Dr. Katz discussed various aspects of the 2018 Council meeting and requested suggestions for potential changes for the 2019 meeting. The Steering Committee recommended that the Council continue to be encouraged to discuss resolution on engagED before the annual meeting. There was consensus to maintain the Town Hall meeting as an interactive session and allow time for questions and answers. Several topics were suggested for the Town Hall meeting:

- role of physician assistants and nurse practitioners in the ED
- wellness/burnout
- physician suicide

- growth of the Council and potential changes
- scope of emergency medicine practice
- psychiatric boarding

It was suggested that the Council officers consider two concurrent Town Hall meeting discussions. The Annual Meeting Subcommittee will review the Town Hall meeting format and provide suggestions for potential topics for the 2019 meeting. The subcommittee will also review the demographic data questions and provide suggestions for the 2019 questions. The Steering Committee suggested three questions for the subcommittee to consider:

1. Does your ED function without a board certified emergency physician, or without any physician coverage?
2. What percent of your ED's visits are seen exclusively by physician assistants or nurse practitioners?
3. Has your ED or group undertaken any initiatives to increase diversity?

Request from the American Osteopathic Board of Emergency Medicine (AOBEM)

Dr. McManus discussed AOBEM's request to address the Council at the annual meeting. He reviewed the differences between the American Board of Emergency Medicine (ABEM) and AOBEM and why ABEM has always provided a verbal and written report. The Steering Committee considered whether to allow written reports only and no verbal reports and instead allow ABEM and AOBEM to respond to questions from the Council and the option to submit a video report. There was consensus to allow ABEM and AOBEM to provide verbal reports and submit written reports.

The Council officers were encouraged to use the timer for all verbal reports and to consider moving some of the reports to the second day while election results are being tabulated. The Annual Meeting Subcommittee will review the timing of the reports and provide their recommendation to the Steering Committee.

Elections Process

Dr. McManus led a discussion of the campaign and elections process, including candidate videos, candidates as award recipients, travel restrictions, broadcast communications/mass mailings, potential spending limits for campaigning, monitoring of the campaign process, and ensuring compliance with the Candidate Campaign Rules. He reminded the Steering Committee that the Council Standing Rules give the Steering Committee the authority to develop and amend the Candidate Campaign Rules. Staff provided several housekeeping changes to the Candidate Campaign Rules for consideration. There was consensus to approve the housekeeping changes.

It was moved THAT THE CANDIDATE CAMPAIGN RULES, ITEM 13.I., BE AMENDED TO DELETE THE PROHIBITION TO MASS MAILINGS. The motion was adopted.

It was moved THAT THE STEERING COMMITTEE RECONDISER THEIR DECISION TO DELETE THE PROHIBITION TO MASS MAILINGS. The motion was adopted.

It was moved THAT THE PROHIBITION TO MASS MAILINGS BE RETAINED. The motion was adopted.

It was moved THAT THE TRAVEL RESTRICTIONs FOR PRESIDEN-ELECT CANDIDATES BE REMOVED. The motion was adopted.

It was clarified that travel restrictions for Speaker, Vice Speaker, and Board of Directors will remain in effect. There was consensus to approve the amended Candidate Campaign Rules.

It was suggested that the Candidate Forum discuss innovative ways (such as a webinar, Zoom Forum, etc.) to publicize the candidates to the Council and provide a recommendation to the Steering Committee.

Amended Resolution 11(15) Ethical Violations by Non-ACEP Members

Ms. Moore explained the difficulty and potential legal ramifications in implementing Amended Resolution 11(15) Ethical Violations by Non-ACEP Members that was adopted by the Council and the Board of Directors. She also reviewed the draft model state legislation developed by Mr. Monroe. The model legislation requires expert witnesses to be licensed in the state in which they are providing testimony as well as maintain expertise in emergency medicine. The Board will discuss a recommendation to rescind their motion to adopt Amended Resolution 11(15), overrule the resolution, and approve the model state legislation at their January 30-31, 2019, meeting. If the recommendation is approved, the vote and position of each Board member will be reported to the Steering Committee at the May 5, 2019, meeting and will also be provided to the 2019 Council.

Council Forum at the 2019 Leadership & Advocacy Conference (LAC)

Dr. Katz led a discussion regarding a Council Forum Session at the 2019 LAC. The Steering Committee expressed support for holding a session that is structured to discuss current issues that may necessitate a resolution and also review the "anatomy" of a resolution. It was suggested that the session be promoted with communications about LAC and to bring resolution ideas for discussion.

Action on Resolutions

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2018, 2017, and 2016 Council meetings were provided for review. The reports were assigned to the Annual Meeting Subcommittee for further review.

Subcommittee Appointments

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

Annual Meeting Subcommittee: Dr. Baker (Chair), Dr. Fairless, Dr. Freess, Dr. Husainy, Dr. Kelen, Dr. Miller, Dr. Moulin, Dr. Rudy, Dr. Spano, Dr. Vafaie, and Dr. Venkat.

Bylaws & Council Standing Rules Subcommittee: Dr. Kraus (Chair), Dr. Baker, Dr. Costello, Dr. Jackson, Dr. Kelen, Dr. Miller, Dr. Moulin, Dr. Rudy, Dr. Smith, Dr. Vafaie, and Dr. Venkat.

Candidate Forum Subcommittee: Dr. McManus (Chair), Dr. Costello, Dr. Fairless, Dr. Freess, Dr. Husainy, Dr. Jackson, Dr. Kraus, Dr. Rudy, Dr. Smith, and Dr. Spano.

The subcommittee objectives and deadlines will be provided by e-mail. The subcommittee reports will be discussed at the May 5, 2019, Steering Committee meeting.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Sunday, May 5, 2019, at the Grand Hyatt in Washington, DC.

With no further business, the meeting was adjourned at 2:10 pm Central time on Tuesday, January 29, 2019.

Respectfully submitted,

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

Approved by,

John G. McManus, Jr., MD, FACEP
Council Speaker and Chair

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Meeting
May 5, 2019
Grand Hyatt Washington
Washington, DC

Minutes

Speaker John McManus, MD, FACEP, called to order a regular meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:19 am Eastern time on Sunday, May 5, 2019, at the Grand Hyatt Washington in Washington, DC.

Steering Committee members present for all or portions of the meeting were: Michael Baker, MD, FACEP; Melissa Costello, MD, FACEP; Dan Freess, MD, FACEP; Muhammad Husainy, DO, FACEP; Gary Katz, MD, FACEP, vice speaker; Gabor Kelen, MD, FACEP; Chadd Kraus, DO, FACEP; Gregg Miller, MD, FACEP; John McManus, MD, FACEP, speaker; Matthew Rudy, MD, FACEP; Sullivan Smith, MD, FACEP; Susanne Spano, MD, FACEP; Arvind Venkat, MD, FACEP; and Nathan Vafaie, MD.

Other members and guests present for all or portions of the meeting were: J.T. Finnell, MD, FACEP; Vidor Friedman, MD, FACEP, president; Olga Gokova, MD; Jeff Goodloe, MD, FACEP; Kelly Gray-Eurom, MD, FACEP; Andrea Green, MD, FACEP; Alison Haddock, MD, FACEP; Sanford Herman, MD, FACEP; Jon Mark Hirshon, MD, FACEP; William Jaquis, MD, FACEP, president-elect; Christopher Kang, MD, FACEP; Paul Kivela, MD, FACEP, immediate past president; Michael McCrea, MD, FACEP; Scott Pasichow, MD; Mark Rosenberg, DO, FACEP, secretary-treasurer; Karina Sanchez, MD; Gillian Schmitz, MD, FACEP; and Liam Yore, MD, FACEP,

Staff present for all or portions of the meeting were: Robert Heard, MBA, CAE; Sonja Montgomery, CAE; Leslie Moore, JD; and Dean Wilkerson, JD, MBA, CAE.

Minutes

The minutes of the January 29, 2019, Steering Committee meeting were approved as written.

Officer and Staff Reports
Speaker

Dr. McManus thanked the Steering Committee subcommittees for their work and announced the 2019 Council awards recipients:

Council Meritorious Service Award – John Proctor, MD, FACEP
Council Teamwork Award – Laura Tilley, MD, FACEP; Anne Zink, MD, FACEP; Brad Gruehn; SHIELDS Act Team
Council Horizon Award – Zachary Jarou, MD
Council Champion in Diversity & Inclusion Award – Bruce Lo, MD, FACEP
Council Curmudgeon Award – Bradford Walters, MD, FACEP

Dr. McManus announced the 2019 candidates.

President-Elect: Jon Mark Hirshon, MD, FACEP (MD)
Mark Rosenberg, MD, FACEP (NJ)

Speaker: Gary Katz, MD, FACEP (OH) – unopposed

Vice Speaker: Kelly Gray-Eurom, MD, FACEP (FL)
Andrea Green, MD, FACEP (TX)
Howard Mell, MD, FACEP (IL)

Board of Directors: Michael Baker, MD, FACEP (MI)
Jeff Goodloe, MD, FACEP (OK)
Rachelle Greenman, MD, FACEP (NJ)
Gabor Kelen, MD, FACEP (AACEM)
Pamela Ross, MD, FACEP (VA)
Gillian Schmitz, MD, FACEP (incumbent – GS)
Ryan Stanton, MD, FACEP (KY)
Thomas Sugarman, MD, FACEP (CA)

Vice Speaker

Dr. Katz thanked everyone for their participation and commitment to the College.

President

Dr. Friedman reported on out-of-network/balance billing discussions and three potential legislative proposals.

President-Elect

Dr. Jaquis gave an overview of the two alternate payment models developed by ACEP and reported on the American Hospital Association (AHA) meeting he attended on May 4, 2019.

Executive Director

Mr. Wilkerson reported on attendance for the Legislative & Advocacy Conference, ACEP's membership and budget challenges, and new approaches to address the needs of international members.

Annual Meeting Subcommittee

Dr. Baker 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 2019 Town Hall meeting topic. The subcommittee did not recommend any changes to the format of the Town Hall meeting. There was consensus for the Town Hall meeting to focus on a single topic and present various aspects of the issue by high-level speakers/ content experts and include time for Q & A from the Council. The Council officers will make the final determination about the format, topic, and speakers this summer.

The subcommittee reviewed the Board's actions on 2016-2018 resolutions and concurred that the actions taken are consistent with the Council's expectations. The Actions on Resolutions reports will be updated to reflect additional activity that may have occurred since January 2019. The updated reports will be provided to the Council and will also be available in the Council section of the ACEP Website. The subcommittee recommended that the Council speaker highlight some of the actions on the prior year's resolutions during his report to the Council.

The subcommittee concurred that certain demographic questions should be asked every year to analyze demographic changes within the Council and that the survey should be brief with a maximum of 10 questions. The Steering Committee reviewed the draft questions developed by the subcommittee. The final questions will be developed in consultation with the Tellers, Credentials, & Elections Committee chair and approved by the Council officers.

The subcommittee reviewed the Council meeting agenda and the timing of verbal reports. The subcommittee recommended moving the EMF and NEMPAC reports to Day 2 while election results are being tabulated (or in between the various elections) but maintain the EMF and NEMPAC Council challenges that occur in the morning on Day 1. Status reports of the EMF and NEMPAC challenges would continue to be given throughout Day 2. It was

noted that moving some reports to in between election ballots could allow for a longer period of time for councillors to consider the next round of candidates for voting. There was consensus from the Steering Committee to retain the EMF and NEMPAC reports on Day 1 and find ways to expand the time to allow for thoughtful consideration of the second ballot during elections.

Bylaws & Council Standing Rules Subcommittee

Dr. Kraus presented the subcommittee's report on their assigned objectives. The subcommittee discussed whether the Council Standing Rules (CSR) "Elections Procedures" section, paragraph 2, should be revised to allow 60 seconds or 90 seconds for each ballot instead of the current 30 seconds. The Steering Committee did not support submitting a CSR resolution to make this change because 30 seconds is sufficient for voting the majority of the time. It was noted that the Tellers, Credentials, & Elections Committee chair has discretion to make adjustments in the timing for voting as needed.

The subcommittee discussed whether the Council meeting agenda should be revised to intersperse the elections between Reference Committee reports, or in between other business that needs to be conducted, instead of all elections occurring as the last order of business. There was no consensus from the Steering Committee to implement this change.

The subcommittee discussed the pros and cons of extending the Board of Directors term with no re-election required instead of the current three-year term with the ability to seek re-election. An alternative suggestion was for the Council to reaffirm the election of an incumbent instead of conducting an actual re-election. There was no consensus from the subcommittee or the Steering Committee to submit a Bylaws amendment to lengthen the Board of Directors term of office or eliminate the re-election process for incumbent candidates.

Other EM Organizations Seeking Representation in the ACEP Council

The Steering Committee discussed the College Manual "Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council." There was consensus for the Steering Committee to submit a College Manual amendment to the 2019 Council to clarify that other emergency medicine organizations seeking representation in the Council need to meet the eligibility criteria at the time the resolution is submitted.

Candidate Forum Subcommittee Report

Dr. McManus presented the subcommittee's report on their assigned objectives. The majority of the subcommittee's objectives will be completed this summer and during the 2019 Council meeting.

The subcommittee reviewed the Candidate Campaign Rules regarding "broadcast election communications and mass mailings" (13.i.). There was consensus that no revisions were needed to the Candidate Campaign Rules.

The subcommittee discussed potential additional ways to publicize the candidates to the Council. The Steering Committee did not support hosting a videoconference for the Council and the candidates in advance of the Council meeting. There was consensus that allowing candidates to participate in videoconferences or conference calls with chapters is sufficient.

Amended Resolution 11(15) Ethical Violations by Non-ACEP Members

Dr. McManus gave an overview of the Board of Directors discussion and subsequent position and vote to overrule Amended Resolution 11(15) Ethical Violations by Non-ACEP Members. A report of this action will be provided to the Council as directed by the Bylaws.

Growth of the Council Task Force Report

Dr. McCrea presented the task force's report. The Steering Committee supported having the 2019 Town Hall meeting feature this report and for the Council to discuss the various options presented to address the growth of the Council.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Thursday, October 24, 2019, at the Hyatt Regency at Colorado Convention Center in Denver, CO.

With no further business, the meeting was adjourned at 11:52 am Eastern time on Sunday, May 5, 2019

Respectfully submitted,

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

Approved by,

John G. McManus, Jr., MD, FACEP
Council Speaker and Chair

DEFINITION OF COUNCIL ACTIONS

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 9-22

Larisa M. Traill, MD, FACEP (MI), Chair
Mariana Karounos, DO MS, FACEP (NJ)
Kurtis Mayz, JD, MD, MBA, FACEP (IL)
Robert C. Solomon, MD, FACEP (PA)
James D. Thompson, MD, FACEP (CO)
L. Carlos Zapata, MD, FACEP (NY)

Leslie Moore, JD
Maude Surprenant Hancock

Reference Committee B
Advocacy & Public Policy
Resolutions 23-39

Catherine A. Marco, MD, FACEP (OH), Chair
Bradley Burmeister, MD (WI)
Zachary J. Jarou, MD (EMRA)
Thom R. Mitchell, MD, FACEP (TN)
Randy L. Pilgrim, MD, FACEP (LA)
Lindsay M. Weaver, MD, FACEP (IN)

Ryan McBride, MPP
Harry Monroe

Reference Committee C
Emergency Medicine Practice
Resolutions 40-54

Michael A. Turturro, MD, FACEP (PA) Chair
Sara A. Brown, MD, FACEP (IN)
Angela P. Cornelius, MD, FACEP (LA)
Steven M. Hochman, MD, FACEP (NJ)
Matthew J. Sanders, DO, FACEP (OH)
John C. Soud, DO, (FL)

Margaret Montgomery, RN, MSN
Travis Schulz, MLS, AHIP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

INTRODUCTION

2019 Annual Council Meeting
Thursday Evening, October 24 through Saturday, October 26, 2019
Hyatt Regency at the Colorado Convention Center

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 Council officer candidates, President-Elect candidates, Board of Directors candidates, and the resolutions.

The ACEP staff and your Council officers have prepared background information for the resolutions submitted by the deadline. Please review the resolutions and background information in advance of the Council meeting. *We strongly encourage online discussion of the resolutions via the Council's engagED (the Council's e-list) community.* Post a message to the engagED community by using this email address, acep_council@ConnectedCommunity.org.

Councillors and others receiving these materials are reminded that these items are yet to be considered by the Council and are for information only.

Only resolutions subsequently adopted by both the Council and the Board of Directors (except for Council Standing Rules resolutions) become official. For those of you who may be new to the Council resolution process, only the RESOLVED sections of the resolutions are considered by the Council. The WHEREAS statements are informational or explanatory only.

Additional documents may be added to the Council Meeting Web site over the next several days, so please check back if what you need is not currently available.

We are looking forward to seeing everyone in Denver!

Your Council officers,

John G. McManus, Jr., MD, MBA
Speaker

Gary R. Katz, MD, MBA, FACEP
Vice Speaker

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Paul D. Kivela, MD, MBA, FACEP *California Chapter*	
2	Commendation for Kevin M. Klauer, DO, EJD, FACEP *Ohio Chapter*	
3	Commendation for John G. McManus, Jr., MD, MBA, FACEP *Government Services Chapter*	
4	Commendation for Debra G. Perina, MD, FACEP *Virginia College of Emergency Physicians*	
5	Commendation for Rhonda R. Whitson, RHIA *Michael Brown, MD, MSc, FACEP* *Stephen Cantrill, MD, FACEP* *Stephen Karas, MD, FACEP* *Stephen Wolf, MD, FACEP*	
6	In Memory of Jonathan Eric Epstein, MD, FACEP *New York Chapter*	
7	In Memory of Rakesh Engineer, MD, FACEP *Ohio Chapter*	
8	In Memory of Kevin Scott Mickelson, MD, FACEP *Indiana Chapter*	
9	Criteria for Eligibility for EM Organizations Seeking Representation in the Council – College Manual Amendment *Council Steering Committee*	A
10	Procedures for Addressing Charges of Ethical Violations and Other Misconduct – College Manual Amendment *Ethics Committee* *Board of Directors*	A
11	International Member Eligibility for FACEP- Bylaws Amendment *Nicholas Peschanski, PhD, MD* *Rahul Sethi, MD*	A
12	ACEP Composition Annual Report *Emergency Medicine Resident's Association* *American Association of Women Emergency Physicians Section* *Diversity, Inclusion, & Health Equity Section*	A

Resolution #	Subject/Submitted by	Reference Committee
13	Eliminating Use of the Word "Provider" in All ACEP Communications *Utah Chapter*	A
14	Implicit Bias Awareness and Training *Elizabeth Dubey, MD, FACEP* *American Association of Women Emergency Physicians Section* *Diversity, Inclusion, & Health Equity Section* *Quality Improvement & Patient Safety Section* *Wisconsin Chapter*	A
15	Increased Transparency in NEMPAC Contributions *American Association of Women Emergency Physicians Section*	A
16	Opposition to the AAMC Standardized Video Interview *Emergency Medicine Residents' Association*	A
17	Pay Transparency *Sarah Hoper, MD, JD, FACEP* *American Association of Women Emergency Physicians Section* *Diversity, Inclusion, & Health Equity Section* *Quality Improvement & Patient Safety Section* *Wisconsin Chapter*	A
18	Promoting Emergency Medicine Physicians *Emergency Medicine Residents' Association* *Texas College of Emergency Physicians*	A
19	Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) *Illinois College of Emergency Physicians*	A
20	Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders *Illinois College of Emergency Physicians*	A
21	Video Conferencing for Chapter and Section Meetings *Hawaii Chapter*	A
22	Visual White Coat for Emergency Medicine Advocacy Efforts *Carrieann Drenten, MD, FACEP* *Douglas Gibson, MD, FACEP* *Vikant Gulati, MD, FACEP* *Susanne Spano, MD, FACEP* *Andrea Wagner, MD, FACEP* *Delaware Chapter*	A
23	Allow Emergency Physicians to Prescribe Buprenorphine *Alaska Chapter* *California Chapter* *New Mexico Chapter* *Oregon Chapter* *Washington Chapter* *Pain Management & Addiction Medicine Section*	B

Resolution #	Subject/Submitted by	Reference Committee
24	CMS Sepsis Core Measure and the Legal Standard of Care *Kyle Fischer, MD, FACEP* *Maryland Chapter* *New Jersey Chapter* *Ohio Chapter*	B
25	Rational Crystalloid Hydration in Sepsis *Illinois College of Emergency Physicians* *Maryland Chapter* *Pennsylvania College of Emergency Physicians* *South Carolina College of Emergency Physicians* *West Virginia Chapter*	B
26	EMTALA Professional Liability Coverage *Arjun Chanmugam, MD, FACEP* *Maryland Chapter* *New Jersey Chapter* *Ohio Chapter*	B
27	Ensuring Public Transparency & Safety by Protecting the Terms ED and ER as Markers of Physician-Led Care *Sean Ochsenbein, MD, MBA* *Nathaniel Westphal, MD*	B
28	Expanding the Benefits of EMTALA to Ensure the Safety of the Public *Darrell Calderon, MD* *Ricardo Martinez, MD, FACEP*	B
29	Extending Medicaid Coverage to 12-Months Postpartum *Sarah Hoper, MD, JD, FACEP* *Lisa Maurer, MD, FACEP* *Rachel Solnick, MD* *American Association of Women Emergency Physicians Section*	B
30	High Threat Emergency Casualty Care *David Callaway, MD, FACEP* *Eric Goralnick, MD, MS, FACEP* *Richard Kamin, MD, FACEP* *Gina Piazza, DO, FACEP* *E. Reed Smith, MD, FACEP* *Matthew Sztajnkrycer, MD, FACEP* *Disaster Medicine Section* *EMS-Prehospital Care Section* *Government Services Chapter* *Tactical Medicine Section*	B
31	Improving Emergency Physicians Utilization of Medication for Addiction Treatment *Missouri College of Emergency Physicians* *New Jersey Chapter* *Ohio ACEP*	B
32	Legal and Civil Penalties for the Routine Practice of Medicine *Kyle Fischer, MD, FACEP* *Maryland Chapter*	B

Resolution #	Subject/Submitted by	Reference Committee
33	National Medical Tort Reform as a "CMS Best Practice" *Bret Frey, MD, FACEP* *Nevada Chapter*	B
34	Opposing Naloxone Addition to the Prescription Drug Monitoring Program *Illinois College of Emergency Physicians* *Missouri College of Emergency Physicians* *Pennsylvania College of Emergency Physicians* *West Virginia Chapter*	B
35	Prudent Layperson Visit Downcoding *Georgia College of Emergency Physicians* *Missouri College of Emergency Physicians* *Ohio Chapter*	B
36	Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence *Illinois College of Emergency Physicians*	B
37	Single-Payer Health Insurance *Larry Bedard, MD, FACEP* *Kathleen Cowling, DO, MBA, FACEP* *Gregory Gafni-Pappas, DO, FACEP* *Jacob Manteuffel, MD, FACEP* *James Mitchiner, MD, MPH, FACEP* *Robert Solomon, MD, FACEP* *Nicholas Vasquez, MD, FACEP* *Bradford Walters, MD, FACEP*	B
38	Standards for Insurance Denials *Kerry Forrestal, MD, FACEP* *Mark Goldstein, MD, FACEP* *Maryland Chapter* *New Jersey Chapter*	B
39	Work Requirements for Medicaid Beneficiaries *Joseph J. Calabro, DO, FACEP* *Neal Cohen, MD* *Michael Gratson, MD, MHSA* *Dennis Hsieh, MD, JD* *James Maloy, MD* *Jacob Manteuffel, MD, FACEP* *Therese Mead, DO, FACEP* *Sar Medoff, MD, MPP* *James Mitchiner, MD, MPH, FACEP* *Dan Morhaim, MD, FACEP* *Larisa Traill, MD, FACEP* *Bradford Walters, MD, FACEP* *Nicholas Vasquez, MD, FACEP*	B
40	Advancing Quality Care in Rural Emergency Medicine *Rural Emergency Medicine Section* *Florida College of Emergency Physicians* *Idaho Chapter* *Nebraska Chapter* *West Virginia Chapter*	C

Resolution #	Subject/Submitted by	Reference Committee
41	Establish a Rural Emergency Care Advisory Board *Rural Emergency Medicine Section* *Young Physicians Section* *Alaska Chapter* *Florida College of Emergency Physicians* *Idaho Chapter* *Missouri College of Emergency Physicians* *Montana Chapter* *Nebraska Chapter* *Nevada Chapter* *New Mexico Chapter* *West Virginia Chapter* *Wyoming Chapter*	C
42	Artificial Intelligence in Emergency Medicine *Zach Jarou, MD* *John Rogers, MD, FACEP* *Emergency Medicine Informatics Section*	C
43	Droperidol is Safe to Use in the ED *Illinois College of Emergency Physicians* *Maryland Chapter* *Missouri College of Emergency Physicians* *Pennsylvania College of Emergency Physicians* *South Carolina College of Emergency Physicians* *West Virginia Chapter*	C
44	Independent ED Staffing by Non-Physician Providers *Indiana Chapter* *New Jersey Chapter* *Missouri College of Emergency Physicians* *Ohio Chapter*	C
45	Medical Neutrality *International Emergency Medicine Section* *Social Emergency Medicine Section*	C
46	Mental Health Care for Vulnerable Populations *Kerry Forrestal, MD, FACEP* *Erik Schobitz, MD, FACEP* *Maryland Chapter* *New Jersey Chapter*	C
47	Prevention of Self -Harm & Accidental Injury by Internet Challenges and Social Media Posts *Indiana Chapter*	C
48	Promotion of Maternal and Infant Health *Massachusetts College of Emergency Physicians*	C

Resolution #	Subject/Submitted by	Reference Committee
49	Protecting Emergency Physician Compensation During Contract Transitions Arizona *College of Emergency Physicians* *District of Columbia Chapter* *Idaho Chapter* *Illinois College of Emergency Physicians* *Maryland Chapter* *New Jersey Chapter* *Pennsylvania College of Emergency Physicians* *West Virginia Chapter*	C
50	Social Work in the Emergency Department *Social Emergency Medicine Section* *New York Chapter*	C
51	Stimulating Telemedicine Researchers and Programs *Alexander Chiu, MD, MBA, FACEP* *Mark E. Escott, MD, MPH, FACEP* *Adam Ash, DO, FACEP* *Joo Yup Shaun Chun MD, FACEP* *David Ernst, MD, FACEP* *Alina Ershova BA* *Hartmut Gross, MD, FACEP* *William Holubek, MD, FACEP* *Nizar Kifaieh, MD, MBA, FACEP* *Arkansas Chapter* *District of Columbia Chapter* *Hawaii Chapter* *Iowa Chapter* *Nebraska Chapter* *New Jersey Chapter* *New York Chapter* *Virginia College of Emergency Physicians* *West Virginia Chapter* *Critical Care Section* *EMS-Prehospital Care Section* *Wilderness Medicine Section*	C
52	Telehealth Emergency Physician Inclusion *Edward Shaheen, MD, FACEP* *Emergency Telehealth Section*	C
53	Supporting Vaccination for Preventable Diseases *Illinois College of Emergency Physicians*	C
54	Vaccine Preventable Illnesses Toolkit *New York Chapter*	C

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 1(19)

SUBMITTED BY: California Chapter

SUBJECT: Commendation for Paul D. Kivela, MD, MBA, FACEP

WHEREAS, Paul D. Kivela, MD, MBA, FACEP, has been an energetic and visionary leader for the American College of Emergency Physicians while serving on the Board of Directors 2010-19 and in his roles as Secretary-Treasurer 2013-14, Vice President 2014-15, President-Elect 2016-17, President 2017-18, and Immediate Past President 2018-19; and

WHEREAS, During his tenure on the Board of Directors, Dr. Kivela's top priority was to focus on initiatives that improved the daily lives and practice of emergency physicians; and

WHEREAS, Dr. Kivela facilitated several key initiatives for ACEP, including the redesign of the website, creation of the Reimbursement Leadership Development Program, development and promotion of the "Until Help Arrives" program, and outreach to other emergency medicine organizations; and

WHEREAS, Dr. Kivela was instrumental in ACEP moving forward with a comprehensive emergency medicine workforce study that addresses the future of emergency medicine practice for emergency physicians as well as the impact of nurse practitioners and physician assistants practicing in the emergency department; and

WHEREAS, Dr. Kivela has been a staunch advocate for preserving reimbursement for emergency physicians; and

WHEREAS, Dr. Kivela has served as a member, chair, and Board Liaison to various ACEP committees, task forces, and sections; and

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

WHEREAS, Dr. Kivela demonstrated leadership through chapter involvement as a member of the California Chapter and served on the Board of Directors 2001-06 and as President 2004-05; and

WHEREAS, Dr. Kivela maintained an active clinical schedule during his time on the ACEP Board of Directors; and

WHEREAS, In all his meetings and travels, Dr. Kivela represented the College with diplomacy and was a role model of commitment and productivity; and

WHEREAS, Dr. Kivela has contributed to the growth and maturation of emergency medicine and will continue to be committed to its cause and mission; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Paul D. Kivela, MD, MBA, FACEP, for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 2(19)

SUBMITTED BY: Ohio Chapter

SUBJECT: Commendation for Kevin M. Klauer, DO, EJD, FACEP

WHEREAS, Kevin M. Klauer, DO, EJD, FACEP, has been a steadfast and dedicated member of the American College of Emergency Physicians since 1992; and

WHEREAS, Dr. Klauer served on the Board of Directors of the Emergency Medicine Residents' Association as secretary 1993-95; and

WHEREAS, Dr. Klauer served on the Ohio Chapter Board of Directors 1998-08 and as chapter president 2002-03; and

WHEREAS, Dr. Klauer has a long history of service to the Council as a councillor, alternate councillor, and as a member and chair of several Council committees, including the Council Steering Committee, Candidate Forum Subcommittee, Council Awards Committee, Nominating Committee, Leadership Development Advisory Group, and Reference Committees, and he was ultimately elected as Vice Speaker in 2011 and Speaker in 2013; and

WHEREAS, Dr. Klauer was elected to the national ACEP Board of Directors in 2016 and brought the depth and breadth of his experience to his role on the Board of Directors; and

WHEREAS, Dr. Klauer served as the Medical Editor in Chief of *ACEP Now* for six years and through his tireless efforts transformed the publication, which resulted in numerous awards for journalistic excellence and reinforced *ACEP Now* as "The Official Voice of Emergency Medicine;" and

WHEREAS, Dr. Klauer served as a member, chair, and Board Liaison to various ACEP committees, task forces, and sections; and

WHEREAS, Dr. Klauer has been an articulate spokesperson for ACEP's advocacy agenda and a champion for the National Emergency Medicine Political Action Committee by serving on its Board of Trustees 2010-19 and working to increase contributions to advance critical issues for ACEP members; and

WHEREAS, Dr. Klauer is a visionary and influential leader with a distinguished career in emergency medicine as a clinician, educator, and mentor and has received many awards and accolades; therefore be it

RESOLVED, That the American College of Emergency Physicians extends heartfelt appreciation and gratitude and commends Kevin M. Klauer, DO, EJD, FACEP, for his dedication as an emergency physician and his outstanding service and leadership to the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 3(19)

SUBMITTED BY: Government Services Chapter

SUBJECT: Commendation for John G. McManus, Jr., MD, MBA, FACEP

WHEREAS, John G. McManus, Jr., MD, MBA, FACEP, has served the American College of Emergency Physicians with distinction and dedication as Council Vice Speaker 2015-17 and Council Speaker 2017-19; and

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

WHEREAS, Dr. McManus deftly and efficiently led the Council during debate of contentious issues; and

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

WHEREAS, Dr. McManus welcomed and encouraged the participation of new councillors and alternate councillors on Council committees; and

WHEREAS, Dr. McManus has demonstrated a long history of service to the Council including serving as a councillor and alternate councillor and on various Council committees; and

WHEREAS, Dr. McManus has maintained an active presence in the Government Services Chapter and served on the Board of Directors 2003-08 and as president 2006-07; and

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

WHEREAS, Dr. McManus is a recognized leader, educator, and advocate for the specialty; and

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

RESOLVED, That the American College of Emergency Physicians commends John G. McManus, Jr., 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.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 4(19)

SUBMITTED BY: Virginia College of Emergency Physicians

SUBJECT: Commendation for Debra G. Perina, MD, FACEP

WHEREAS, Debra G. Perina, MD, FACEP, has served the American College of Emergency Physicians with honor and distinction since becoming a member in 1983; and

WHEREAS, Dr. Perina has served in many leadership roles at the national level, including the national ACEP Board of Directors 2013-19, chair of the Board 2017-18, as a member of the *ACEP Now* Editorial Board 2013-present, and as a member and Board Liaison to numerous committees, task forces, and sections; and

WHEREAS, As chair of the Board, Dr. Perina displayed extraordinary leadership by keeping participation balanced and meetings focused while guiding the Board through many difficult issues with exemplary and wise counsel; and

WHEREAS, During her tenure on the Board, Dr. Perina served as a liaison representative to the American Academy of Pediatrics and the American College of Surgeons – Committee on Trauma and provided keen insight for ACEP's relations with the American Board of Emergency Medicine, the Council of Emergency Medicine Residency Directors, the National Association of EMS Physicians, the Society of Academic Emergency Medicine, and other organizations; and

WHEREAS, Dr. Perina demonstrated leadership through chapter involvement as a member of the South Carolina College of Emergency Physicians 1983-94, the Board of Directors 1989-95, and as chapter president 1991-93, and as a member of the Virginia College of Emergency Physicians since 1995;

WHEREAS, Dr. Perina served the ACEP Council as a councillor 1992-94 and as an alternate councillor 2010-13; and

WHEREAS, Dr. Perina has helped train and mentor numerous emergency medicine residents, and has served as Professor, Department of Emergency Medicine at the University of Virginia, Charlottesville since 2012; and

WHEREAS, Dr. Perina's passion for emergency medicine includes serving on the Board of Directors of multiple emergency medicine organizations including the American Board of Emergency Medicine 2003-11 and as President 2009-10, the Council of Emergency Medicine Residency Directors 1996-05 and as President 2001-03, the National Association of EMS Physicians 2002-03, the Society for Academic Emergency Medicine 1997-98, and the Accreditation Council of Continuing Medical Education 2007-13 and as Chair 2010-2011; and

WHEREAS, Dr. Perina has enjoyed a distinguished career serving patients by continually striving for excellence in clinical care and as a compassionate and capable emergency physician; and

WHEREAS, Dr. Perina has contributed to the growth and maturation of emergency medicine and will continue to serve the College and the specialty of emergency medicine in the future; therefore, be it

RESOLVED, That the American College of Emergency Physicians commends Debra G. Perina, MD, FACEP, for her dedication as an emergency physician, educator, and leader in the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 5(19)

SUBMITTED BY: Michael Brown, MD, MSc, FACEP
Stephen Cantrill, MD, FACEP
Stephen Karas, MD, FACEP
Stephen Wolf, MD, FACEP

SUBJECT: Commendation for Rhonda R. Whitson, RHIA

WHEREAS, Rhonda R. Whitson, RHIA, served the American College of Emergency Physicians (ACEP) with distinction and dedication for nearly 33 years; and

WHEREAS, Ms. Whitson provided support to the Emergency Medicine Standards Task Force beginning in 1988 and later the Standards Committee and Clinical Policies Committee; and

WHEREAS, Ms. Whitson provided unwavering guidance to hundreds of members of the Clinical Policies Committee since its inception in 1992; and

WHEREAS, Ms. Whitson played a critical role in the evolution and development of the clinical policy process while providing advice and direction to the Clinical Policies Committee; and

WHEREAS, Ms. Whitson was instrumental in the development and publication of more than 60 clinical policies and 11 policy statements including ACEPs first clinical policy on chest pain in 1990; and

WHERAS Ms. Whitson was a vital part of the creation of the ACEP Member Wellness Booth and tirelessly involved in the development, growth, and implementation of the Member Wellness Booth for 26 years; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Rhonda R. Whitson, RHIA, for her service as Clinical Practice Manager.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 6(19)

SUBMITTED BY: New York Chapter

SUBJECT: In Memory of Jonathan Eric Epstein, MD, FACEP

WHEREAS, Jonathan Eric Epstein, MD, FACEP's very essence was about duty, responsibility, and kindness; and

WHEREAS, Dr. Epstein's entire career displayed his indefatigable work ethic, his intellect, and his dedication to improve the care of underserved populations, exemplified by collaboratively founding and leading the first ED-based observation unit among New York City public hospitals; and

WHEREAS, Dr. Epstein's career was driven by a commitment to service, working only in public hospitals, and creating clinical schedules that favored others above himself; and

WHEREAS, Dr. Epstein's even-keeled and steady leadership as Assistant Director of Emergency Medicine at Queens Hospital Center, one of New York City's busiest public hospitals, became instrumental in steering and grounding the department and its staff; and

WHEREAS, He advanced emergency medicine as an educator of students, residents and colleagues, and as an Assistant Professor at the Icahn School of Medicine at Mount Sinai; and

WHEREAS, He was reserved, but had a wry wit and dry sense of humor appreciated by all who knew him; and

WHEREAS, His devotion and love for his wife Stacey and son Steven were always evident, as was his loyalty and dedication to his family and friends; and

WHEREAS, Dr. Epstein was an avid attendee at ACEP events annually, both locally and nationally; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes Jonathan Eric Epstein, MD, FACEP, commemorates his dedication to emergency medicine and the College, and celebrates his many accomplishments during his too brief life and career.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 7(19)

SUBMITTED BY: Ohio Chapter

SUBJECT: In Memory of Rakesh Engineer, MD, .FACEP

WHEREAS, The field of emergency medicine lost an outstanding clinician and friend when Rakesh Engineer, MD, FACEP, passed unexpectedly in his sleep on May 10, 2019, at the age of 49; and

WHEREAS, Dr. Engineer earned his Bachelor of Science and Doctor of Medicine Degrees from The Ohio State University; and

WHEREAS, Dr. Engineer completed post-graduate training at Washington University in St. Louis, Missouri and Spectrum Health in Grand Rapids, Michigan; and

WHEREAS, Dr. Engineer devoted his 18 years of practice to the Cleveland Clinic and the Case Western Reserve University/MetroHealth/Cleveland Clinic residency program; and

WHEREAS, Dr. Engineer was an active member of Ohio ACEP, encouraging membership and participation from the beginning of residency; and

WHEREAS, Dr. Engineer contributed extensively to academic conferences, completing numerous research and quality improvement projects throughout his career, steadfast in his commitment to evidence-based medicine; and

WHEREAS, Dr. Engineer's legacy is concisely yet eloquently stated on an anonymous patient survey quote hanging in the halls of the Cleveland Clinic: "Dr. Engineer took great care of me"; and

WHEREAS, Dr. Engineer was a loving father and husband, always encouraging his residents and colleagues to spend quality time with their families; therefore be it

RESOLVED, That the American College of Emergency Physicians extends to the family of Rakesh Engineer, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his service to his residents and the countless patients who have benefited from his care.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 8(19)

SUBMITTED BY: North Dakota Chapter

SUBJECT: In Memory of Kevin Scott Mickelson, MD, FACEP

WHEREAS, With the untimely death of Kevin S. Mickelson, MD, FACEP, on Monday, July 15, 2019, ACEP lost a gifted communicator and a tireless emergency medicine advocate; and

WHEREAS, Dr. Mickelson received his medical degree from the University of North Dakota and completed his emergency medicine residency at Hennepin County Medical Center in Minneapolis, MN in 1986; and

WHEREAS, Dr. Mickelson is widely viewed by those who knew him from Hennepin County Medical Center as having performed in an outstanding fashion as a former resident, colleague, and friend in emergency medicine; and

WHEREAS, Dr. Mickelson possessed an enthusiastically positive outlook on life, projected a happy and gregarious demeanor, and whose personal interactions were a pleasure; and

WHEREAS, Dr. Mickelson had a long and distinguished service as a member of ACEP and the North Dakota Chapter for 30 years; and

WHEREAS, Dr. Mickelson served the North Dakota Chapter as councillor, president-elect, and then president; and

WHEREAS, Dr. Mickelson was a passionate witness on behalf of emergency physicians in the state legislature; and

WHEREAS, Dr. Mickelson served his community for 30 years as an emergency physician and tirelessly worked at St. Alexius Medical Center in Bismarck; and

WHEREAS, Dr. Mickelson additionally practiced emergency medicine in Fargo, ND where he touched many lives with his kindness, compassion, and desire to truly help mankind; and

WHEREAS, Dr. Mickelson was recognized for his deep empathy and compassion for medicine which earned him the exuberant gratitude and admiration of his patients; and

WHEREAS, Dr. Mickelson will be missed by his friends and colleagues who were privileged to know him for his strength of character, but most importantly that he knew kindness mattered; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with honor and appreciation the accomplishments and contributions of a gifted emergency physician, Kevin S. Mickelson, MD, FACEP, and extends condolences and gratitude to his wife, Colette, family, and friends for his service to the specialty of emergency medicine and to patient care.

2019 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 9-22

Larisa M. Traill, MD, FACEP (MI), Chair
Mariana Karounos, DO MS, FACEP (NJ)
Kurtis Mayz, JD, MD, MBA, FACEP (IL)
Robert C. Solomon, MD, FACEP (PA)
James D. Thompson, MD, FACEP (CO)
L. Carlos Zapata, MD, FACEP (NY)

Leslie Moore, JD
Maude Surprenant Hancock

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

College Manual Amendment

RESOLUTION: 9(19)

SUBMITTED BY: Council Steering Committee

SUBJECT: Criteria for Eligibility for EM Organizations Seeking Representation in the Council

PURPOSE: Amends the College Manual to clarify that the eligibility criteria for emergency medicine organizations seeking representation in the Council must be met at the time the representation is sought.

FISCAL IMPACT: Budgeted staff resources to update the College Manual.

WHEREAS, The ACEP Bylaws Article VIII – Council, Section 1 – Composition of the Council, paragraph two states: "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."; and

WHEREAS, The College Manual states that "a majority of the organization's physician members are ACEP members" but does not specify that this requirement must be met at the time the Bylaws resolution is submitted; therefore be it

RESOLVED, That the College Manual be amended to read:

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.

Background

This resolution amends the College Manual to clarify that the eligibility for emergency medicine organizations seeking representation in the Council must be met at the time the representation is sought, i.e., when the resolution submitted.

The 2018 Council and the Board of Directors adopted resolution 9(18) ACOEP Councillor Allocation that amended the Bylaws to allocate one councillor to ACOEP. It was unknown at the time the resolution was submitted, and subsequently adopted, whether a majority of ACOEP's members were also members of ACEP. Staff were not successful in obtaining the ACOEP membership data for a comparison with ACEP membership data before the 2018 Council meeting. It was clarified at the Council meeting that the membership comparison would be completed based on the ACOEP membership as of December 31, 2018. This date is consistent with the Bylaws Article VIII – Council, Section 1 – Composition of the Council, that states: "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."

The membership data comparison of ACEP and ACOEP members was completed by February 5, 2019. Multiple reviews were conducted to verify the information, including a manual search of each non-member name to ensure that names were not missed when the electronic comparison was conducted. The analysis revealed that only 28% of ACOEP's physician members were ACEP members, therefore, ACOEP was not eligible for a councillor for the 2019 Council meeting.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective F – Provide and promote leadership development among emergency medicine organizations and strengthen liaison relationships.

Fiscal Impact

Budgeted staff resources to update the College Manual.

Prior Council Action

Resolution 9(18) ACOEP Councillor Allocation adopted.

Resolution 5(15) EMRA Councillor Allocation adopted. Increased EMRA's councillor allocation from four councillors to eight councillors.

Resolution 13(13) Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council – College Manual Amendment adopted. Amended the College Manual to include criteria for eligibility and approval of organizations seeking representation in the Council.

Resolution 9(13) Criteria for Inclusion of Organizations in the ACEP Council – Bylaws Amendment adopted. Amended the Bylaws to specify that organizations seeking representation in the Council must meet the criteria in the College Manual.

Resolution 12(12) Criteria for Inclusion of Organizations in the ACEP Council adopted. Tasked the Council Steering Committee to develop criteria for inclusion of additional organizations as component bodies of the Council and develop a report for the 2013 ACEP Council no later than six weeks prior to the deadline for submission of regular resolutions.

Resolution 17(11) SAEM Councillor Allocation adopted. Established that SAEM will be allocated one councillor.

Resolution 7(10) CORD Councillor Allocation adopted. Established that CORD will be allocated one councillor.

Resolution 8(09) AACEM Councillor Allocation adopted. Established that AACEM will be allocated one councillor.

Resolution 2(92) EMRA Councillor Allotment adopted. Increased EMRA's councillor allocation from two seats to four.

Resolution 1(88) EMRA Councillor Allotment adopted. Increased EMRA's councillor allocation to two seats.

Resolution 2(76) adopted, which codified in the Bylaws the allocation of one councillor for EMRA.

Resolution 1(75) adopted, which allocated one councillor for EMRA at the 1975 Council meeting with full voting privileges and future representation to be determined.

Prior Board Action

Resolution 9(18) ACOEP Councillor Allocation adopted.

Resolution 5(15) EMRA Councillor Allocation adopted.

Resolution 13(13) Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council adopted.

Resolution 9(13) Criteria for Inclusion of Organizations in the ACEP Council – Bylaws Amendment adopted.

Resolution 12(12) Criteria for Inclusion of Organizations in the ACEP Council adopted. Resolution 17(11) SAEM Councillor Allocation adopted.

Resolution 7(10) CORD Councillor Allocation adopted.

Resolution 8(09) AACEM Councillor Allocation adopted.

October 1992, Resolution 2(92) EMRA Councillor Allotment adopted.

September 1988, Resolution 1(88) EMRA Councillor Allotment adopted.

October 1976, Resolution 2(76) adopted.

October 1975, Resolution 1(75) adopted.

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

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

College Manual Amendment

RESOLUTION: 10(19)

SUBMITTED BY: Ethics Committee
Board of Directors

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

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

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The review of complaints regarding ethical violations or other matters requires adequate due process to ensure it is fair to both the complainant and respondent; and

WHEREAS, A review by legal counsel, the ACEP Board of Directors and a subcommittee of the Ethics Committee determined that a more efficient complaint review process is needed based upon the increasing number of ethics complaints filed annually; and

WHEREAS, The ACEP Board of Directors approved a revision to the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* at its meeting in June 2019; and

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

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

Procedures for Addressing Charges of Ethical Violations and Other Misconduct

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

A. Definitions

1. **ACEP shall mean the American College of Emergency Physicians**
2. ***Code of Ethics* shall mean the *Code of Ethics for Emergency Physicians***
3. ***Principles of Ethics* shall mean *Principles of Ethics for Emergency Physicians***
4. ***Procedures* shall mean *Procedures for Addressing Charges of Ethical Violations and Other Misconduct***
5. **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**
6. **Bylaws Committee refers to the Bylaws Committee or appointed subcommittee**
7. **Board Hearing Panel consists of the ACEP Vice-President, Chair of the Board, and Board Liaison to the Ethics Committee or Bylaws Committee, as appropriate**

~~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 ACEP Bylaws, current ACEP ~~"~~*Principles of Ethics*, ~~for Emergency Physicians,"~~ other current ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within ~~twelve (12)~~ **seven (7)** 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 **guidelines and timetables**~~elements~~ that **will**~~must~~ be **followed**~~addressed~~ in **this matter. Requests complainant sign acknowledgement specifying intent to file** an ethics complaint **and to be bound by the *Procedures*.**

~~1.~~2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the ***Procedures***. ~~"Procedures for Addressing Charges of Ethical Violations and Other Misconduct" ("Procedures")~~

~~2.~~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.

~~3.~~4. a. Determines, in consultation with the ACEP President and the chair of the Ethics **Committee** ~~and/~~or **the** Bylaws Committee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the *Code of Ethics* **or**~~*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~~, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics* ~~*for Emergency Physicians*~~, and if so, forwards the complaint and the response together, as soon as both are received, to each member of the Ethics **Complaint Review Panel**~~Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose~~, or

c. Determines, in consultation with the **ACEP President and the Chair of the** Bylaws Committee ~~chair~~, that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, as soon as both are received, to each member of the Bylaws Committee, or at the discretion of the ~~chair~~**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**~~Board of Directors~~ will review the President's action**.** ~~at the next regularly scheduled Board meeting.~~ The President's action can be overturned by a majority vote of the **appropriate review bodies**. ~~Board, or~~

~~4.~~5. Within ten (10) business days after the determination~~s~~ specified in Section ~~B~~**C**.4.b. or Section ~~B~~**C**.4.c. of these *Procedures*, forwards the complaint to the respondent by **USPS Certified Mail**~~certified U.S. mail~~ with a copy of these *Procedures* and requests a written response within thirty (30) days of receipt of the documents. The communication will indicate that ACEP is providing notice of the complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the ~~Board~~ **appropriate review panel**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 **review and hearing panels**~~,~~ 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 **Complaint Review Panel or** ~~Committee,~~ the Bylaws Committee~~, or the subcommittee~~ appointed to review the complaint, as appropriate.

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

1. Reviews the written record of any complaint that alleges a violation of current~~the~~ ACEP *Principles of Ethics* or other current ACEP ethics policies ~~Bylaws~~ and the accompanying response**.**
2. Discusses the complaint and response by telephone conference call~~:~~ **.**
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Current ACEP *Principles of Ethics* or other current ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of current ACEP *Principles of Ethics* or other current ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.

~~6. Develops a report regarding the complaint and recommendation for action. Minority reports may also be presented.~~

~~7. The Ethics Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Ethics Committee shall recommend that the Board of Directors:~~

5. **Decides to**:

a. Dismiss the complaint; or
b. ~~Take disciplinary action, the specifics of which shall be included in the committee's report.~~ **Ethics Complaint Review Panel renders a decision to impose disciplinary action 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.

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 and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:

a. Current ACEP Bylaws apply.
b. Alleged behavior constitutes a violation of current ACEP Bylaws.
c. Alleged conduct warrants censure, suspension, or expulsion.

5. Decides to:

~~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. The Bylaws Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors:~~

a. Dismiss the complaint; or
b. ~~Take disciplinary action, the specifics of which shall be included in the committee's report.~~ **Bylaws Committee renders a decision to impose disciplinary action 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:~~
~~Render a decision to impose disciplinary action based on the written record.~~
~~4. If the Bylaws Committee Board determines to impose disciplinary action pursuant to Section E.53.b., the respondent will be provided with notification of the Bylaws Committee'sBoard's determination and the option of:~~
~~a. A hearing; or~~
~~b. The imposition of the Bylaws Committee'sBoard 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 **Ethics Complaint Review Panel or Bylaws Committee**~~Board~~ 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 G~~H~~. below. The respondent's request for a hearing must be submitted in writing to the Executive Director within thirty (30) ~~business~~ days of receipt of the notice of right to a hearing. In the event of no response, the ~~ACEP President may determine the manner of proceeding~~**applicable 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 **Hearing Panel**~~, its subcommittee pursuant to Section H.6. below, or an Ad Hoc Committee pursuant to Section F.,~~ intends to call in the hearing.
2. The Executive Director will send a notification **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 will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person. Hearings may not take place by telephone conference call.**
7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.
8. The Board **Hearing Panel**~~, its appointed subcommittee, or an Ad Hoc Committee~~ will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the

filing of any written briefs, conclude the hearing.

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

~~10.~~**9.** ~~The decision of the Board or Ad Hoc Committee~~ **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's or Ad Hoc Committee's~~ **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 appropriate committee or panel 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 Actions**

a. Censure~~**, Suspension, or Expulsion**~~

~~1. 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.2.~~ **B.2.** above**. The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or bylaw 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 bylaw 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 suspension to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.**

~~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 **announced in an appropriate ACEP publication. The published announcement**~~disclosed, but the fact that such a letter has been issued~~ shall **also state which ACEP policy or Bylaws provision was violated by**~~be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed.~~

~~b. Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.~~

~~c. Suspension: the dates of suspension, including whether or not~~ the member **and shall inform ACEP members that they**~~was reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which~~ may **request further information about the disciplinary**~~result in a report of such~~ 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~~ **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:~~**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.~~**appropriate 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~~ **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, **at which time the ACEP President will appoint a replacement**. ~~Any committee member who recuses himself or herself shall report this recusal promptly to the committee chair, and any Board member who recuses himself or herself shall report this recusal promptly to the chair of the Board.~~
6. Once the ~~Board~~ **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**, or the Board Hearing Panel** ~~pursuant to Section F.~~ may make a decision on the complaint solely on the basis of the information it has received.

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

~~10.~~**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.

Background

This resolution amends by substitution ACEP's "Procedures for Addressing Charges of Ethical Violations and Other Misconduct."

In 1997, ACEP established procedures by which its members may initiate complaints against fellow members for violations of ACEP's *Code of Ethics for Emergency Physicians* ("*Code of Ethics*"). These procedures have been revised several times, most recently in 2013. In accordance with the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* (the "*Procedures*"), the current structure for review of ethics complaints is:

1. ACEP's President, Chair of the Ethics Committee, and its Executive Director conduct an initial review of a filed complaint, with input from the General Counsel. This review is limited to providing a determination as to whether the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in ACEP's *Code of Ethics* or Bylaws or if it should move forward for additional review by ACEP's Ethics Committee or subcommittee.[1]
2. Should the case proceed to a formal review, a subcommittee of the Ethics Committee examines the complaint and response of the accused. It then provides the Board of Directors with a written recommendation to either dismiss the complaint or take disciplinary action.
3. The Board of Directors reviews the complaint, response, and any additional information it deemed relevant. At its next meeting, the Board deliberates the ethics case and renders a determination to dismiss the complaint or impose disciplinary action.
4. If the respondent requests a hearing after receipt of notice regarding disciplinary action taken against him or her, an in-person hearing is held before the Board of Directors or a subcommittee of the Board.

Following establishment of the *Procedures*, 20 cases have been decided by the Board of Directors, 4 of which have resulted in hearings. The frequency of complaints varies annually; however, on average 1-2 cases are reviewed per year. During the 2017-18 fiscal year, the Board reviewed 3 cases, one of which required a hearing.

A 2017 survey of Ethics Committee members who have served on the complaint subcommittee revealed that each member spends an average of 8-12 hours reviewing case documents, as well as participating in a 90-120-minute conference call to deliberate the facts of the case and vote on a recommendation to the Board of Directors. This does not include additional hours required of the subcommittee chair to collaborate with staff in drafting the recommendation, as well as participate in the Board deliberations and possible hearing.

The Board of Directors also spends a commensurate amount of time reviewing documents and preparing for ethics complaint deliberations. Should the respondent request a hearing in the case, a Board member will likely spend several hours refamiliarizing him/herself with the facts of the case. At Board meetings, deliberations and hearings can take up to 3 hours.

Because of the burden these responsibilities place on the Board and Ethics Committee, the committee was requested to develop an alternative process by which ethics complaints could be adjudicated in a manner that still provides adequate due process to the parties as required under the Health Care Quality and Improvement Act. After studying review processes used by other medical societies, researching ACEP's legal responsibilities, and discussing the needs of the College, the following revised process is proposed:

Step 1. This step remains the same, with a broad review of the complaint by the President, Ethics Chair and ACEP's Executive Director, with input from the General Counsel.

Step 2. A standing subcommittee of members from the Ethics Committee and Medical-Legal Committee will review the complaint and response from the parties and make its determination, which will be forwarded to the parties.

Step 3. Should a hearing be requested, a panel consisting of the Ethics Committee Chair, Medical-Legal Committee Chair, and one member of the Board of Directors will conduct the hearing and render its decision.

Step 4. At the next Board meeting following a final determination from the subcommittee or hearing panel, the Board will review the case for procedural matters only. It will not review the facts or merits of the case.

---

[1] The *Procedures* also provide an opportunity for members to file complaints regarding violations of ACEP's Bylaws; however, no complaint of this nature has ever been filed. As such, a discussion regarding complaints alleging violations of ACEP's Bylaws have been omitted from this memo.

It is important that the Board maintain oversight of the process; however, this streamlined version should substantially reduce the amount of time and preparation required of the Board, as its role will be limited solely to ensuring the reviewing body acted in compliance with the *Procedures.* Several medical specialty societies, such as the American Academy of Otolaryngology and the Society of Thoracic Surgeons, engage in similarly structured reviews.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Membership Engagement
Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

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

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

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

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

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

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

Prior Board Action

June 2019, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting a College Manual resolution to the 2018 Council.

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

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

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

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

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

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

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

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

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

Resolution 5(99) College Manual adopted.

August 1998 Procedures for Addressing Ethics Charges adopted.

Background Information Prepared by: Leslie Moore, JD
General Counsel and Chief Legal Officer

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Bylaws Amendment

RESOLUTION: 11(19)

SUBMITTED BY: Nicolas Peschanski, PhD, MD
Rahul Sethi, MD

SUBJECT: International Member Eligibility for FACEP

PURPOSE: Amends the Bylaws to clarify the requirements for international members to become an ACEP fellow.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, Many international members are interested in becoming an ACEP fellow; and

WHEREAS, The criteria for international members to be eligible for FACEP are not clear; and

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility, be revised to read:

Fellows of the College shall meet the following criteria:

1. Be regular or international members for three continuous years immediately prior to election.
2. ~~Be certified in emergency medicine a~~At the time of election**, meet all the requirements for certification in emergency medicine** by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics. **Requirements for board certification, depending on the member's country of training, may include: holding Educational Commission for Foreign Medical Graduates (ECFMG) certification, passing all three United Stated Medical Licensing Examinations (USMLE), holding an active medical license that meets the certifying board's policy, and completion of a residency in emergency medicine in a country approved by the certifying board.**
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.

Background

This resolution amends the Bylaws to clarify the requirements for international members to become an ACEP fellow.

Many international members are confused about the requirements for FACEP, and particularly that they must be board-certified in emergency medicine by a certifying board recognized by ABEM. It is also unclear that international members who completed training outside of the U.S. must have ECFMG certification, having passed all three USMLE, hold an active medical license that meets the certifying board's policy, and completion of a residency in emergency medicine in a country approved by the certifying board.

ABEM was contacted to ensure understanding of the certification requirements for foreign medical graduates and Canadians who can apply through ABEM without holding ECFMG certification or completing the USMLE. ABEM responded:

> "ABEM recognizes ACGME-accredited, Royal College of Physicians and Surgeons of Canada-accredited, and Australasian College of Emergency Medicine-approved emergency medicine training. ABEM does not accept College of Family Physicians of Canada training and whether a provider takes the "step exam" is irrelevant. A provider must have a medical license that meets ABEM policy to become ABEM certified."

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective B – Increase total membership and retain graduating residents.
Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

The Council has discussed and adopted many resolutions regarding fellowship. The following resolutions are relevant to fellowship for international members.

Resolution 8(10) International Honorary Fellow not adopted. The resolution called for creating a new category of fellowship for international members who are either current or former International Federation of Emergency Medicine board representatives.

Resolution 10(09) International Fellow not adopted. The resolution called for creating a new criterion for fellowship for international members.

Prior Board Action

None specific to fellowship requirements for international members.

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

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 12(19)

SUBMITTED BY: Emergency Medicine Resident's Association
American Association of Women Emergency Physicians Section
Diversity, Inclusion, & Health Equity Section

SUBJECT: ACEP Composition Annual Report

PURPOSE: Provide the Council with an annual report, by chapter, on the demographics of councillors, alternate councillors, committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, life stage, and employment environment.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, ACEP has committed to working on strategies to increase diversity within its Council and its leadership[1]; and

WHEREAS, Studies have shown that increased diversity directly correlates to organizational performance[1]; and

WHEREAS, A resolution was adopted in 2018 encouraging ACEP chapters to select, appoint, or elect councillors that represent the diversity of their membership[2]; and

WHEREAS, The ACEP Council created a task force to study the size but not the composition of the Council[3]; and

WHEREAS, The purpose of Council is to represent the members of our organization and a regular report on various diversity metrics is a method used by other organizations in determining how well their deliberative bodies meet this representative goal[4]; and

WHEREAS, An annual report of the composition of ACEP's membership and leadership will provide members with transparency regarding Council representation of ACEP members and how they self-identify; and

WHEREAS, Currently ACEP does not regularly produce an official document that tracks the demographics of organizational leadership or councillors relative to its membership; therefore be it

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, life stage, and employment environment.

References

[1] Parker RB, Stack SJ, Schneider SM, et al. Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians' Future Success. Annals of Emergency Medicine. June 2017. Volume 69, Issue 6, Pages 714–717.
[2] 2018 ACEP Council Resolution 14: Diversity of ACEP Councillors. Diversity of ACEP Councillors.
[3] 2018 ACEP Council Resolution 13: Growth of the ACEP Council.
[4] AMA Policy G-600.035 and G-635.125
AMA Policy G-600.035, "House of Delegates Demographic Report" which states: A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

Full Text: "1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year.
3. Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations."

AMA Policy G-635.125, "AMA Membership Demographics," which states: Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
Full Text: "1. Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. Our AMA will immediately release to each state medical and specialty society, on request, the names, category and demographics of all AMA members of that state and specialty.
3. Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner."

Background

This resolution call for ACEP to provide the Council with an annual report, by chapter, on the demographics of councillors, alternate councillors, committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, life stage, and employment environment.

EMRA was asked to clarify the type of information requested for life stage and education. For education, they are seeking to capture whether someone is US/Canadian MD, DO, or International Medical Graduate. For life stage, they desire to capture: Student, Resident, Young Physician (Under Age 40 or First 10 Years of Practice), Mature (Age 40-64), Senior (Age 65+). "Age" would track: under 40, 40-49, 50-59, 60-69, 70 or more. Although "age" and "life stage" overlap, "life-stage" focuses on residency and then proximity to residency and retirement age, while "age" is a simple decade stratification.

The AMA's Council on Long Range Planning and Development recently developed a report that was used as the basis for the type of information this resolution requests. https://www.ama-assn.org/system/files/2019-08/a19-clrpd-report-1.pdf

ACEP is committed to increasing the diversity of members in leadership positions in the Council, the national Board of Directors, committees, sections, and chapters. It is important for residents, young physicians, and others who represent a minority of members of the College, to become active in their chapters and sections and to seek appointment or election as a councillor or alternate councillor, and to apply and be selected to serve on national ACEP committees. Increasing diversity in leadership at the chapter and section levels will automatically increase the diversity in leadership within the Council.

ACEP's membership database has the ability to capture the diversity components that are requested in the resolution. The data is limited to the extent that members provide this information in their membership profile. Many members choose not to answer the profile questions on race/ethnicity, career status, emergency medicine career information (the hospital where they practice), and group information (name of group).

Amended Resolution 14(18) Diversity of ACEP Councillors directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members. A notice was sent to chapters in March 2019 reminding them of this resolution.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership directed the ACEP Board of Directors to work in a coordinated effort with the component bodies of the Council to develop strategies to increase diversity within the Council and its leadership and report back to the Council on effective means of implementation. The

Diversity & Inclusion Task Force and the Leadership Diversity Task Force were appointed in response to the resolution. The Diversity & Inclusion Task Force conducted a survey of the membership to better understand the diversity within ACEP's membership and the degree to which members' backgrounds influence their interactions with ACEP and their practice of emergency medicine.

In May 2018, the Board of Directors approved the Leadership Diversity Task Force's recommendations:

1. Collection of demographic data, including the proportion of underrepresented populations within ACEP's overall membership and leadership (including the Board of Directors, Council, sections, and committees) and including, but not limited to, domains such as gender, race, ethnicity, sexual orientation, and age.
2. Reviewing diversity data every three years and presenting the findings to the ACEP Council to determine whether efforts have been effective in promoting increased diversity within ACEP leadership and to inform future initiatives to increase diversity.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective B – Increase total membership and retain graduating residents.

Fiscal Impact

Budgeted staff resources – approximately 16 hours of IT time develop and run reports.

Prior Council Action

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

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

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

Prior Board Action

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

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

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

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

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

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

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 13(19)

SUBMITTED BY: Utah Chapter

SUBJECT: Eliminating Use of the Word "Provider" in All ACEP Communications

PURPOSE: Eliminate the use of the word "provider' when referring to physicians and non-physicians and refer to them instead by their educational degree and titles.

FISCAL IMPACT: None

WHEREAS, The word/term "provider" has become commonplace in referring to medical professionals; and

WHEREAS, This term is generic, and provides no descriptor for patients or staff, giving them no clues as to the level of expertise or training attained by a given medical professional; and

WHEREAS, This generic term is ubiquitous and often refers to routine services such as internet provider, insurance provider, food service provider, sanitation provider, etc.; and

WHEREAS, No other professions such as attorneys, engineers, architects, dentists, or accountants, et al., refer to people with differing levels of training or expertise by a single non-specific generic term; and

WHEREAS, This generic term denigrates and devalues all medical professions and the people who have attained professional status in medicine; and

WHEREAS, It is not difficult to refer to medical professionals by the titles they have earned; and

WHEREAS, Referring to medical professionals by the generic term "provider" also devalues their role in patient care; therefore be it

RESOLVED, That ACEP, in its official publications, discussions, announcements, communications, and documents, etc., will work to eliminate the use of the word "provider" when referring to physician and non-physician healthcare practitioners, instead referring to them more accurately by the educational degree(s) and titles that they obtained.

Background

This resolution calls for ACEP to eliminate the use of the word "provider' when referring to physicians and non-physicians and refer to them instead by their educational degree and titles.

The word "provider" derives from the Latin *providere*, which means look ahead, prepare, supply. The word "physician" derives from *physic*, the Latin word for natural science and art of healing, The word "doctor" is derived from the Latin *doctus*, meaning to teach or instruct. The term doctor is used in many languages for a physician or medical doctor.

Federal statute 825.125 defines a health care provider as

(1) A doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or

(2) Any other person determined by the Secretary to be capable of providing health care services.

(b) Others capable of providing health care services include only:

(1) Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in the State and performing within the scope of their practice as defined under State law;

(2) Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are performing within the scope of their practice as defined under State law;

(3) Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts. Where an employee or family member is receiving treatment from a Christian Science practitioner, an employee may not object to any requirement from an employer that the employee or family member submit to examination (though not treatment) to obtain a second or third certification from a health care provider other than a Christian Science practitioner except as otherwise provided under applicable State or local law or collective bargaining agreement;

(4) Any health care provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits; and

(5) A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of his or her practice as defined under such law.

(c) The phrase authorized to practice in the State as used in this section means that the provider must be authorized to diagnose and treat physical or mental health conditions.

Under federal regulations, a "health care provider" is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the state and performing within the scope of their practice as defined by state law, or a Christian Science practitioner. Employers may use the term to identify a health care provider from whom their group health plan will accept medical certification for an insurance claim. The term has become common vernacular, appearing in pre-programed text on electronic medical records and insurance forms, and has become part of the language used inside and outside of hospitals. Interestingly in the UK, the term refers to a system or institution, rather than an individual person.

Many have decried the growing use of the word "provider" to include physicians. Hartzband and Groopman in *The New England Journal of Medicine*, wrote: "… care is fundamentally a prepackaged commodity on a shelf that is "provided" to the "consumer," rather than something personalized and dynamic, crafted by skilled professionals and tailored to the individual patient." Suneel Dhand wrote that "Calling us providers is a small but significant step in the commoditization of health care in general." He continues, "The word provider has done, and is doing, a tremendous amount of damage to our profession." He suggests we use the term "doctor" or "physician" for a physician, and the term "clinician" for all other non-physician providers. In a recent article in the *Journal of the American Medical Association (JAMA)*, Allan Goroll, MD wrote that "Assigning the 'provider' designation to primary care health professionals also risks deprofessionalizing them."

The nurse practitioners (NPs) and physician assistants (PAs) have also raised concerns with the term "provider." Once referred to as "mid-level providers," the preference is now to be called NPs or PAs.

The AMA has a policy regarding the use of the term provider in contracts, advertising, and communication that suggests that the writer specify the type of provider being referred to using a recognizable title that details their education, training, licensing and qualifications. The AMA policy goes on to state that provider as a term is inadequate to describe physicians. It has an editorial policy now in place that prohibits the term "provider" in lieu of "physician" in all AMA publications.

In 2014, as a result of a Council resolution, ACEP adopted the policy statement "Use of the Title 'Doctor' in the Clinical Setting," which states that "anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a 'doctor', and who is not a 'physician' {defined as an individual who has received a Doctor of Medicine or a Doctor of Osteopathic Medicine or equivalent degree} "must specifically and simultaneously declare themselves a 'non-physician' and define the nature of their doctorate degree."

ACEP has convened a multi-organizational task force examining the scope of practice and supervision requirements for PAs and NPs. That report will be presented to the ACEP Board of Directors on October 24, 2019 and may contain language regarding the titles used by non-physicians in the ED. ACEP does not have specific policy regarding the use of the term "provider."

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective A – Improve the practice environment and member well-being.

Fiscal Impact

None

Prior Council Action

Substitute Resolution 30(13) Use of the Title "Doctor" in the Clinical Setting adopted. Directed that ACEP affirm that a physician is an individual who has received a Doctor of Medicine or Doctor of Osteopathic Medicine degree or an equivalent degree; and that ACEP require anyone in a hospital environment who has direct contact with a patient who presents themselves as a "doctor" and is not a "physician" must declare themselves a non-physician and define the nature of their doctorate degree.

Prior Board Action

The Board has removed the term provider in lieu of physician in several policies and information papers in the past several years.

April 2014, approved the policy statement "Use of the Title 'Doctor' in the Clinical Setting."

Substitute Resolution 30(13) Use of the Title "Doctor" in the Clinical Setting adopted.

Background Information Prepared by: Sandra Schneider, MD, FACEP
Associate Executive Director, Clinical Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 14(19)

SUBMITTED BY: Elizabeth Dubey, MD, FACEP
American Association of Women Emergency Physicians Section
Diversity, Inclusion, & Health Equity Section
Quality Improvement & Patient Safety Section
Wisconsin Chapter

SUBJECT: Implicit Bias Awareness and Training

PURPOSE: Develop and publicize a policy statement that promotes implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles; and continue to create and advertise free, CME- eligible, online training related to implicit bias.

FISCAL IMPACT: Budgeted committee or section and staff resources to develop a policy statement. Minimum of $12,000 to accredit an enduring course. Actual costs depend on the scope of the course(s) and whether honorarium is provided to the content developer(s).

WHEREAS, Implicit bias is a ubiquitous and physiologic process by which unconscious assumptions and associations are attributed to individuals and groups based on characteristics such as gender, age, race, religious preference, and sexual orientation, resulting in oftentimes negative judgments, perceptions, and subsequent treatment towards these individuals and groups; and

WHEREAS, Implicit biases routinely influences management of both medical staff and patients and has been shown to result in poor outcomes; and

WHEREAS, ACEP's Diversity and Inclusion Survey of 2017 revealed that 23% of ACEP members feel that their career advancement was hindered or delayed based on gender, race, age, sexual orientation, or religious preference - 61% of whom cited gender as the issue[15]; and

WHEREAS, Implicit bias exists in medicine at all levels and affects hiring, pay and promotion[1-3];and

WHEREAS, Studies suggest that when hiring, both men and women show a stronger preference for male candidates, and that there is preference for male over female leaders[4]; and

WHEREAS, A 2016 study showed female physicians make $18,677 less than their male counterparts even after adjusting for hours worked, their productivity and years of experience[5]; and

WHEREAS, Minority physicians suffer from an even more evident pay gap, with one study showing that across specialties, black male physicians earn $64,812 less than while male physicians, and white and black female physicians earn $89,808 and $100,258 less than white males physicians, respectively[6]; and

WHEREAS, Women are less likely to get a raise than men when they ask for one[7]; and

WHEREAS, When women leaders engage in agentic traits, or historically "masculine" leadership traits, they receive lower evaluations among men and women leaders[8]; and

WHEREAS, While for 25 years, there have been near-equal percent of men and women in medical schools, women continue to lag behind in advancement and women currently make up only 38% of medical school faculty,

21% of full professors, and 16% of deans[9]; and

WHEREAS, Only 4% of full-time physician faculty are black or African American, when the general population is 8.9% black or African American[10]; and

WHEREAS, Studies have shown that gender and racial bias negatively influences clinical decision-making and outcomes as related to managing cardiovascular disease, pain management, and diagnosing mental illness[16, 17]; and

WHEREAS, Evidence indicates that the negative impact of implicit bias can be ameliorated by education to increase awareness and provide bias reduction strategies[11-13]; and

WHEREAS, The ACEP Diversity & Inclusion Task Force developed a three-part comprehensive CME-eligible online course on implicit bias entitled "Unconscious Bias in Clinical Practice: Protect Yourself and Your Patients"[14]; and

WHEREAS, The ACEP Board of Directors and staff underwent formal implicit bias training in June 2017; therefore be it

RESOLVED, That ACEP develop and publicize a policy statement that encourages implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles; and be it further

RESOLVED, That ACEP continue to create and advertise free, CME-eligible, online training related to implicit bias.

References

1. Moss-Racusin CA, Dovidio JF, Brescoll VL, Graham MJ, Handelsman J. Science faculty's subtle gender biases favor male students. *Proc Natl Acad Sci U S A.* 2012;109(41):16474-16479.
2. Correll S, Benard, S., & Palik, I. Getting a Job: Is There a Motherhood Penalty? *American Journal o fSociology.* 2007;112(5):1297-1338.
3. Amanatullah ET, Morris MW. Negotiating gender roles: gender differences in assertive negotiating are mediated by women's fear of backlash and attenuated when negotiating on behalf of others. *J Pers Soc Psychol.* 2010;98(2):256-267.
4. Eagly AH, Karau SJ, Makhijani MG. Gender and the effectiveness of leaders: a meta-analysis. *Psychol Bull.* 1995;117(1):125-145.
5. Desai T, Ali S, Fang X, Thompson W, Jawa P, Vachharajani T. Equal work for unequal pay: the gender reimbursement gap for healthcare providers in the United States. *Postgrad Med J.* 2016;92(1092):571-575.
6. Ly DP, Seabury SA, Jena AB. Differences in incomes of physicians in the United States by race and sex: observational study. *BMJ.* 2016;353:i2923.
7. Artz B, Goodall, A., Oswald, A. Do Women Ask? *Industrial Relations: A Journal of Economy and Society.* 2018;57:611-636.
8. Eagly AH, Karau SJ. Role congruity theory of prejudice toward female leaders. *Psychol Rev.* 2002;109(3):573-598.
9. Lautenberger DM, Dandar, V.M., & Raezer, C.L. *The state of women in academic medicine: the pipeline and pathways to leadership.* Association of American Medical Colleges2014.
10. Nivet M, Castillo-Page, L. *Diversity in the Physician Workforce: Facts & Figures 2014.* aamcdiversityfactsandfigures.org: Association of American Medical Colleges;2014.
11. Devine PG, Forscher PS, Austin AJ, Cox WT. Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. *J Exp Soc Psychol.* 2012;48(6):1267-1278.
12. Rudman LA, Ashmore RD, Gary ML. "Unlearning" automatic biases: the malleability of implicit prejudice and stereotypes. *J Pers Soc Psychol.* 2001;81(5):856-868.
13. Mitchell JP, Nosek BA, Banaji MR. Contextual variations in implicit evaluation. *J Exp Psychol Gen.* 2003;132(3):455-469.
14. ACEP. Unconsious Bias in Clinical Practice. 2017.
15. ACEP/AAMC Diversity and Inclusion Survey. Web-based. July to September 2017.
16. Kim et al. Sex-based Disparities in Incidence, Treatment, and Outcomes of Cardiac Arrest in the United States, 2003-2012. Journal of American Heart Association. 2016 June 22;5(6).
17. Hoffman et al. Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences Between Blacks and White. Proceedings of Natl Academy of Sciences. 2016 Apr 19; 113(16): 4296-4301.

Background

This resolution calls for the College to develop and publicize a policy statement that promotes implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles and encourages ACEP to continue to create and advertise free, CME-eligible, training related to implicit bias.

In March 2018, ACEP launched an Unconscious Bias in Clinical Practice 1- hour, accredited CME course, which was developed by the Diversity & Inclusion Task Force. The course focused on the following objectives:

- Defining unconscious/implicit bias and its manifestations, based on metacognition and brain function.
- Discuss the link between social determinants of health, cultural competence, bias, and patient care.
- Review evidence on effects of implicit bias on clinical practice and disparities in patient care and outcomes.
- Identify strategies to protect against and minimize the impact of implicit bias on patient care

ACEP's policy statement "Workforce Diversity in Health Care Settings" supports that hospitals and emergency physicians should staff emergency departments with a diverse workforce. ACEP's goal is to attain a diverse, well-qualified physician workforce that truly reflects our multicultural society. Implicit bias serves as an influencer of management and medical staff and be a hindrance of the career advancement of physicians based on characteristics, such as gender, race, age, sexual orientation or religious preference.

ACEP's policy statement "Cultural Awareness and Emergency Care" supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias, as cultural awareness helps combat negative assumptions and associations. Implicit Bias is recognized by the individual and mitigated through education recalling stereotypical thought processes.

ACEP's policy statement "Non-Discrimination and Harassment" advocates tolerance and respect for all and opposes all forms of discrimination and harassment.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine

Fiscal Impact

Budgeted committee or section and staff resources to develop and publicize a policy statement. Minimum of $12,000 to accredit an enduring course. Actual costs depend on the scope of the course(s) and whether honorarium is provided to the content developer(s).

Prior Council Action

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution directed that ACEP oppose all forms of discrimination against patients and oppose employment discrimination in emergency medicine.

Prior Board Action

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

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

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

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

Background Information Prepared by: Riane Gay, MPA
Senior Manager, Grants & Development

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 15(19)

SUBMITTED BY: American Association of Women Emergency Physicians Section

SUBJECT: Increased Transparency in NEMPAC Contributions

PURPOSE: Support increased NEMPAC transparency by making available online to ACEP members the voting and sponsorship record of key ACEP legislation for NEMPAC sponsored candidates

FISCAL IMPACT: Budgeted staff resources to update relevant information on the NEMPAC website. Unbudgeted and unknown vendor costs.

WHEREAS, The National Emergency Medicine Political Action Committee (NEMPAC) is a voice for emergency medicine physicians in the federal political arena; and

WHEREAS, NEMPAC is a voluntary, nonprofit, unincorporated association operating as a separate segregated fund of ACEP; and

WHEREAS, NEMPAC accepts voluntary personal contributions from ACEP members and makes contributions to candidates for federal office; and

WHEREAS, Over 5,000 emergency medicine physicians make personal contributions annually; and

WHEREAS, NEMPAC currently ranks fourth among all physician specialty groups in funds raised and contributions made to candidates, and has brought in over $2 million each cycle since 2010; and

WHEREAS, In past election cycles, NEMPAC has given larger amounts of campaign contributions to candidates that have had voting records at odds with ACEP policy/supported legislation of grave public health impact[1-3]; and

WHEREAS, To determine campaign contributions, NEMPAC examines candidates' and incumbents' support of key ACEP legislative priorities by way of support and co-sponsorship of key ACEP legislation and other factors include: committee assignment, leadership position, competitiveness, working relationship with ACEP staff, and members and input from the state chapters; and

WHEREAS, NEMPAC releases an election report every cycle listing candidates supported; and

WHEREAS, NEMPAC does not release the internally tracked legislation record used to determine campaign contributions for these candidates; therefore be it

RESOLVED, ACEP support the practice of increased NEMPAC transparency through making available online to ACEP members the voting/sponsorship record of key ACEP legislation for NEMPAC sponsored candidates.

References

1. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2725481
2. https://www.acep.org/patient-care/policy-statements/firearm-safety-and-injury-prevention/
3. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2725483

Background

This resolution asks the College to support increased NEMPAC transparency by making available online to ACEP members the voting/sponsorship record of key ACEP legislation for federal candidates supported by NEMPAC.

The ACEP Board of Directors initially approved the National Emergency Medicine Political Action Committee (NEMPAC) Articles of Association on November 5, 1987. The amended Articles of Association were approved by the ACEP Board of Directors in April 2008 (Attachment A).

The NEMPAC Articles of Association Article IV – Purposes and Powers, Section 1 states: "The purpose of NEMPAC is to provide the opportunity for individuals interested in the future of emergency medicine to contribute to the support of worthy candidates for federal offices who believe, and have demonstrated their beliefs, in the principles to which emergency medicine is dedicated. To further these purposes, NEMPAC is empowered to solicit, directly or indirectly, and accept voluntary personal contributions, and to make expenditures in connection with the attempt to influence the selection, nomination, or election of any individual to any elective federal office."

Article VIII – Trustees, Section 1 establishes the governing body of NEMPAC. "Subject to the ultimate authority of the National ACEP Board of Directors, the governing body of NEMPAC shall be a Board of Trustees, composed of an Immediate Past President and twelve (12) additional individuals who shall serve staggered terms of three (3) years each."

Article VIII – Trustees, Section 2 states: "Subject to review and approval of the National ACEP Board of Directors, the Board of Trustees shall set basic policies with respect to the collection and disbursement of NEMPAC funds, including but not limited to protecting the property and affairs, and carrying out the purposes of the NEMPAC. In particular, the Board of Trustees shall determine, with assistance and advice of the Treasurer, the procedures for solicitation and collection of contributions and subsequent distribution of funds to candidates in accordance with the Act(s) and Regulations(s) of the Federal Election Commission, and other applicable laws and regulations."

Since its inception, NEMPAC has served a vital role in advancing ACEP's legislative agenda and in broadening ACEP's visibility with Congress. In the 2018 election cycle, NEMPAC contributed nearly $2.2 million to candidates, party committees, leadership PACs, and independent expenditure campaigns. At the beginning of each two-year election cycle, the NEMPAC Board of Trustees develops a NEMPAC Contribution Guidelines/Strategic Plan and Budget. The 2020 Cycle Plan and Budget was approved by the NEMPAC Board of Trustees on May 5, 2019 (Attachment B).

Federal candidates are evaluated using multiple criteria, including but not limited to, votes and co-sponsorship of ACEP priority legislation. The 2020 criteria follow the past NEMPAC practice of focusing on a candidate's support and co-sponsorship of ACEP's key legislative and regulatory initiatives, committee assignments, leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions. Incumbents and new candidates seeking NEMPAC support that meet criteria in several categories are eligible for more support. Additionally, a list of NEMPAC Champions was identified by the NEMPAC Board and staff. The Champions receive maximum financial support and additional resources that NEMPAC is able to provide.

Although a candidate may be budgeted a certain contribution amount, the candidate will not necessarily receive the full amount for which he or she is budgeted. A significant change in the legislative/political climate may dictate that we reach as many candidates as possible (rather than a targeted focus on candidates on a committee). Ongoing assessments by the NEMPAC Board of Trustees determine which overall approach is most compatible with ACEP's legislative and regulatory agenda.

An internal spreadsheet is maintained by NEMPAC staff and tracks criteria for every seated member of Congress and includes recommended budget amounts for each member. This document is reviewed and modified throughout the election cycle to reflect movement on legislation considered by Congress, campaign activity, election ratings, and ACEP staff and member interactions with legislators. The internal document includes voting/sponsorship records of

key ACEP legislation for that Congress and votes and sponsorships of key legislation in prior Congressional sessions if applicable. The decision to track specific votes and co-sponsorships is based on the legislative priorities established by the ACEP Federal Government Affairs (FGA) Committee at the beginning of each Congress. Although ACEP may track multiple issues and bills in any given congressional session, only those that are determined by the ACEP FGA Committee and ACEP Board of Directors to be key issues for emergency medicine that are moving through the congressional process either by accumulating co-sponsors, consideration by congressional committees, or inclusion in House or Senate floor votes, for example, are tracked.

The NEMPAC website contains detailed information on guidelines established by the NEMPAC Board of Trustees to determine candidate support and lists of candidates supported in current and past election cycles. NEMPAC also produces an Election Report at the end of each cycle that contains this information and is either mailed or sent electronically to all regular ACEP members.

The votes and co-sponsorships records of all members of Congress are available to the public on https://www.congress.gov/ and disbursement information from federally registered PACs to federal candidates is available to the public on www.Fec.gov. Currently, NEMPAC staff are evaluating several outside vendors that offer tools such as PAC and legislative scorecards that would have the ability to track activities by legislators such as votes or co-sponsorships relating to emergency medicine issues and advocacy activities with ACEP members and staff. The information could be made available on the member-protected NEMPAC website. There is currently no funding in the FY20 NEMPAC administrative budget for new vendor contracts for this purpose.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Goal 2 Enhance Membership Value and Member Engagement
Objective B – Increase total membership and retain graduating residents.

Fiscal Impact

Budgeted staff resources to update relevant information on the NEMPAC website. Unbudgeted and unknown costs in contracting with an outside vendor to purchase software to produce legislative scorecards and the framework for updating information on existing ACEP and NEMPAC websites. There are no funds budgeted in the FY20 NEMPAC administrative budget for hiring or contracting with new vendors for this purpose or for additional staff time.

Prior Council Action

None

Prior Board Action

April 2008, approved the amended NEMPAC Articles of Association.

November 1987, approved the NEMPAC Articles of Association.

Background Information Prepared by: Jeanne Slade
Director, NEMPAC and Grassroots Advocacy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

ARTICLES OF ASSOCIATION
OF THE
NATIONAL EMERGENCY MEDICINE POLITICAL ACTION COMMITTEE
OF THE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

As initially approved by vote of the ACEP Board of Directors on November 5, 1987.
As amended by vote of the ACEP Board of Directors on April 4, 2008.

ARTICLE I – NAME

The name of this association shall be the National Emergency Medicine Political Action Committee of the American College of Emergency Physicians, also known and hereinafter referred to as "NEMPAC."

ARTICLE II – ORGANIZATION

NEMPAC shall be a voluntary, nonprofit, unincorporated association operating as a separate, segregated fund of the American College of Emergency Physicians, a national professional society incorporated in the state of Texas ("National ACEP"). NEMPAC's sole connected organization shall be National ACEP. Neither NEMPAC nor National ACEP has other affiliated committees.

National ACEP shall, within guidelines set forth by the National ACEP Board of Directors, pay all organizational and administrative costs of NEMPAC.

NEMPAC shall be a non-partisan "political committee" and qualify as a "multicandidate committee" under applicable Federal election law, the Federal Election Campaign Act as amended from time to time (the "Act") and implementing regulations ("Regulations") promulgated by the Federal Election Commission (the "Commission"). The NEMPAC is a political organization under federal tax exemption law.

ARTICLE III – PRINCIPAL OFFICE AND ADDRESS

The principal office of NEMPAC shall be located in the headquarters of the National ACEP or in any other location designated by National ACEP.

ARTICLE IV – PURPOSES AND POWERS

Section 1. The purpose of NEMPAC is to provide the opportunity for individuals interested in the future of emergency medicine to contribute to the support of worthy candidates for federal offices who believe, and have demonstrated their beliefs, in the principles to which emergency medicine is dedicated. To further these purposes, NEMPAC is empowered to solicit, directly or indirectly, and accept voluntary personal contributions, and to make expenditures in connection with the attempt to influence the selection, nomination, or election of any individual to any elective federal office.

Section 2. NEMPAC and its officers and subcommittees shall possess all powers and privileges necessary to the conduct, promotion, or attainment of the purposes set forth in this Article.

ARTICLE V – PARTICIPATION

All U.S. citizens are eligible to contribute to NEMPAC and NEMPAC is authorized to solicit contributions from the executive and administrative personnel and members (and their families) of National ACEP and its affiliated organizations. NEMPAC may only solicit contributions from its individuals within its "restricted class," as that term is defined by federal law. It may also accept contributions from all U.S. citizens and any other persons who legally may contribute as long as it does not solicit such contributions or inform individuals that such contributions are acceptable.

ARTICLE VI – CONTRIBUTIONS

All contributions to NEMPAC shall be voluntary, and no contribution shall be solicited or secured by physical force, job discrimination, or financial reprisal, or threat thereof, or as to a condition of employment by or of membership in National ACEP. The Executive Committee shall control the disbursement of funds to implement the

policies established by the Board of Trustees, subject to the ultimate authority of the National ACEP Board of Directors. No contribution shall be accepted, and no expenditure made by or on behalf of NEMPAC when the offices of the Treasurer and Assistant Treasurer are both vacant.

ARTICLE VII – SEPARATE SEGREGATED ACCOUNT

All legal contributions to NEMPAC, other than those from incorporated member practices, shall be maintained as a separate segregated account in one or more designated depositories, and all contributions to any candidate or political committee shall be made from that fund. Contributions from member corporate accounts received by NEMPAC shall be promptly transferred to the appropriate National ACEP general treasury account and used solely to offset NEMPAC administrative and solicitation costs. Any prohibited contributions received by National ACEP or NEMPAC shall be returned to the donor within the time limits established under federal law.

NEMPAC shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of its Board of Trustees and Executive Committee. All books and records are subject to the inspection of any member of the National ACEP Board of Directors, or his or her agent or attorney for any purpose at any reasonable time. NEMPAC books and records shall be maintained by the Treasurer. All records shall be kept, and the preparation and filing of all required reports of receipts and expenditures conducted in compliance with the Act(s) and Regulations(s) of the Federal Election Commission, and other applicable laws and regulations.

ARTICLE VIII – TRUSTEES

Section 1. Subject to the ultimate authority of the National ACEP Board of Directors, the governing body of NEMPAC shall be a Board of Trustees, composed of and Immediate Past President and twelve (12) additional individuals who shall serve staggered terms of three (3) years each. The initial twelve (12) individuals will be appointed by the ACEP President as follows:

Four (4) individuals to serve a one year term.
Four (4) individuals to serve a two year term.
Four (4) individuals to serve a three year term.

Other than the initial trustees, who will serve initial one-year or two-year terms and may serve an additional three-year term, the twelve (12) individuals appointed to the NEMPAC Board of Trustees may serve up to two (2) complete three (3)-year terms. The National ACEP President-Elect and Immediate Past President shall serve as a NEMPAC Trustee for the duration of his/her term in such National ACEP office. All Trustees must be members of National ACEP. The ACEP President shall appoint an individual to fill any vacancy in the NEMPAC Board of Trustees.

Section 2. Subject to review and approval of the National ACEP Board of Directors, the Board of Trustees shall set basic policies with respect to the collection and disbursement of NEMPAC funds, including but not limited to protecting the property and affairs, and carrying out the purposes of the NEMPAC. In particular, the Board of Trustees shall determine, with assistance and advice of the Treasurer, the procedures for solicitation and collection of contributions and subsequent distribution of funds to candidates in accordance with the Act(s) and Regulations(s) of the Federal Election Commission, and other applicable laws and regulations.

Section 3. The Chair of the Board of Trustees shall be appointed by the ACEP President from the twelve (12) Trustees who are not serving as National ACEP officers and who have one or more years remaining in his/her term as Trustee. The Chair shall be appointed for a one (1) year term and may be reappointed to subsequent terms by the National ACEP President if the Chair has one (1) or more years remaining in the Chair's term as Trustee.

ARTICLE IX – MEETINGS OF THE BOARD OF TRUSTEES

Section 1. Regular meetings of the Board of Trustees may be held without notice at such time and at such places as shall from time to time be determined by the Board of Trustees, provided that at least one regular meeting of the Board of Trustees shall be held each calendar year.

Section 2. Special meetings of the Board of Trustees may be called by the Chair or may be called by the Secretary upon the written request of a majority of the members of the Board of Trustees. Written notice of special meetings of the Board of Trustees shall be given to each Trustee at least seventy-two (72) hours before the time of the

meeting. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Trustees need be specified in the notice or waiver of such meeting.

Section 3. A majority of the Trustees shall constitute a quorum for the transaction of business and the actions of the majority of the Trustees present at a meeting at which a quorum is present shall be the actions of the Board of Trustees, unless a greater number is otherwise required by law or by these Articles for a vote on a particular matter. If a quorum shall not be present at any meeting of the Board of Trustees, the Trustees present thereat may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

Section 4. Any action required or permitted to be taken at a meeting of the Board of Trustees may be taken without a meeting if a consent in writing (including but not limited via fax or e-mail or other electronic transmission or voting method), setting forth the action taken, is signed by all members of the Board of Trustees, and such consent shall have the same force and effect as a unanimous vote of the Board of Trustees at a meeting.

Section 5. Trustees may participate in and hold a meeting by means of conference telephone or similar communication equipment by means of which all persons participating in the meeting can hear each other.

Section 6. Committees. The Board of Trustees may designate one or more committees, each consisting solely of members of the Board, with the authority to conduct the affairs of NEMPAC~~,~~ including but not limited to the Executive Committee.

ARTICLE X – EXECUTIVE COMMITTEE

Section 1. The policies established by the Board of Trustees shall be implemented by an Executive Committee composed of the Chair of the Board of Trustees, the President-Elect of National ACEP, the Immediate Past President of National ACEP, and a fourth member appointed from among the Board of Trustees by its Chair.

Section 2. The Executive Committee shall control the collection and expenditure of NEMPAC funds~~,~~ subject to the ultimate authority of the National ACEP Board of Directors.

Section 3. The Chair shall preside at meetings of the Executive Committee. In the absence of the Chair, the ACEP President-Elect shall temporarily serve as Chair.

Section 4. A majority of the members of the Executive Committee shall constitute a quorum for the transaction of business, and the actions of the majority of the members of the Executive Committee present at a meeting at which a quorum is present shall be the actions of the Executive Committee. If a quorum shall not be present at any meeting of the Executive Committee, the members present thereat may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

ARTICLE XI – ADMINISTRATIVE OFFICERS

Section 1. The administrative officers of NEMPAC shall be the Treasurer, the Assistant Treasurer, the Secretary, and the Assistant Secretary, who shall be selected by the Executive Committee. The Administrative Officers, as well as Executive Director and Associate Executive Director for Public Affairs of the National ACEP, shall serve as nonvoting ex officio members of the Board of Trustees and the Executive Committee.

Section 2. The chief financial officer of National ACEP shall serve as the Treasurer of NEMPAC. The Treasurer of NEMPAC shall be its chief financial officer, shall keep the financial and other records of NEMPAC, shall comply with all applicable laws, and shall perform such other duties as may be assigned to him/her by the Chair.

Section 3. The Assistant Treasurer shall, in the absence of the Treasurer, have all the power and perform all duties of the Treasurer. In the event of a vacancy in the office of the Treasurer, the Assistant Treasurer shall immediately become the acting Treasurer.

Section 4. The Secretary shall attend all meetings of the Board of Trustees and Executive Committee and shall record all the proceedings of such meetings in a book to be kept for that purpose and shall perform like duties for any standing or specially appointed committees of the Board of Trustees when required. The Secretary shall give, or cause to be given, notice of all meetings and shall perform such other duties as may be prescribed by the Chair, under whose supervision he/she shall be.

Section 5. The Assistant Secretary shall, in the absence of the Secretary, have all the power and perform all duties of the Secretary. In the event of a vacancy in the office of the Secretary, the Assistant Secretary shall immediately become the acting Secretary.

The Chair and all administrative officers of NEMPAC may be assisted in their duties by one or more National ACEP staff members.

ARTICLE XII – NOTICES

Section 1. Notices to Trustees shall be delivered personally, mailed to the Trustees at their last known addresses, or sent by fax or electronic mail. Notice by mail shall be deemed to be given at the time when deposited in the U.S. Mail.

Section 2. Whenever any notice is required to be given, a waiver thereof in writing signed by the person or persons entitled to such notice shall be equivalent to such notice. Any such waiver may be communicated by mail, fax, or electronic mail.

Section 3. Attendance of a Trustee at a meeting shall constitute a waiver of notice of such meeting, except where a Trustee attends a 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.

ARTICLE XIII – ADOPTION AND AMENDMENTS

Section 1. These Amended Articles shall be adopted effective April 4, 2008.

Section 2. These Articles may be amended from time to time by a two-thirds (2/3) majority vote of the National ACEP Board members present and voting at any duly called and constituted meeting of the National ACEP Board.

ARTICLE XIV – DISSOLUTION

NEMPAC may be dissolved at any time by the two-thirds (2/3) majority vote of the National ACEP Board members present and voting at any duly called and constituted meeting of the National ACEP Board. In the event of such dissolution, all funds contained in NEMPAC's campaign depository shall be distributed for lawful purposes determined by Board of Trustees.

ARTICLE XV – DEPOSITORY

The Board of Trustees, upon advice and recommendation of the Treasurer, shall designate from time to time a depository institution in accordance with the Act(s) and Regulation(s) of the Federal Election Commission, and all other applicable laws and regulations for checking accounts and other accounts as deemed necessary or appropriate.

2020 Election Cycle Guidelines

NEMPAC Contribution Guidelines/Strategic Plan and Budget for 2020 Cycle

(as approved by the NEMPAC Board of Trustees on May 5, 2019)

Background

NEMPAC serves a vital role in advancing ACEP's legislative agenda and in broadening ACEP's visibility with Congress. As contributions to the PAC have increased, NEMPAC has become involved in more congressional races and expanded ACEP's influence. In the 2018 election cycle, NEMPAC contributed nearly $2.2 million to candidates, party committees, leadership PACs, and independent expenditure campaigns. NEMPAC's fundraising success in this cycle of $2,145,072 raised in hard and soft dollars allowed NEMPAC to be active in more races and to make larger contributions to individual candidates than in past cycles.

In the 2020 election cycle, it is recommended that we adopt the following strategies:

- Identify "Champions" of emergency medicine who would receive maximum funding for their re-election campaigns ($10,000) and for the Leadership PACs (if applicable) of $5000 per year, in addition to other benefits identified below.
- Continue to budget hard dollars for independent expenditures.
- 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 local events for their Members of Congress.
- Prioritize check deliveries and attendance at fundraisers by ACEP members, in particular ACEP leaders, Chapter Leaders, and NEMPAC VIP Donors. In the 2018 election cycle, NEMPAC sent or delivered 1400+ checks. About 15 percent were delivered or associated with an ACEP member present.
- Concentrate remaining funds on candidates that meet some or all the criteria below.

This guidelines for the 2020 election cycle will expand and build upon past NEMPAC guidelines and reflect the projected level of funds available to NEMPAC. The NEMPAC budget will guide NEMPAC's contributions through the election cycle and it will be subject to modification as the election cycle progresses and races take shape.

Evaluation Categories

2020 evaluation criteria follow past NEMPAC practice of focusing on a candidate's support of ACEP's key legislative and regulatory initiatives, co-sponsorship of ACEP legislation, committee assignment, leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions. As we look at incumbents and new candidates for NEMPAC support, those that meet criteria in several categories would be eligible for more support. In addition, an initial list of NEMPAC Champions will be identified by the NEMPAC Board and staff. The champions will receive maximum financial support and additional resources that NEMPAC can provide (see below).

Although a candidate may be budgeted a certain contribution amount, the candidate will not necessarily receive the full amount for which he or she is budgeted. A significant change in the legislative/political climate may dictate that we reach as many candidates as possible (rather than a targeted focus on candidates on a committee). Ongoing assessments will enable us to determine which overall approach is most compatible with ACEP's legislative and regulatory agenda.

2020 Senate Budget Spreadsheet Categories

The current Senate budget tracks the following metrics in additional to year of re-election:

- Committee Assignments and Leadership Positions
    - Finance, HELP, Appropriations Health Subcommittee
- Emergency Department Visit back home or district director meeting
- Dine-around participant at LAC meetings
- Co-sponsorship of S.527 in the 115th Congress, EMTALA Liability Reform Legislation
- Cosponsorship of S.916, POWER Act (Administration of MAT in the ED) in 115th Congress
- Co-sponsorship of S.260, IPAB Repeal in 115th Congress

- Co-sponsorship of S.2516, the ALTO Bill in the 115th Congress
- Signee of Drug Shortage Letter to FDA in the 115th Congress
- Co-sponsor of S.1531, Cassidy workgroup surprise billing legislation – 116th Congress
- Co-sponsor of S.1334, ACEP Mental Health/Psychiatric Patient Boarding Bill – 116th Congress
- Co-sponsor of S.851, Workplace Violence Bill – 116th Congress
- Co-sponsor of S.42, Background Check Expansion Act – 116th Congress
- Amounts donated in prior election cycles

*Also indicates if the Senator introduced ACEP resolution S.723 in the 115th Congress
**Indicates member of Cassidy transparency workgroup in the 116th Congress.

As we get closer to the 2020 elections, we will add indicators for competitiveness of race.

2020 House Budget Spreadsheet Categories

The current House budget tracks the following metrics:

- Committee Assignments and Leadership Positions
    - Ways and Means, Energy and Commerce, Education and Labor, Appropriations including health subcmt assignments
- Attended new member coffee, district meeting, Emergency Department Visit or fundraiser with ACEP member attendance back home
- Dine-around participant at LAC meetings
- Co-sponsorship of H.R.4365, EMS Standing Orders Bill in the 115th Congress
- Vote against ACA Repeal in the 115th Congress
- Vote for IPAB Repeal in the 115th Congress
- Cosponsorship of H.R. 5176, POWER Act (Administration of MAT in the ED) in 115th Congress
- Co-sponsorship of S.260, IPAB Repeal in 115th Congress
- Co-sponsorship of H.R.5197, the ALTO Bill in the 115th Congress
- Signee of Drug Shortage Letter to FDA in the 115th Congress
- Vote on HR.8 - Bipartisan Background Checks Act
- Co-sponsor of H.R. 3502 – Protect Patients from Surprise Medical Bills Act – 116th Congress
- Co-sponsor of H.R. 2519 – ACEP Mental Health/Psychiatric Patient Boarding Bill – 116th Congress
- Co-sponsor of H.R. 1309 – Workplace Violence Bill – 116th Congress
- Co-sponsor of H.R. 3984 – ACEP EMTALA Liability Bill – 116th Congress
- Amounts donated in prior election cycles

As we get closer to the 2020 elections, we will add indicators for competitiveness of race.

The relative weights placed on these issues will vary from year to year and will be determined by the NEMPAC Board of Trustees at the beginning of each election cycle. The Board will maintain flexibility throughout the cycle in assessing the importance of these issues and they will be considered important information when determining a candidate's level of support from NEMPAC.

"Friendly Incumbent" Guidelines

NEMPAC will continue to follow "friendly incumbent" guidelines for contributions used in past election cycles. These guidelines recommend that NEMPAC should not contribute campaign funds to a candidate running against an incumbent determined to be friendly or supportive to ACEP. In situations where physicians, members of ACEP, or other candidates strongly supported by an ACEP state chapter run against a "friendly incumbent," the NEMPAC Board may vote to modify this guideline after careful consideration of factors such as electability, support of ACEP's legislative and regulatory agenda and relationship to ACEP members in the district or state.

In an "open seat" situation, where neither candidate is an incumbent, each candidate will be evaluated to determine if the candidates' positions on important healthcare issues are consistent with ACEP policy.
Input from the state chapters, local ACEP leaders, and 911 Network members will also be considered. All open seat and challenger candidate contributions must be approved by the NEMPAC Board of Trustees or the NEMPAC

Executive Committee if time is of the essence. The open seat candidates will be asked to complete a 2020 NEMPAC Candidate Questionnaire.

NEMPAC Candidate Questionnaire

At the beginning of each election cycle, NEMPAC will develop a candidate survey that highlights ACEP core legislative and regulatory principles and requests information from the candidate about their background and campaign operation. Open seat and challenger candidates will be strongly urged to complete and return the survey for consideration of NEMPAC support. Exceptions may be permitted if time constraints are present if the NEMPAC Board of Trustees or Executive Committee are made aware of the circumstances, and they are documented, as to why the survey was not completed prior to making and/or approving a donation.

Contributing to Two Candidates Running for the Same Congressional or Senate Seat

NEMPAC will maintain the practice of supporting only one candidate in a race. In instances where the candidate supported by NEMPAC loses a primary election, the NEMPAC Board may consider supporting another candidate in the general election since the original candidate supported would be out of the race.
In rare circumstances and after careful consideration by the NEMPAC Board of Trustees, there may be flexibility in this practice so that an exception could be made for NEMPAC to donate to two different candidates running for the same office.

Contribution Strategy and Delivery Methods

Direct Contributions to Re-Election Campaigns and Leadership PACs.
As in previous election cycles, NEMPAC will direct its contributions to those candidates (primarily sitting Members of Congress) who serve on key committees and subcommittees, hold positions of leadership or who have supported ACEP's key legislative priorities through bill cosponsorship or votes in favor of ACEP-supported legislation. Candidates who have a history of working with ACEP staff and members and who have received contributions from NEMPAC in previous election cycles will also be considered for contributions.

When delivering contributions, we will give priority to participating in smaller healthcare-specific meetings and fundraisers. The smaller events allow the candidates to focus solely on healthcare issues and to hear ACEP's concerns and priorities in the current Congress.

Funds will also be set aside for "dine-around" events at future Leadership and Advocacy Conferences for targeted members.

NEMPAC will also target events and meetings back home in the state and district where ACEP members can deliver a NEMPAC check personally to their Member of Congress. NEMPAC will attempt to target contributions to Members of Congress who represent the states and congressional districts of ACEP Board of Directors members and members of the NEMPAC Board of Trustees. This strategy will enhance the contacts between these ACEP leaders and their federal legislators. The NEMPAC Board, ACEP Board and Council will be provided with regular updates of check deliveries and fundraisers attended by ACEP members.

Independent Expenditures

NEMPAC should continue to have the option to make independent expenditures in support of candidates in key races if funds are available for this allocation. Independent expenditure can be made for communications expressly advocating the election or defeat of a candidate that are not made in cooperation or consultation with or at the request or suggestion of, a candidate's campaign or representatives. These expenditures allow NEMPAC to go beyond the limits of $5,000 per primary and $5,000 per general to individual candidates' campaigns and can provide significant and much appreciated campaign support to candidates while enhancing ACEP's and NEMPAC's political influence.

Committee Assignments

NEMPAC contributions should be directed to those candidates who serve on committees with jurisdiction over healthcare issues. The committees can be designated as either a "key" committee (a committee with primary jurisdiction over healthcare issues), or a "secondary" committee (a committee with jurisdiction over some aspects of

healthcare legislation). Contribution amounts are based on which committee a Member serves, his or her leadership position on the committee, and whether the Member also serves on the healthcare subcommittee of the committee.
Key committees in the House are:

- Ways and Means
- Energy and Commerce
- Education and Labor (added in 2020 election cycle due to surprise billing issue)
- Appropriations

Secondary committees in the House are:

- Homeland Security
- Judiciary
- Rules

Key committees in the Senate are:

- Finance
- Health, Education, Labor and Pensions (HELP)
- Appropriations

Secondary Senate committees are:

- Budget
- Judiciary
- Homeland Security

Members of Congress on a key committee are eligible to receive a minimum of $2500 and/or $5000 if on the health subcommittee without Board approval. Members on Secondary Committees may receive up to $1,000 without Board approval. Additional funds to these members would require Board approval.

Relationship to ACEP

The relationship a candidate (Member of Congress) has with ACEP leadership, 911 members, staff and other ACEP members is another factor to consider when evaluating contribution requests. If a candidate has a good relationship with someone associated with ACEP, he or she is more likely to take the time to listen to ACEP's position on an issue. Although NEMPAC will direct most contributions to candidates (Members) who have shown concrete support for ACEP's priorities, a special relationship with ACEP can be an important factor in considering a contribution request.

Co-Sponsorship of ACEP Legislation

Members of Congress who do not serve on a key or secondary committee but who support ACEP's legislative agenda by co-sponsoring key legislation would be eligible for $2,500 - $5,000 during the election cycle. Also, Members of Congress who participate in press conferences, co-sign letters of support for an ACEP legislative priority, or host meetings for ACEP members, etc., would be considered for a NEMPAC contribution on a case-by-case basis in the same contribution range.

Difficulty of Race

As we move through the election cycle, the difficulty of a candidate's race or Members re-election campaign will become an important factor in determining if NEMPAC contributes to or increases the amount budgeted to a candidate. NEMPAC can have a greater impact by making contributions to candidates who face a difficult election.

National Party Committees

Prior to 2015, the maximum allowable annual donation from a PAC to a party committee was $15,000. NEMPAC consistently donated $15,000 to the NRSC, NRCC, DSCC and DCCC over the years to main parity and bi-partisanship in our giving strategy.
In 2015, three new types of political funds for national party committees went into effect.

- A **party convention fund** for the Republican National Committee and Democratic National Committee that may accept up to $45,000 per year from a multicandidate PAC.

- A **building fund** that may accept up to $45,000 per year from a multicandidate PAC. The RNC, NRSC, NRCC, DNC, DSCC and DCCC are eligible to accept these funds.
- A **recount & legal proceedings fund** that may accept up $45,000 per year from a multicandidate PAC. The above committees are also eligible for these types of funds.

In the 2018 election cycle, NEMPAC contributed:
$60,000 to the National Republican Congressional Committee (NRCC),
$45,000 to the Democratic Congressional Campaign Committee (DCCC)
$39,500 to the National Republican Senatorial Committee (NRSC)
$45,000 to the Democratic Senatorial Campaign Committee (DSCC).

Contributing to these Committees allows ACEP leadership (i.e., Board members, FGA Committee members, etc.) and staff to participate in special briefings, roundtables and out of town events throughout the year held specifically for donors to the campaign committees. These events allow for greater access to Congressional leaders and will help establish ACEP as an important player on the political scene, and the travel expenses for ACEP members and staff participating in these and other candidate-related activities can be reimbursed by NEMPAC's administrative fund or hard dollars if needed.

Going forward in the 2020 cycle, it is recommended that NEMPAC continue to make a $15,000 annual contribution to these four committees. Because the amount allowable from PACs to these committees has dramatically increased, the possibility of exceeding the status quo should be considered by the NEMPAC Board on a case-by-case basis. Higher contributions to these committees can also result in access and VIP treatment options at the two national Presidential conventions in the summer of 2020.

Leadership PACs

Leadership PACs are separate funds established by Members of Congress that have separate and distinct limits from their campaign committees. Leadership PACs can accept up to $5,000 per year from other PACs. Legislators often use their leadership PACs to support the campaigns of other federal candidates who may not have the ability to raise significant or adequate funds on their own. When considering a contribution to a Member's leadership PAC, NEMPAC will observe the same criteria as for contributions to that member's campaign committee.

NEMPAC will budget $5,000 annually to the leadership PACs of NEMPAC "Champions" and consider other requests on an ad hoc basis. Leadership PAC contributions should be looked at carefully and not be given if there is the potential to reduce the amount available for other approved candidate's re-election campaigns.

Post Election/Debt Retirement

Some Members of Congress request contributions following a general election to help retire debts from the previous campaign. Debt retirement can offer ACEP the opportunity to establish relationships with Members of Congress that NEMPAC did not contribute to in the general election, to forge relationships with newly elected Members of Congress, and to maintain strong relationships with Members of Congress who have generally been supportive of ACEP's legislative agenda.

NEMPAC will continue its policy of considering on a case-by-case basis, contributions to Members' debt retirement accounts. These contributions will be considered only to victorious candidates, will not count towards a Member's total NEMPAC eligibility for the upcoming election cycle, and will not exceed the contribution level the candidate was eligible for under NEMPAC criteria in the just completed election cycle.

NEMPAC "Champions"

It is suggested that NEMPAC develop a list of "NEMPAC Champions" not to exceed a total of 20 incumbent Senators or Representatives and candidates. These champions would be eligible to receive the following financial support and other benefits from NEMPAC if available:

- Maximum donation to primary and general election campaign ($5K to each)
- Maximum donation to leadership PAC if applicable ($5K)
- Campaign highlighted in NEMPAC newsletter during the cycle with link to campaign website
- Campaign highlighted on NEMPAC website

- NEMPAC would host or co-host a MADPAC event for the Member during the election cycle
- NEMPAC staff or ACEP member would attend one out of town event for the Member per cycle
- NEMPAC staff would serve on the Member's fundraising steering committee
- NEMPAC would "tally" part of our party committee donation to that member.
- NEMPAC would conduct a dine-around event for the member during LAC.
- NEMPAC would fund or co-fund an independent expenditure for the member.

Ethical Issues

The NEMPAC Board will consider contributions to Members of Congress under investigation for ethical violations in Congress and/or outside criminal or civil investigations on a case by case basis with no formal written policy.

NEMPAC Board and ACEP Board Involvement

To show ACEP members the strength of support for NEMPAC and its activities by the leadership of ACEP, all members of both the ACEP Board of Directors and the NEMPAC Board of Directors should make significant contributions to NEMPAC each year.

Members of both Boards will be encouraged to "Give-a-Shift" ($1,200) each year to NEMPAC and maintain this giving level throughout their tenures. They will also be encouraged to attend and contribute to NEMPAC dine-around events at LAC annually.

As previously, Members of both Boards will be encouraged to attend at least one fundraiser or other event for their Representative and Senators in the next two years to enhance contacts between these ACEP leaders and their Members of Congress. NEMPAC will contribute to the federal representatives of Board members to allow those Board members to attend the event. A minimum amount will be contributed to each Board member' Representative and Senators, even if that Representative or Senator is not a strong supporter of ACEP's legislative priorities. This minimum contribution is simply designed to foster improved contacts between Board members and their Members of Congress.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 16(19)

SUBMITTED BY: Emergency Medicine Residents' Association

SUBJECT: Opposition to the AAMC Standardized Video Interview

PURPOSE: Oppose further study or use of the Association of American Medical Colleges Standardized Video Interview (SVI) for emergency medicine applicants.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Medical students comprise 31.3% of ACEP's candidate members and 10.7% of ACEP's total membership (as of December 2018); and

WHEREAS, The number of applications per applicant to emergency medicine residency programs has doubled over the past decade[1], resulting in residency programs needing to screen applications when deciding which students to invite for in-person residency interviews; and

WHEREAS, A 2016 Association of American Medical Colleges (AAMC) survey revealed that program directors do not feel that they have adequate tools to assess an applicant's interpersonal and communication skills and professionalism[2]; and

WHEREAS, The AAMC has been piloting the Standardized Video Interview (SVI) since 2016, an 18-minute interview where applicants speak to a computer while responding to six questions for three minutes each; and

WHEREAS, the AAMC states that the SVI would benefit applicants by giving them the opportunity to feel holistically reviewed[3] yet only 31% of students agree that SVI would help program directors conduct a more holistic evaluation of applicants[4]; and

WHEREAS, Less than one-quarter of applicants agree that the SVI gave them an opportunity to describe their interpersonal and communication skills or knowledge of professional behavior and only half agree they were able to answer SVI based on past experiences[4]; and

WHEREAS, more than half of applicants were satisfied with program director use of USMLE Step 1 and Step 2 CK scores as filters in the residency selection process (55% and 64%, respectively), while only 10% were satisfied with SVI as a filter[4]; and

WHEREAS, SVI scores are currently assigned by human reviewers with the intention of being scored by machine learning algorithms in the future and 80% of students are not comfortable with SVI being scored by computer[4]; and

WHEREAS, After three years of the SVI pilot, the AAMC has not provided pricing information about the cost of the SVI if implemented or who would bear those costs; and

WHEREAS, There have been ethical concerns raised about coercing students to participate in a "mandatory" research study without their consent[5]; and

WHEREAS, The AAMC states that the goal of the SVI is to "widen the pool of applicants invited to interview in person, including those who might not have otherwise been considered for interview," yet a study

performed across nine residency programs showed that in 93% of cases, SVI scores did not change likelihood to interview[6]; and

WHEREAS, Evidence has shown that evaluation of professionalism and interpersonal communications skills by emergency medicine faculty during in-person interviews poorly correlate with SVI scores[7]; and

WHEREAS, Only 85% of residency programs initially opted to participate in the SVI pilot[8] and two-thirds of participating programs reported that SVI scores are not important in deciding whom to invite to an in-person interview, and most programs did not take missing SVI scores into consideration in making selection decisions, and only 57% of programs who used the SVI planned to use it in the future; therefore be it

RESOLVED, That ACEP oppose further study or use of the Association of American Medical Colleges Standardized Video Interview for emergency medicine applicants.

References

[1] Jarou ZJ. President's Message: Apply Smarter, Not Harder. EM Resident. 10 Apr 2018. https://www.emra.org/emresident/article/presidents-message-apply-smarter-not-harder/
[2] AAMC. Results of the 2016 Program Directors Survey. https://store.aamc.org/results-of-the-2016-program-directors-survey.html
[3] AAMC. About the SVI. https://students-residents.aamc.org/applying-residency/article/about-svi/
[4] Deiorio NM, Jarou ZJ, Alker A, Bird SB, et al. Applicant Reactions to the AAMC Standardized Video Interview During the 2018 Application Cycle. Academic Medicine: June 18, 2019. https://journals.lww.com/academicmedicine/Abstract/publishahead/Applicant_Reactions_to_the_AAMC_Standardized_Video.97550.aspx
[5] Davis JJ. The 2017–2018 Standardized Video Interview: An Ethical Concern. Academic Medicine: January 2018 - Volume 93 - Issue 1 - p 11. https://journals.lww.com/academicmedicine/FullText/2018/01000/The_2017_2018_Standardized_Video_Interview___An.9.aspx
[6] Husain A, Li I, Ardolic B, Bond MC, et al. The Standardized Video Interview: How Does It Affect the Likelihood to Invite for a Residency Interview? AEM Education and Training. 25 February 2019. https://doi.org/10.1002/aet2.10331
[7] Hopson LR, Dorfsman ML, Branzetti J, Gisondi MA, et al. Comparison of the Standardized Video Interview and Interview Assessments of Professionalism and Interpersonal Communication Skills in Emergency Medicine. AEM Education and Training. 2019;00:1-10. https://onlinelibrary.wiley.com/doi/epdf/10.1002/aet2.10346
[8] Gallahue FE, Hiller KM, Bird SB, Calderone Haas MR, et al. The AAMC Standardized Video Interview Reactions and Use by Residency Programs During the 2018 Application Cycle. Academic Medicine: March 19, 2019. https://journals.lww.com/academicmedicine/Abstract/publishahead/The_AAMC_Standardized_Video_Interview__Reactions.97647.aspx

Background

This resolution calls on ACEP to oppose further study or use of the Association of American Medical Colleges (AAMC) Standardized Video Interview (SVI) for emergency medicine applicants.

The AAMC designed the Standardized Video Interview (SVI) to assess knowledge in two ACGME competencies: interpersonal and communication skills, and knowledge of professional behaviors. According to the AAMC website, the SVI consists of six, non-clinical questions that ask an applicant to "demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals," and to "demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles." The questions are presented in an online, unidirectional (no live interviewer) interview as text prompts. Applicants have 30 seconds to read the prompt and up to three minutes to record their response. The videos are then evaluated by six reviewers, each assigned to a single question.

The AAMC website states that the "emergency medicine program community has endorsed the use of the Standardize Video Interview during the ERAS® 2020 application cycle for all applicants to emergency medicine residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). All applicants to

ACGME-accredited emergency medicine residency programs are required to complete the Standardized Video Interview as a component of the ERAS® 2020 application." The AAMC also states that the SVI is not intended to replace the in-person interview or Standardized Letters of Evaluation but is intended to "enable applicants to share objective, performance-based information about themselves" in order to demonstrate their abilities beyond traditional test scores. The AAMC's intent in launching the SVI was to provide programs with an objective data point (outside of a CV or SLOE) to assess an applicant's professionalism as well as provide information about an applicant beyond Board scores and academic metrics. Their goal was to provide more holistic data to potentially broaden the scope of those invited to interview. The AAMC decided to pilot the SVI first with emergency medicine because of its "proven record of working to improve the selection process," diversity of applicant pool, and specialty size.

The AAMC conducted its own survey of EM program directors participating in the SVI 2019 pilot. One of the key findings discovered that 42% of survey respondents considered SVI scores during the selection process, down from 54% in the 2018 pilot. Thirty percent said that they used SVI scores to "identify applicants with strong interpersonal and communication scores and professionalism," and 27% used the SVI to find "diamonds in the rough." The survey also found that of the 50 respondents who said they did not use the SVI scores at any point, the majority said that it was because they were not sure how to incorporate the scores into their current selection process and they were waiting for additional research as to the utility of the scores. An additional reason cited by programs for not utilizing SVI videos was lack of time to watch them. Of the 34 respondents using the SVI scores during the selection process, both the SVI video and SVI total score ranked least when considering an applicant for an in-person interview. However, of the 34 respondents using the scores, 41% said they were somewhat or more likely to extremely likely to consider SVI scores when finalizing rank order lists.

One study looked at applicant's USMLE and SVI scores to determine if there was correlation. The findings suggest that while there was no correlation between the scores, the SVI provides unique information to program directors that is distinct from USMLE Step 1 and 2 scores and might provide some dimensionality to the applicant. Another study's findings suggest that SVI scores did not change the likelihood of being invited to an in-person interview in 93% of cases; however it did find that there was an impact on the likelihood to invite on subgroup analysis (i.e., those with lower SVI scores were less likely to be invited). A survey of SVI interviewees found that applicants had generally negative reactions to the SVI with most dissatisfaction towards the overall SVI and total score.

Arguments against the use of SVI include: redundancy with the Step 2 Clinical Skills examination; questions about the utility of an additional interview (i.e., there are approximately 192-288 hours of observed EM performance during EM rotations where an applicant's professionalism and communication are directly observed); the potential added expense and time to the applicant; and additional time/burden on the residency program to review more materials. One study noted the potential administrative burden to the residency program. Using the example of a program that receives more than 1,500 applications a year, it estimated that 450+ hours might be spent watching the SVIs. Other arguments against use of the SVI include: discomfort with the potential for computer (rather than human) scoring; studying students as a vulnerable population; questions about the potential impact on diversity; and questions about the validity of SVI score on predicting future performance.

The AAMC has convened an Emergency Medicine Standardized Video Interview Working Group (EMSVI), composed of SAEM, CORD, CDEM, AACEM, EMRA, AAEM-RSA, AAMC-GSA, and AAMC-GDI representatives. The AAMC website states that the committee has met monthly since the fall of 2016 with the group's efforts focused on SVI policy, research agenda, utility of the SVI, interpreting findings to date, and disseminating results. The website also states that an additional group, the SVI Local Validity Study Working Group, has been established to conduct a longitudinal study on the Emergency Medicine SVI, evaluating psychometrics, application and program director reactions, fairness and preparation, and prediction of PGY-1 performance.

An AMA resolution, "Medical Student Involvement and Validation of the Standardized Video Interview Implementation," was submitted to the 2017 House of Delegates by the Medical Student Section. It called on the AMA to advocate for delaying the expansion of the SVI until the utility of scores on performance was established and for the AMA to work in collaboration with the AAMC to study the potential implications of the SVI. Since the 2017 resolution was adopted, a 2018 AMA status report indicates that the AAMC was notified of the action, a meeting was

scheduled with a program director, and the AAMC and the Council will continue to monitor the issue. An additional resolution (314 "Evaluation of Changes to Residency and Fellowship Application and Matching Processes"), adopted by the 2019 AMA House of Delegates (HOD), called on the AMA to oppose changes to the application requirements until a number of conditions have been met, such as, "data available to demonstrate that the new application requirements, reduce, or at least do not increase, the impact of implicit bias…" and that "costs to medical students and residents are mitigated."

EMRA supports the National Residency Match Program and National Matching Services process as it exists in 2013. The EMRA Policy Compendium (Section XI. The Match and Residency and Fellowship Application Process) outlines a number of criteria that must be met before EMRA will consider supporting any proposed changes to the resident and fellowship application or match process. Changes will only be considered when: changes have been evaluated by working groups which have adequate students and residents as representatives; there are published data which demonstrates that the proposed application components contribute to an accurate and novel representation of the candidate, and are shown from an applicant and program perspective to add value to the application overall; there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds; costs to medical students and residents are mitigated. EMRA also "opposes the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application and match process until such time as the above conditions are met." Based on the criteria outlined, the SVI does not meet the EMRA requirements.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective B – Increase total membership and retain graduating residents.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 17(19)

SUBMITTED BY: Sarah Hoper, MD, JD, FACEP
American Association of Women Emergency Physicians Section
Diversity, Inclusion, & Health Equity Section
Quality Improvement & Patient Safety Section
Wisconsin Chapter

SUBJECT: Pay Transparency

PURPOSE: Develop a policy statement in favor of physician salary and benefit package transparency.

FISCAL IMPACT: Budgeted committee and staff resources for development and distribution of policy statements.

WHEREAS, Men in academic emergency medicine make 18% more than women[1]; and

WHEREAS, In 2019, Doximity reports that male physicians make $1.25 for every $1 female physicians earn and this equates to $90,490 less compensation for the average female physician; and

WHEREAS, Female specialists make 23% less than their male counterparts and female primary care physicians make 15% less than their male counterparts[2]; and

WHERAS, A 2016 study showed female physicians make $18,677 less than their male counterparts even after adjusting for how hard a physician works, their productivity, and years of experience[3]; and

WHEREAS, Women are viewed as less likable when they negotiate [4]; and

WHEREAS, Women are less likely to get a raise than men when they ask for a raise[5]; and

WHEREAS, The U.S. Bureau of Labor Statistics estimates the national gender gap across industries and occupations is 19%, in other words, women are taking home .81 cents on the dollar[6]; and

WHEREAS, Minorities also suffer from the pay gap; and

WHEREAS, According the US Department of Labor in April 2019, the median weekly earnings for black men are 74.7% of the median for white men and the median earnings for hispanic men are 70.5% of the median for white men, and black women's median earnings are 85.8% of white women, and earnings for Hispanic women are 76.4% of white women[7]; and

---

[1] Wiler JL, Rounds K, McGowan, Baird J. Continuation of Gender Disparities in Pay Among Academic Emergency Medicine Physicians. Acad Emerg Med 2019;26:286-92. https://onlinelibrary.wiley.com/doi/pdf/10.1111/acem.13694

[2] Doximity 2019 Annual Physician Compensation Report: 3rd annual study. March 2019. https://s3.amazonaws.com/s3.doximity.com/press/doximity_third_annual_physician_compensation_report_round4.pdf

3 Desai T, Ali S, Fang X, Thompson W, Jawa P, Vachharajani T. Equal work for unequal pay: the gender reimbursement gap for healthcare providers in the United States. *Postgraduate Medical Journal*, 2016; postgradmedj-2016-134094 DOI: 10.1136/postgradmedj-2016-134094

[4] Amanatullah ET, Morris MW. Negotiating gender roles: gender differences in assertive negotiating are mediate by women's fear of backlash and attenuated when negotiating on behalf of others. J Pers Soc Psychol. 2010 Feb; 98(2):256-67

[5] Artz B, Goodall A, Oswald A. Do Women Ask? Industrial Relations: A Journal of Economy and Society. Vol 57 Issue 4.

[6] https://www.bls.gov/opub/ted/2019/women-had-higher-median-earnings-than-men-in-relatively-few-occupations-in-2018.htm

[7] https://www.bls.gov/news.release/pdf/wkyeng.pdf

25 WHEREAS, A 2013 study has shown that workers are more productive when salary is transparent[8]; and
26
27 WHEREAS, pay transparency can make employers aware of implicit bias in payment structures, allow
28 employees to know their fair value, and give employees a basis for negotiation; therefore be it
29
30 RESOLVED, That ACEP develop a policy statement in favor of physician salary and benefit package
31 transparency.

Background

This resolution calls for ACEP to develop a policy statement in favor of physician salary and benefit package transparency.

Women currently are paid less than men in many fields, including emergency medicine. The pay gap in emergency medicine has remained the same for the past four years, even though wages increased in the industry as a whole. A recent report from Doximity[2] found that male physicians still earn roughly $1.25 for every $1 paid to female physicians.

Pay transparency – where employees know what each of their colleagues make – could be a tool to close the pay gap. Several companies from different fields have started to make pay information available publicly; some have even gone so far as to publish this information, while others are simply encouraging colleagues to discuss pay rates among themselves. According to a 2016 study, pay transparency can lead to higher rates of employee productivity and satisfaction. In some states, it can be illegal for colleagues to discuss salaries and compensation. Several states have passed laws banning employers from penalizing workers for discussing their salary with colleagues.

There are several factors that contribute to pay inequality. Conscious and unconscious biases can result in lower pay for women, specifically minority women. There is an assumption that women will leave the workforce to raise children, and this assumption is reflected in pay. Women are also less likely than men to negotiate their salaries, which can lead to a legacy of lower pay and poorer benefits. Research indicates that women are more likely to be penalized than men for negotiating salary and benefits, which also contributes to a legacy of lower pay.

ACEP policy statements "Non-Discrimination and Harassment" and "Workforce Diversity in Health Care Settings" do not address pay transparency specifically, but the Workforce Diversity policy statement affirms that "hospitals and emergency physicians should work together to promote staffing of hospitals and their emergency departments with qualified individuals of diverse race, ethnicity, sex (including gender, gender identity, sexual orientation, pregnancy, marital status), nationality, religion, age, ability or disability, or other characteristics that do not otherwise preclude an individual emergency physician from providing equitable, competent patient care." The policy also states that "attaining diversity with well qualified physicians in emergency medicine that reflects our multicultural society is a desirable goal." The Non-Discrimination policy statement affirms that ACEP opposes all forms of discrimination based on "race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, sexual orientation, or any other classification protected by local, state or federal law."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments

Goal 2 Enhance Membership Value and Member Engagement

---

[8]Huet-Vaugh E. Striving for Status: A Field Experiment on Relative Earnings and Labor Supply. http://econgrads.berkeley.edu/emilianohuet-vaughn/files/2012/11/JMP_e.pdf

Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine

Fiscal Impact

Budgeted committee and staff resources for development and distribution of policy statements.

Prior Council Action

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution directed that ACEP oppose all forms of discrimination against patients and oppose employment discrimination in emergency medicine.

Prior Board Action

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

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

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

Background Information Prepared by: Mandie Mims, MLS
Clinical Practice Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 18(19)

SUBMITTED BY: Emergency Medicine Residents' Association
Texas College of Emergency Physicians

SUBJECT: Promoting Emergency Medicine Physicians

PURPOSE: Create a public awareness campaign to highlight the unique skill set, knowledge base, and value of residency trained and board-certified emergency medicine physicians.

FISCAL IMPACT: Costs could range from $5,000 to $1 million depending on the scope of the campaign.

WHEREAS, The American College of Emergency Physicians (ACEP)[1], the Emergency Medicine Residents' Association (EMRA)[2], the Society of Academic Emergency Medicine (SAEM)[3], and the American Academy of Emergency Medicine (AAEM)[4] have policy highlighting board certified emergency physicians are the most appropriately trained and safest practitioners of emergency medicine; and

WHEREAS, ACEP believes that "PAs and APRNs do not replace the medical expertise and patient care provided by emergency physicians;"[1] and

WHEREAS, "ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care"[1] but are valued members of physician-led emergency care teams; and

WHEREAS, Nationally there has been an increase in the number of patients seen by PAs and NPs in the emergency department from 12.9% of all patients in 2005[5] to 28.8% of all patients in 2016,[6] and 42% of these patients seen by PAs and NPs are not currently seen by an emergency physician[6]; and

WHEREAS, The American Association of Nurse Practitioners (AANP) supports independent practice for NPs in the emergency department[7] and the American Academy of Physician Assistants (AAPA) recently adopted a resolution that to "replace obsolete supervisory agreement laws with practice-level decision-making about collaboration" and "authorize PAs to be directly reimbursed by all public and private insurers"[8]; and

WHEREAS, There is literature showing lower quality care provided by PAs and NPs in non-emergency settings related to avoidable imaging[9], antibiotic prescriptions[10,11], appropriateness of specialist referrals[12], unnecessary opiate, antipsychotic, and antidepressant medication prescriptions[13]; and

WHEREAS, Non-academic emergency departments staffed with non-physician providers have higher rates of imaging and admissions compared to emergency departments staffed solely by physicians, with projected additional costs of $425,725 per 1,000 visits;[14] and

WHEREAS, The combined number of osteopathic and allopathic residency positions in emergency medicine has increased 20.5% between 2015 and 2019[15], creating more board eligible/certified emergency physicians, decreasing the need for non-emergency physicians to practice emergency medicine;[16] and

WHEREAS, Public campaigns have been created by non-physician providers in the health care space to promote their positions to the general public[17]; and

WHEREAS, In September 2018, a resolution was adopted by the Representative Council of the Emergency

38 Medicine Residents' Association, asking EMRA to submit a resolution to ACEP requesting a public awareness
39 campaign highlighting the value of residency-trained, board-certified emergency physicians; therefore, be it
40
41 RESOLVED, That ACEP create a public awareness campaign to highlight the unique skill set, knowledge
42 base, and value of residency trained and board certified emergency medicine physicians.

References

[1] ACEP. Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department. https://acep.org/patient-care/policy-statements/guidelines-regarding-the-role-of-physician-assistants-and-advanced-practice-registered-nurses-in-the-emergency-department/
[2] EMRA Policy Compendium. Section III: The Emergency Medicine Workforce. https://www.emra.org/globalassets/emra/about-emra/governing-docs/policycompendium.pdf
[3] SAEM Position Statement on the Qualifications forUnsupervised Emergency Department Care (2000). https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1553-2712.2000.tb02075.x
[4] AAEM. Our Values. https://www.aaem.org/about-us/our-values
[5] Nawar EW, Niska RW, Xu J. National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary. CDC Advance Data From Vital and Health Statistics. Number 386. June 29, 2007. https://www.researchgate.net/publication/6135583_National_Hospital_Ambulatory_Medical_Care_Survey_2005_Emergency_Department_Summary
[6] National Hospital Ambulatory Medical Care Survey (NHAMCS): 2016 Emergency Department Summary Tables. Table 23. Providers seen at emergency department visits: United States, 2016. https://www.cdc.gov/nchs/data/nhamcs/web_tables/2016_ed_web_tables.pdf
[7] AANP Position Statement: Scope of Practice for Nurse Practitioners. https://www.aanp.org/advocacy/advocacy-resource/position-statements/scope-of-practice-for-nurse-practitioners
[8] AAPA. Frequently Asked Questions: Optimal Team Practice. https://www.aapa.org/wp-content/uploads/2017/11/110917-Core-FAQ-Revised-FINAL.pdf
[9] Hughes DR, Jiang M, Duszak R. "A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits." JAMA Intern Med. 2015;175(1):101–107. doi:10.1001/jamainternmed.2014.6349
[10] Schmidt, M., Spencer, M., & Davidson, L. (2018). Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. *Infection Control & Hospital Epidemiology*, 1-9. doi:10.1017/ice.2017.263
[11] Sanchez GV, Hersh AL, Shapiro DJ, Cawley JF, Hicks LA. "Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants." Open Forum Infectious Diseases. 2016;3(3):ofw168. doi:10.1093/ofid/ofw168.
[12] Lohr, Robert H. et al. "Comparison of the Quality of Patient Referrals From Physicians, Physician Assistants, and Nurse Practitioners." Mayo Clinic Proceedings, Volume 88, Issue 11, 1266 – 1271
[13] Muench, Ulrike Perloff, Jennifer Thomas, Cindy Parks Buerhaus, Peter I. et al. "Prescribing Practices by Nurse Practitioners and Primary Care Physicians: A Descriptive Analysis of Medicare Beneficiaries." Journal of Nursing Regulation, Volume 8, Issue 1, 21-30.
[14] Aledhaim A, Walker A, Vesselinov R, Hirshon JM, Pimentel L. Increased Resource Utilization by Advanced Practice Providers in Non-Academic Emergency Departments. Western Journal of Emergency Medicine. Volume 20, no. 4: July 2019. https://escholarship.org/uc/item/01q814f4
[15] NRMP. Results and Data 2019 Main Residency Match. http://www.nrmp.org/one-nine-press-release-thousands-resident-physician-applicants-celebrate-nrmp-match-results/
[16] Reiter M, Wen LS, Allen BW. The Emergency Medicine Workforce: Profile And Projections. The Journal of Emergency Medicine. 2016: 50(4): 690-3. http://dx.doi.org/10.1016/j.jemermed.2015.09.022
[17] "We Choose NPs." American Association of Nurse Practitioners. https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners-aanp/media/media-campaigns/a-national-awareness-campaign-starring-you

Background

This resolution calls for the College to create a public awareness campaign to highlight the unique skill set, knowledge base, and value of residency trained and board-certified emergency medicine physicians.

There has been an increase nationally in the number of patients seen by PAs and NPs in the emergency department, and many of those patients are not treated by an emergency physician. However, studies show that non-academic emergency departments staffed with non-physician providers have higher rates of imaging and admissions compared to emergency departments staffed solely by physicians. Meanwhile, there has been a significant rise in the number of

osteopathic and allopathic residency positions in emergency medicine, creating more board eligible/certified emergency physicians, and decreasing the need for non-emergency physicians to practice emergency medicine. In addition, some non-physician providers in the health care space have created public awareness campaigns to promote their positions.

A campaign of this nature would build on previous public relations campaigns that highlight the value of emergency medicine, including:

- The "2 percent campaign," which highlighted that emergency medicine represents only two percent of health costs;
- "Saving Millions," which recognized that emergency physicians save lives and limit spending in other areas; and
- Most recently, ACEP's 50th anniversary campaign, which showcased the evolving role and increasing value of emergency physicians within hospital walls and beyond.

There is a wide range in scope for a potential public education campaign. The College should consider the ultimate goal of a public education campaign, including the key decision makers. Campaigns with a discrete objective that target a limited number of audiences will be less costly and likely easier to measure its effectiveness compared to a national campaign that seeks to influence the "general public."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Fiscal Impact

Costs could range from $5,000 for simple campaign collateral development to $1 million for a comprehensive paid national campaign. Costs are dependent on the type and scope of activities undertaken.

Prior Council Action

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

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

Prior Board Action

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

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

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

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

Background Information Prepared by: Maggie McGillick
Public Relations Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 19(19)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM)

PURPOSE: 1) Support a public health approach to firearms-related violence and prevention of firearm injuries and deaths as enumerated in the 2018 American College of Physicians Position Paper. 2) Support the mission and vision of AFFIRM and partner with them to advocate for the allocation of federal and private research dollars.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, In 2015, the American College of Emergency Physicians joined with eight professional health organizations and the American Bar Association in a call to action, and put forth a list of specific measures aimed at reducing deaths and injury related to firearms[1]; and

WHEREAS, In October 2018, the American College of Physicians (ACP) published a list of position statements and recommendations to develop and support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths[2]; and

WHEREAS, The American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) is a 501(c)(3) non-profit corporation comprised of healthcare professionals and researchers working together to find lasting solutions to curb the epidemic of firearm violence across the United States[3]; and

WHEREAS, AFFIRM funding goes directly to research that will inform protocols for everyone working on the frontlines of healthcare, develop innovative solutions that connect our network to other first responders and stakeholders, and create education and information for healthcare professionals and the public; and

WHEREAS, Our organizations share a common vision to reduce the human and financial costs of firearm injury and ACEP abhors the current level of intentional and accidental firearm injuries and supports AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death[4]; and

WHEREAS, ACEP also supports the development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence[2]; therefore be it

RESOLVED, That ACEP support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 American College of Physicians Position Paper; and be it further

RESOLVED, That ACEP support the mission and vision of the American Foundation for Firearm Injury

---

[1] Weinberger SE, et al. Firearm-related injury and death in the United States: a call to action from 8 health professional organizations and the American Bar Association. *Ann Intern Med*. 2015;162:513-6.
[2] Butkus R, Doherty R, Bornstein SS, for the Health and Public Policy Committee of the American College of Physicians. Reducing Firearm Injuries and Deaths in the United States: A Position Paper From the American College of Physicians. *Ann Intern Med*. 2018. 169:704–707. doi: 10.7326/M18-1530
[3] affirmresearch.org
[4] Letter to Dr. Chris Barsotti from Dr. Paul Kivela, ACEP President. March 8, 2018.

30 Reduction in Medicine (AFFIRM) and will partner with AFFIRM to advocate for the allocation of federal and
31 private research dollars to further this agenda.

Background

This resolution calls for ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 American College of Physicians Position Paper; and support the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) and partner with AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

In March 2018, ACEP provided a letter of support for the mission and vision of AFFIRM. The letter outlined ACEPs support of 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. In January 2019, the Board of Directors approved a $20,000 donation to AFFIRM.

ACEPs legislative and regulatory priorities over the years have included 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. ACEP has worked with the AMA and other stakeholders to address firearm injury prevention and research on this issue.

The College has addressed the issue of firearms multiple times over the years through Council resolutions and policy statements. A compilation of resources for physicians impacted by active shooter mass casualty incidents is available on the ACEP website.

The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants. An Early Career Research Development Grant for $150,000 was awarded to Kristen Mueller, MD from Washington University in St. Louis in June 2019 for "Firearm Injuries and Recidivism at St. Louis Level 1 Trauma Hospitals." AFFIRM contributed $37,5000 and EMF contributed $112,000 to fund this grant. A $5,000 Medical Student Research Grant was awarded in June 2019 to Henry Schwimmer, BA from Emory University School of Medicine for "Rural Emergency Department Firearm Assessment, Screening, and Treatment (FAST) Trial." AFFIRM contributed $2,500 and EMF contributed $2,500 for this award. AFFIRM, EMF and the Emergency Nurses Association Foundation (ENAF) are partnering to fund another research grant to be awarded in July 2020, with each organization contributing $25,000. ACEP members are represented as leaders in AFFRIM, have attended strategic planning meetings, and an ACEP staff member is also member of their Research Council, participating in monthly conference calls.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted. Directed ACEP to support Extreme Risk Protection Orders (ERPO) legislation at the federal level; promote and assist chapters to enact ERPOs by creating a toolkit and other appropriate resources; and encourage and support further research of the effectiveness and ramifications of ERPOs and Gun Violence Restraining Orders

(GVROs).

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.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. Directed ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence, devise strategies to help emergency physicians to work with stakeholders to mitigate patient risk of self-directed or interpersonal harm, investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes, and explore similar precedents currently in use.

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.

Amended Resolution 41(04) Assault Weapon Ban adopted. ACEP deplores 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 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.

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

June 2019, discussed proposed revisions to the statement "Firearm Safety and Injury Prevention." The policy statement was referred back to the Public Health & Injury Prevention Committee for further revision.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement "Domestic Family Violence;" reaffirmed June 2013; originally approved October 2007 replacing seven rescinded policy statements.

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).

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed "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.

Substitute Resolution 21(14) Emergency Department Mental Health Exchange adopted.

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.

April 2013, approved the revised policy statement, "Firearm Safety and Injury Prevention;" replacing the "Firearm Injury Prevention" policy statement that was revised and approved in October 2012 and January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Amended Resolution 41(04) Assault Weapon Ban adopted.

November 2000, assigned Resolution 14(00) Childhood Firearm Injuries to the Public Health & Injury Prevention Committee.

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.

Amended Resolution 69(95) Firearm Legislation adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Resolution 47(94) Firearm Classification referred to the Board of Directors.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted.
Substitute Resolution 45(94) Firearm Possession adopted.

Substitute Resolution 44(94) Firearm Legislation adopted.

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 16(93) Possession of Handguns by Minors adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Amended Resolution 14(89) Ban on Assault Weapons adopted.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted.

Substitute Resolution 16(84) Ban on Handguns adopted.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Sandra M. Schneider, MD, FACEP
Associate Executive Director, Clinical Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 20(19)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders

PURPOSE: Promote awareness of ACEP policy statements that oppose barriers to physicians seeking treatment for mental health and substance use issues and 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.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The physician suicide rate is 1.5 times higher for male physicians and 2.3 times higher for female physicians compared to the general population[1]; and

WHEREAS, According to a 2014 study by the Substance Abuse and Mental Health Services Administration, 43.6 million American adults suffer from some form of mental illness, 20.2 million report having a substance abuse disorder, and 7.9 million report having both a mental illness and a substance abuse disorder[2]; and

WHEREAS, Physicians have similar rates of mental illness and substance use disorders compared to the general population according to studies from the *Journal of the American Medical Association*[3]; and

WHEREAS, All but three states – California, Nebraska, and Wisconsin – have Physician Health Programs (PHPs) that refer doctors to a treatment program where they can spend up to 90 days in an inpatient facility without fear of disciplinary action from a state medical board[4,5]; and

WHEREAS, Physicians in general and emergency physicians enrolled in PHPs for substance use disorders have a high rate of success with reported 5-year abstinence rate between 75-90%[6,7,8]; and

WHEREAS, There is renewed focus on the reintegration of physicians into medical practice while ensuring patient safety[9]; and

WHEREAS, There is movement to focus on wellness and safety and solutions that are supportive rather than punitive; and

WHEREAS, For physicians, whether for substance use disorder, mental health, or other issues, there remains significant stigma that instills judgement, loss of privacy, or discriminatory treatment; and

WHEREAS, For physicians, whether for substance use disorder, mental health, or other issues, there is a significant fear of loss of licensure, loss of income, and fear of required in-patient treatment preventing them from seeking support and treatment; therefore be it

RESOLVED, That ACEP promote awareness of current ACEP policy statement that supports decreasing the barriers, perceived or real, to physicians to feel safe seeking treatment for mental health, substance use, and other issues; and be it further

RESOLVED, That ACEP work with the American Medical Association and state medical societies to advocate for a change at state medical boards for protections for licensure for physicians to seek help and treatment for mental health, substance use, and other disorders.

References

[1] Drummond, D. Stop Physician Burnout: What to Do When Working Harder Isn't Working. 2014.
[2] https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUHFRR1-2014.pdf.
[3] https://jamanetwork.com/journals/ jama/fullarticle/2474424 and the Mayo Clinic Proceedings (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704134/).
[4] https://www.modernhealthcare.com/article/20160514/MAGAZINE/305149988/when-the-addict-is-a-doctor
[5] https://www.fsphp.org/state-programs
[6] Boisaubin EV, Levine RE. Identifying and assisting the impaired physician. Am J Med Sci. 2001;322(1):31-36. doi: S0002-9629(15)34629-2 [pii].
[7] Rose JS, Campbell M, Skipper G. Prognosis for emergency physician with substance abuse recovery: 5-year outcome study. West J Emerg Med. 2014;15(1):20-25. doi: 10.5811/westjem.2013.7.17871 [doi].
[8] Rose JS, Campbell MD, Yellowlees P, Skipper GE, DuPont RL. Family medicine physicians with substance use disorder: A 5-year outcome study. J Addict Med. 2017;11(2):93-97. doi: 10.1097/ADM.0000000000000278 [doi].)
[9] ACP Position Paper, Physician Impairment and Rehabilitation: Reintegration Into Medical Practice While Ensuring Patient Safety: A Position Paper From the American College of Physicians, 4 June, 2019.

Background

This resolution calls ACEP to promote awareness of ACEP policy statements that oppose barriers to physicians seeking treatment for mental health and substance use issues and 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

After the passage of the Americans with Disabilities Act (ADA) in 1990, professional organizations, such as the American Psychiatric Association (APA), proposed guidelines for state licensing boards when asking about a physician's mental health. Title II of the ADA prohibits discrimination by public entities on the basis of disability, including psychiatric disabilities. Since the ADA's passage, medical board screening of applicants of prior history of mental illness or substance use disorders (SUD) using broad or hypothetical questions has been increasingly seen as discriminatory. Arguments have been raised about the necessity and legitimacy of broad-based inquiries into a physician's history with mental illness or SUD and their use as a proxy for a physician's ability to currently practice competently and without impairment. However, state boards often find challenges complying with the recommendations as they attempt to identify the line between an applicant's right to privacy with the sense of duty to protect the public.

State board licensing application questions about physician mental health vary. Some states ask broad, general questions such as, "Are you now, or have you ever been, diagnosed with or treated for mental illness?" while others follow the recommendations of the American Medical Association (AMA), Federation of State Medical Boards (FSMB), and APA, using a more targeted question intended to address *current* functional impairment. The AMA, FSMB, and APA have issued formal guidelines opposing expansive questions about mental health. In June 2018, the AMA amended its policy on *Access to Confidential Health Services for Medical Students and Physicians*. The policy states in part, "Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept 'safe haven' non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety." The FSMB, in it's policy *Physician Wellness and Burnout,* adopted in April 2018, recommends that state medical boards consider whether it is necessary to include "probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure," noting also that these questions are likely to discourage treatment-seeking among applicants.

A recent analysis of medical licensure application questions found that only 18 of 32 applications appropriately addressed this issue by either limiting their questions to "current impairment from a mental health condition," or refrained from the question all together. The remining licensing bodies asked questions considered by many to be outside the limits of ADA standards (i.e. probing too far into the past to demonstrate current impairment, etc.). It has been noted that in states with broad questions about mental health care, physicians are less likely to seek care. One key factor shaping behavior is fear of punitive consequences (either real or perceived) and/or loss of esteem. ACEP

met with the FSMB in the fall of 2018 to further discuss this issue and also met with the National Association of Medical Staff Services (NAMSS) to address these issues in training and certification credentialing processes.

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."

The Federation of State Physician Health Programs (FSPHP) evolved from an initiative of the AMA and state-based physician health programs focused on the rehabilitation and monitoring of physicians with psychoactive SUD as well as physical and mental illness. To date, nearly every state has state physician health programs (PHP) that operate within the parameters of state regulation and legislation. These state programs vary in terms of services they can provide, and typically focus on substance use disorders. The FSPHP website states that the FSPHP and FSMB frequently schedule their meetings in the same location to foster communication and understanding as well as joint participation. A 2010 survey of physicians' taking part in a PHP program found general satisfaction with the program with 92.5% stating they would recommend it to others. However, some recent criticism of PHPs has raised issues such as: concern about its scope of influence, unnecessary treatment and costs of care.

In 2010, the Well-being Committee contributed to a health resource document for emergency physicians. In 2017, ACEP began working with partner organizations, such as CORD and AAEM, on a campaign to raise awareness about physician suicide. One study examined the suicide rates among physicians. It discovered that physicians have higher rates of suicide than the general population. For males, it is 1.41 times higher and for females 2.27 times the general population. A suicide awareness campaign was held in September of 2018, with another campaign planned to occur during National Suicide Prevention Week in 2019. The campaign goals are to shed light on physician suicide, decrease stigma and contribute to a culture of change. In addition, the Wellness Section screened the documentary, DO NO HARM, at *ACEP18* to continue to engage in dialogue about this issue. Another viewing is planned for *ACEP19*. The Well-Being Committee was assigned an objective for the 2018-19 committee year to study specialty-specific factors leading to depression and suicide and develop an action plan to address them. The committee is currently reviewing manuscripts looking at stories told by survivors of suicide attempts and anticipate distributing a quantitative survey to members to gather data for a larger project on suicide prevention.

In response Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care, in June 2019, materials were distributed to chapters with an explanation of the issue with background and talking points as well as a template letter to be used to send to their state medical board and a template letter asking for hospital support on the issue.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted. Directed ACEP to work with stakeholders to advocate for changes in state medical board licensing application questions about physician's mental health.

Resolution 16(18) No More Emergency Physician Suicides adopted. Directed ACEP to study the unique specialty-specific factors leading to depression and suicide in emergency physician and develop an action plan to address them.

Amended Resolution 32(04) Disability in Emergency Physicians adopted. Directed ACEP to evaluate and communicate issues related to disability and impairment in the practice of emergency medicine to members and address barriers to participation for members with disabilities. Also directed ACEP to request that ABEM include information on disability in their Longitudinal Study of Emergency Physicians.

Substitute Resolution 9(99) Federation of State Medical Board Recommendations adopted. Directed ACEP to consider establishing a formal relationship with the FSMB and to develop strategies and tools for members to respond to the FSMB's recommendations in "Maintaining State-Based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession."

Substitute Resolution 43(88) Emergency Physician Wellness adopted. Directed ACEP to endorse the concept of promoting emergency physician wellness and for the Board to report back to the Council Steering Committee on their actions related to the Wellness Working Group report.

Amended Resolution 29(82) Physician Impairment adopted. Directed ACEP to establish a committee to develop a program on addiction education for members and a program to encourage colleagues with substance use disorders to seek help and provide a report to the 1983 Council about the progress on these efforts.

Prior Board Action

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted.

Resolution 16(18) No More Emergency Physician Suicides adopted.

October 2013, approved the revised policy statement "Physician Impairment;" revised and approved October 2006; reaffirmed September 1999; revised and approved April 1994; originally approved September 1990.

Amended Resolution 32(04) Disability in Emergency Physicians adopted.

Substitute Resolution 9(99) Federation of State Medical Boards adopted.

Substitute Resolution 43(88) Emergency Physician Wellness adopted.

Amended Resolution 29(82) Physician Impairment adopted.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION : 21(19)

SUBMITTED BY: Hawaii Chapter

SUBJECT: Video Conferencing for Chapter and Section Meetings

PURPOSE: Facilitate electronic meetings for chapters and sections using the contracted National ACEP videoconferencing service.

FISCAL IMPACT: The cost to ACEP depends on the number of hosts signed up with the service. The annual cost ranges from less than $200 to more than $7,000.

WHEREAS, Technology for videoconferencing and audio meetings has improved to the point of widespread use by multiple organizations including ACEP; and

WHEREAS, Meeting participation for ACEP chapters and sections is challenged by geographic and scheduling constraints; and

WHEREAS, Improved chapter and section communication will help support local and national ACEP initiatives; and

WHEREAS, ACEP "Chapter Services offers a wide range of services and resources to help ACEP chapters and their leaders maximize their effectiveness"; therefore, be it

RESOLVED, That ACEP provide and pay for one videoconference meeting host* for each chapter and section that requests this service.

References

1. Zoom. *Zoom Meeting Plans for Your Business.* Retrieved May 27, 2019 from https://zoom.us/pricing
2. Edinger, S. Harvard Business Review. (June 29, 2018). *Stop Scheduling Conference Calls and Finally Commit to Videoconferencing.* Retrieved May 27, 2019, from https://hbr.org/2018/06/stop-scheduling-conference-calls-and-finally-commit-to-videoconferencing
3. ACEP. (2019). *ACEP Chapter Services.* Retrieved May 27, 2019, from https://www.acep.org/how-we-serve/chapter-services/

* A host is the "owner" of a meeting or webinar and the person who can control the meeting via the host controls.

Background

This resolution calls for ACEP to provide and pay for one videoconference meeting host for each chapter and section that requests this service.

Zoom is the leader in modern enterprise video communications, with an easy, reliable cloud platform for video and audio conferencing, collaboration, chat, and webinars across mobile devices, desktops, telephones, and room systems. ACEP began using Zoom in December 2018. Every staff member has their own user (host) account linked to ACEP's Business account, and can host meetings for their committees, sections, etc., with 200 or less participants per ACEP's contract with Zoom.

The 2019 Chapter Services Survey indicates that "member engagement" is the top item that chapters wish they could spend more time on if they had more resources. Currently, chapters use a variety of teleconferencing services with varied associated costs, and some chapters may already be using Zoom. Zoom may offer more functionality than

many of the other services. Increased functionality may provide an incentive for increased use of webinars and video conference calls, which could increase efficiency and reduce meeting and travel expenses significantly for chapters.

Sections are a subcategory of national ACEP membership. As such, sections are part of national ACEP and do not have separate bylaws or formal incorporation documents. All sections have a staff liaison, employed by ACEP, who already has a Zoom account and can schedule and facilitate Zoom meetings as desired by the section.

Each chapter is a separate corporate entity organized pursuant to the laws of its state. There are 53 ACEP chapters and 10 of those chapters have contracted with ACEP to provide management services. The executive director of the 10 chapters managed by ACEP is employed by ACEP. The other 43 chapters either contract their management services to the state medical society, an association management company, an individual or firm, or employs its own staff. There are currently 40 chapter executive directors who are not employed by ACEP.

Zoom has several options for their services. The Enterprise plan is the top tier with the most benefits. The cost is $19.99 per month and per host for a minimum of 50 hosts. With chapters having only 40 possible hosts (chapter executive directors not employed by ACEP), the Enterprise tier is not an option. The Business plan is the second tier and this is the type of account contracted by ACEP. The retail cost is $19.99 per month and per host for a minimum of 10 hosts. ACEP negotiated a discount for this service at $14.99 per month and per host. Although the benefits are not as comprehensive as the Enterprise plan, the Business plan meets ACEP's needs.

ACEP uses single sign-on (SSO) which allows staff to log in with their computer credentials. The ACEP Business account is administered by ACEP's Chief Technology Officer. Since most chapter staff are not employed by ACEP, they do not (and cannot) have access to ACEP's Zoom account. The 10 chapters currently managed by ACEP do have access to ACEP's account since their executive director is an ACEP employee.

ACEP would need to establish a separate Zoom account for 43 chapters and administer all of the user accounts (hosts). Per Zoom's terms and conditions and ACEP policy, a host subscription may not be shared or used by anyone other than the individual assigned as a host.

It is unknown whether all chapters would utilize such an account. If offered by ACEP, all chapters would likely sign up for the service with the intention of using it because there is no charge to the chapter. ACEP's Chief Technology Officer and ACEP's Zoom account manager, suggests that the Pro tier should meet the needs of chapters. Most small businesses' needs are met by the Pro tier. The Pro tier has less features than the Business tier, but it is unknown whether the added features of the Business tier would be useful to the chapters. The cost of the Pro tier is the same as ACEP's Business account, $14.99 per month per host, with the advantage of having no minimum number of hosts. This means that individual chapters can sign up at the Pro tier and administer their own account. The expense for this service could be submitted to national ACEP for reimbursement annually and would reduce ACEP staff expenses associated with managing the account and users (hosts) on behalf of chapters.

One feature of the Pro tier that could be problematic for some chapters is the 100 participant limit. ACEP meetings with anticipated attendance of 100-500 participants are set up using Zoom Video Webinars, which is an additional feature that is not included in any of the Zoom Meeting plans. ACEP does have a Zoom Video Webinars plan that includes five user accounts (hosts). ACEP staff could help facilitate this option using its Video Webinar account for chapters with this need. For more information on Zoom pricing, visit: https://www.zoom.us/pricing.

ACEP's Chapter Services staff provide other services to improve communications within chapters, including access to the engagED platform, ACEP's online member community. This service is available to all chapters that wish to have an all-member chapter community or communities for their chapter committees, leaders, etc. Chapter Services also offers a free quarterly e-newsletter service to chapters. For each issue, chapters must provide at a minimum a letter from the chapter president or another leader and a calendar of chapter events. National ACEP supplies clinical or state advocacy content, a list of new members to the chapter, and any other valuable information for the chapter, formats the newsletter into an email, and distributes it to the chapter members. Additionally, ACEP also designed, hosts, and helps maintain 29 chapter websites at no cost to the chapter.

It is advisable that ACEP gather data on the usage of Zoom by chapters prior to making a financial commitment. Chapters interested in using Zoom could start with the Basic tier, which is free, or the Pro tier at $14.99 per month per host and report its usage back to ACEP for analysis and further consideration.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Engagement
Objective B.5. – Strengthen chapter operations with resources and services that the growth and efficient operation of chapters.

Fiscal Impact

Option 1: Business tier including ACEP-negotiated discount is $14.99 per month per host with a minimum of 10 hosts. ACEP would need to set up the account and administer all of the user accounts. Possible scenarios:

10 hosts x 12 months at $14.99 per month = $1,798.80
25 hosts x 12 months at $14.99 per month = $4,497.00
40 hosts x 12 months at $14.99 per month = $7,195.20

Option 2: Pro Tier is $14.99 per month per host and has no minimum number of hosts. Chapters can set up and administer their own account. Possible scenarios:

1 host x 12 months at $14.99 per month = $179.88
5 hosts x 12 months at $14.99 per month = $899.40
Pricing for 10 or more hosts is the same as above.

Unbudgeted staff labor to set up a Business account for chapters and administer the individual user accounts (hosts), estimated at a minimum of 8 hours per month.

Prior Council Action

None specific to national ACEP providing videoconferencing services for chapters.

Prior Board Action

None specific to national ACEP providing videoconferencing services for chapters.

Background Information Prepared by: Maude S. Hancock
Chapter Services Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 22(19)

SUBMITTED BY: Carrieann Drenten, MD, FACEP
Douglas Gibson, MD, FACEP
Vikant Gulati, MD, FACEP
Susanne Spano, MD, FACEP
Andrea Wagner, MD, FACEP
Delaware Chapter

SUBJECT: Visual White Coat for Emergency Medicine Advocacy Efforts

PURPOSE: Encourage LAC attendees to wear white coats for their Congressional meetings and require ACEP Board members attending LAC to wear ACEP-branded white coats in their Congressional meetings that day.

FISCAL IMPACT: $2,000 – $5,000 depending on the quality of the medical coats.

WHEREAS, As ACEP continues to be a strong advocate for emergency medicine healthcare; and

WHEREAS, The Leadership & Advocacy Conference continues to grow and become a powerful and effective tool in getting our important message across; and

WHEREAS, The topics we discuss have the opportunity to change legislators, staffers, and regulators minds on issues that impact all emergency physicians, patients, and communities; and

WHEREAS, The white coat symbolizes compassion, honor, and trusted respect; and

WHEREAS, Consultant and advocacy experts advise that legislators respond favorably to those in white coats, which in turn may make our message more effective; and

WHEREAS, When ACEP leaders and members are advocating they do not represent any group but the collective voice of emergency physicians and the patients and communities we serve; and

WHEREAS, Many Leadership & Advocacy Conference participants assume that they should not be wearing their white coat to hill visits because they witness the leaders of the organization wearing more business professional dress over clinical professional dress during previous events; therefore be it

RESOLVED, That ACEP encourage Leadership & Advocacy Conference participants to bring and wear their white coat when making Hill visits to help make a visual impact when meeting with legislators, staffers, and the public who may be also visiting the Hill; and be it further

RESOLVED, ACEP work with a third party vendor to issue branded ACEP white coats to all active national ACEP Board of Directors members to help create a powerful visual that accompanies our advocacy message while also ensuring clarity that our national representative is speaking on behalf of our organization and the specialty while not creating confusion of favoring any group, practice style, etc.

Background

This resolution calls for ACEP to encourage attendees of the Leadership & Advocacy Conference (LAC) to wear white coats for their Congressional meetings and to require the ACEP Board members attending LAC to wear ACEP-branded white coats in their own Congressional meetings that day.

Promotional materials for LAC encourage attendees to wear business attire for their Congressional meetings. Occasionally, some attendees have chosen to wear medical coats on such visits, and it is not discouraged to do so. It is recommended that if medical coats are worn, that business attire be worn underneath the medical coats instead of scrubs.

A poll of 27 medical specialty societies was conducted. Including ACEP, there were 21 responses, and all indicated that they encourage business attire instead of white medical coats for Congressional visits.

American Academy of Dermatology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Neurological Surgeons
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Physical Medicine & Rehabilitation
American College of Physicians
American College of Radiology
American Psychiatric Association
American Society of Anesthesiology
American Society of Clinical Oncology
American Society of Hematology
American Society of Nephrology
American Society of Plastic Surgeons
American Urological Association
College of American Pathologists
Society of Critical Care Medicine
The Society of Thoracic Surgeons

In 2005, Scientific Assembly was hosted in Washington, DC, and as part of the programming, ACEP organized a rally on the lawn of the U.S. Capitol and requested that attendees wear white coats as a visible call for improving access to emergency care for all Americans through legislation that addressed medical liability reform and additional Medicare payments.

In 2017, Scientific Assembly was again hosted in Washington, DC. As part of the programming, ACEP offered "White Coat Day" where conference attendees were able to register to have ACEP arrange Congressional meetings for them and provide advocacy messaging and talking points for these meetings.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.
Strategy 6 – Promote and increase visibility of emergency physicians as leaders in health care.

Fiscal Impact

$2,000 – $5,000 (15 Board members and 2 Council officers) depending on the quality of the medical coats.

Prior Council Action

None

Prior Board Action

June 2005, reviewed the plans to promote ACEP's Rally on the Hill, which included encouraging everyone to wear their white coats.

Background Information Prepared by: Laura Wooster, MPH
Associate Executive Director, Public Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

2019 Council Meeting
Reference Committee Members

Reference Committee B
Advocacy & Public Policy
Resolutions 23-39

Catherine A. Marco, MD, FACEP (OH), Chair
Bradley Burmeister, MD (WI)
Zachary J. Jarou, MD (EMRA)
Thom R. Mitchell, MD, FACEP (TN)
Randy L. Pilgrim, MD, FACEP (LA)
Lindsay M. Weaver, MD, FACEP (IN)

Ryan McBride, MPP
Harry Monroe

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 23(19)

SUBMITTED BY: Alaska Chapter
California Chapter
New Mexico Chapter
Oregon Chapter
Washington Chapter
Pain Management & Addiction Medicine Section

SUBJECT: Allow Emergency Physicians to Prescribe Buprenorphine

PURPOSE: Advocate for the removal of the Drug Enforcement Agency X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine for opioid use disorder.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

WHEREAS, The opioid epidemic shares responsibility for declining life expectancy in the USA by killing 130 Americans daily[1,2,3,4]; and

WHEREAS, Buprenorphine has proven benefit for achieving remission from opiates and decreasing mortality;[5,6] and

WHEREAS, Emergency department-initiated buprenorphine/naloxone treatment increases engagement in addiction treatment;[7] and

WHEREAS, Prescribing buprenorphine requires physicians to obtain a Drug Enforcement Agency (DEA) X license, which can only be obtained after an 8-hour course and caps the number of patients to whom the medication can be prescribed; and

WHEREAS, The requirement for the DEA X-waiver is a barrier to physicians prescribing buprenorphine;[8] and

WHEREAS, More than half of rural counties in the United States have no DEA X-waivered prescribers and consequently no ability to prescribe buprenorphine;[9] and

WHEREAS, Physicians already have unrestricted ability to prescribe far more dangerous and addictive opioids; and

WHEREAS, A country that eliminated special training requirements to prescribe buprenorphine decreased opiate deaths 79%;[10] and

WHEREAS, ACEP already supports the development of educational content around the role of medication assisted treatment with buprenorphine and opioid use disorder for emergency physicians; therefore be it

RESOLVED, That ACEP advocate for the removal of the Drug Enforcement Agency X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine[11] for opioid use disorder.

References

1. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017. Available at http://wonder.cdc.gov.
2. Contribution of Opioid-Involved Poisoning to the Change in Life Expectancy in the United States, 2000-2015 Deborah Dowell, MD, MPH1; Elizabeth Arias, PhD2; Kenneth Kochanek, MA2; et al Robert Anderson, PhD2; Gery P. Guy Jr, PhD, MPH1; Jan L. Losby, PhD, MSW1; Grant Baldwin, PhD, MPH1 JAMA. 2017;318(11):1065-1067. doi:10.1001/jama.2017.9308
3. NCHS Data Brief ■ No. 328 ■ November 2018 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention National Center for Health Statistics Mortality in the United States, 2017 Sherry L. Murphy, B.S., Jiaquan Xu, M.D., Kenneth D. Kochanek, M.A., and Elizabeth Arias, Ph.D.
4. NCHS Data Brief ■ No. 329 ■ November 2018 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention National Center for Health Statistics Drug Overdose Deaths in the United States, 1999–2017 Holly Hedegaard, M.D., Arialdi M. Miniño, M.P.H., and Margaret Warner, Ph.D.
5. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002207. DOI: 10.1002/14651858.CD002207.pub4.
6. BMJ 2017;357:j1550 Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies
7. JAMA. 2015 Apr 28;313(16):1636-44. doi: 10.1001/jama.2015.3474.Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. D'Onofrio G1, O'Connor PG2, Pantalon MV1, Chawarski MC3, Busch SH4, Owens PH1, Bernstein SL1, Fiellin DA5.
8. "To Help Providers Fight The Opioid Epidemic, "X The X Waiver", " Health Affairs Blog, March 5, 2019.DOI: 10.1377/hblog20190301.79453
9. http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2017/05/RHRC_DB162_Andrilla.pdf
10. Curr Psychiatry Rep. 2007 Oct;9(5):358-64.Why buprenorphine is so successful in treating opiate addiction in France. Fatseas M1, Auriacombe M
11. Ref AMA: https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-9-19-Letter-to-President-re-Interim-Opioid-Report.pdf

Background

This resolution calls for ACEP to advocate for the removal of the Drug Enforcement Agency X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine[11] for opioid use disorder.

The scope of this resolution is similar to Resolution 31(19) Improving Emergency Physician Utilization of Medication for Addiction Treatment; therefore, the content of the background information is similar for both resolutions.

The immense scope of opioid use disorder and its associated public health impacts have become increasingly evident across all fields of medicine. The size of the crisis prompted the Department of Health and Human Services to declare the opioid crisis a public health emergency in October of 2017. Yet, despite the wide-ranging nature of this issue, nowhere are its impacts clearer than in the Emergency Department (ED). According to the National Survey on Drug Use and Health, in 2015 approximately 3.8 million people misused pain medications and 329,000 people used heroin. An estimated 135,000 of those people tried heroin for the first time during that year. Despite the scale of opioid misuse in this country, the consequences of that misuse are even more profound. Since 2001 there has been a 200% increase in the rate of death from opioids. In 2016 alone nearly two thirds (66.4%) of all drug overdose deaths involved prescription opioids, illicit opioids, or both, an increase of 27.7% from 2015. Put simply, opioid use disorder is widespread, and its associated mortality is getting worse.

Given the impact of opioid use disorder on ED patients, emergency medicine providers are taking the lead on addressing this crisis. Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder.

Medication for opioid use disorder refers to any addiction treatment that includes pharmacologic therapy. In the context of opioid use disorder this includes medications that act as opioid agonists, partial agonists, or antagonists. Popular examples are methadone, buprenorphine, and naltrexone. There is a growing body of literature showing that Medication Assisted Treatment (MAT) for opioid use disorder improves patient outcomes. Data suggest that patients receiving medication for opioid use disorder have decreased fatal overdose compared to with those who receive counseling alone. Additionally, patients maintained on buprenorphine for at least a year are noted to have less ED visits and inpatient hospital stays.

Yale University recently published a randomized controlled study evaluating the viability and efficacy of ED initiated buprenorphine. They determined that not only was it safe to administer buprenorphine to ED patients, but it also improved patient outcomes. Specifically, they found that compared to brief behavioral counseling or usual care, ED patients receiving buprenorphine where significantly more likely to be engaged in addiction treatment 2 months after their ED visit.

Despite the promise of this therapy they are currently significant barriers to ED administration of medication for opioid use disorder. The Drug Addiction Treatment Act of 2000 (DATA 2000) created a special licensing process for prescribing opioid-based addiction treatment. This special license, colloquially referred to as the X -Waiver, requires physicians to complete an 8-hour training course before they can legally prescribe. This training includes information on identifying appropriate patients for buprenorphine treatment and how to best use this medication within addiction treatment programs. However, the training is not specifically designed with ED providers in mind. Furthermore, the 8-hour training provides a significant barrier for the widespread adoption of medication assisted therapy.

ACEP's policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department" supports all patients being treated appropriately for acute pain with prompt, safe, and effective pain management. The policy statement acknowledges that acute pain management is patient-specific and provides guidance on pharmacological and non-pharmacological pain interventions. This is a joint statement by ACEP, the American Academy of Emergency Nurse Practitioners, and the Emergency Nurses Association. ED physicians will continue to be on the front lines of this public health emergency as the nation struggles with opioid use disorder. Given the scale of this problem it is incumbent upon us to use the best treatment available for our patients. While there are many potential solutions to this issue, medication for opioid use disorder is a promising tool, and is the only evidence-based treatment available for the treatment of opioid use disorder. It has proven to be both an effective and safe treatment for ED patients suffering from opioid addiction.

Most recently, ACEP met with the head of the Substance Abuse and Mental Health Services Administration (SAMHSA), Assistant Secretary for Mental Health and Substance Use Dr. Elinore McCance-Katz, on May 15, 2019. During our meeting with Dr. McCance-Katz, we discussed issues that are extremely important to emergency physicians and our patients, including the ability to administer buprenorphine in the ED for patients with opioid use disorder and how to improve care for patients with mental health illnesses. ACEP mentioned the resources and tools that we have created to help our physicians and patients, highlighting the EM-specific DATA 2000/Medications for Addiction Treatment waiver training course that is now being offered to our members, as well as new web-based and mobile device applications around opioids and the management and treatment of suicidal patients. One of SAMHSA's major goals is to boost the community resources that are available to help clinicians across specialties treat patients with substance abuse disorders and mental illnesses. We expressed our commitment to helping SAMHSA achieve the goal and identified opportunities to work together going forward.

On July 16, 2019, ACEP member Dr. Eric Ketcham participated in a panel discussion sponsored by Pew Charitable Trusts focused on how to reduce barriers that impede the ability for providers to treat patients with Substance Use Disorder (SUD). Dr. Ketcham emphasized the need to remove the X-waiver training requirement. Dr. Ketcham also discussed the importance of initiating buprenorphine in the ED, and how the X-waiver requirement creates an unnecessary barrier that impedes access to this potentially life-saving medication. Finally, he and other panelists talked about other treatment barriers to SUD, including stigma and misperception, outpatient access issues, and insurance prior-authorization, and how policy makers can best address these impediments. Representative Paul Tonko (D-NY) also was present and kicked off the panel discussion. Representative Tonko is the sponsor of the ACEP-supported H.R. 2482, the "Mainstreaming Addiction Treatment Act," which would remove the X-waiver requirement

as well as address other barriers to SUD treatment. ACEP also supports the Senate companion bill, S. 2074, sponsored by Senators Maggie Hassan (D-NH) and Lisa Murkowski (R-AK).

After the panel discussion, Dr. Ketcham and the other panelists met with Admiral Brett Giroir, the Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS). Adm. Giroir's office is looking into possibly reforming the restrictive "three-day" rule for administering buprenorphine. This rule allows non-waivered providers to administer (but not prescribe) buprenorphine to patients for a three-day period. However, the rule forces providers to administer buprenorphine one-day at a time, requiring patients to come back to the ED or other settings each day to receive treatment. ACEP has long advocated for eliminating this unnecessary hurdle and allowing providers to provide the patient with three-days' worth of treatment during one session. We have previously met with Admiral Giroir and others at HHS to discuss this issue and are encouraged that the Department is considering a policy change.

On August 29, 2019, ACEP responded to an HHS request for information on ensuring appropriate access to opioid treatments. In the response, HHS is urged to do what is in their authority to reduce barriers to the treatment of patients with OUD. ACEP also issued a press release highlighting the major points contained in the letter.

In addition to advocating for Congress to remove the X-waiver and pushing for regulatory changes to the "three-day rule," ACEP also:

- Offers an emergency-medicine specific X-waiver training course (including one being held during *ACEP19* in Denver);
- Provides clinical tools for emergency physicians to improve decision making and clinical practices; and
- Operates the EQUAL Network Opioid Initiative, which engages emergency clinicians and leverages emergency departments to improve clinical outcomes.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP position to federal Executive and Legislative branch officials.

Prior Council Action

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research

of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

February 2018, revised and approved the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

June 2012, approved the Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 24(19)

SUBMITTED BY: Kyle Fischer, MD, FACEP
Maryland Chapter
New Jersey Chapter
Ohio Chapter

SUBJECT: CMS Sepsis Core Measure and the Legal Standard of Care

PURPOSE: 1) Not consider the Sepsis CMS Core (SEP-1) Measure as the standard of care for the treatment of patients with sepsis. 2) Approach the CMS to request revision of the current sepsis quality metrics.

FISCAL IMPACT: Budgeted committee/task force and staff resources.

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) is increasingly moving towards reimbursing physicians based on quality of care, rather than quantity; and

WHEREAS, In order to tie reimbursement to quality of care, CMS creates metrics based on medical conditions; and

WHEREAS, The Sepsis Core Measure (SEP-1) has been released as a quality metric for the initial resuscitation of patients in sepsis; and

WHEREAS, SEP-1 defines quality by a bundle of metrics, including but not limited to, serial lactate measurement, a 30mL/kg IV fluid bolus, and reassessment that may include measurement of central venous pressure or central venous oxygenation; and

WHEREAS, Several clinical trials[1,2,3] have demonstrated the addition of many aspects of the bundle do not add clinical benefit; and

WHEREAS, Unique, complex, and oftentimes common clinical scenarios require the clinician to deviate from the SEP-1 bundle to provide high quality emergency care; and

WHEREAS, Core metrics may be cited in quality review or legal settings as the "standard of clinical care;" therefore be it

RESOLVED, That ACEP does not view the current CMS sepsis quality metrics as the standard of care for the treatment of patients with sepsis; and be it further

RESOLVED, That ACEP reach out to the Centers for Medicare and Medicaid Services to revise the current sepsis quality metrics.

References

1. The ProCESS Investigators. A randomized trial of protocol-based care for early septic shock. *NEJM*. 2014;370:1683-1693.
2. The ARISE Investigators and the ANZICS Clinical Trials Group. Goal-directed resuscitation for patients with early septic shock. NEJM. 2014;371:1496-1506.
3. Mouncey PR, Osborn TM, Power GS, et al. Trial of early, goal-directed resuscitation for septic shock. *NEJM*. 2015;372:1301-1311.

Background

This resolution requests ACEP not consider the Sepsis CMS Core (SEP-1) Measure as the standard of care for the treatment of patients with sepsis and that ACEP approach the CMS to request revision of the current sepsis quality metrics.

ACEP has had numerous discussions with the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), and the measure stewards regarding the merits and deficiencies of the various components of the sepsis metrics. To support the highest quality of sepsis care, ACEP has worked closely with the CMS to develop our own quality measures as part of the Clinical Emergency Data Registry (CEDR). Specifically, the CEDR Qualified Clinical Data Registry (QCDR) measures are CMS-approved entities that strive to improve healthcare quality.

For year 2019, ACEP worked closely with the CMS to develop CEDR QCDR measures, ACEP #30 and ACEP #48, that address sepsis and include exclusion criteria specific to fluid resuscitation and lactate levels among sepsis patients with unique, complex, and common comorbidities. The exclusion criteria for ACEP #30 and ACEP #48 include patients with any of the following:

- Acute trauma
- Acute myocardial infarction
- Acute Pulmonary Edema
- Advanced directives present in patient medical record for comfort care
- Anuria
- Burn
- Cardiac arrest within the emergency department visit
- Died during the emergency department visit
- Drug-related conflict with ability to clear lactate (ie, Nucleoside Reverse Transcriptase Inhibitors)
- End stage renal disease
- Gastrointestinal bleeding
- Left before treatment was complete
- Left Ventricular Assist Device (LVAD)
- Liver dysfunction or cirrhosis with decompensation
- Liver failure - End-stage liver disease
- patient hospital setting Left before treatment was complete
- Patient or surrogate decision maker declined care
- Patients with any of the following:
- Receiving epinephrine
- Secondary diagnosis of
- Secondary diagnosis of o Gastrointestinal bleeding
- Seizures
- Severe Heart Failure (LVEF <20%)
- Status Epilepticus
- Stroke
- Toxicological emergencies
- Transferred into the emergency department from another acute care facility or other in-patient hospital setting

ACEP recognizes the current CMS sepsis quality metrics are an ongoing concern with membership and is continually devoting resources and staff time to ensure member voices are heard at the CMS. ACEP will continue to work closely with the CMS to find equitable solutions to the current sepsis quality metrics and influence a revision of the metrics.

In addition to the CEDR QCDR metrics, to support the highest quality of sepsis care, ACEP also developed the Emergency Quality (E-QUAL) Network Sepsis Initiative and the DART online point-of-care tool to assist members in the identification and treatment of patients who develop sepsis, severe sepsis, and septic shock. ACEP is also

currently coordinating a multispecialty panel to develop consensus-based recommendations that address the underlying background, rationale, evaluation, and management of patients with sepsis who present to the emergency department. The deliverables of this project will be a manuscript containing the consensus-based recommendations and an update to the content of the DART online point-of-care tool.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

Resolution 18(16) Opposition to CMS Mandating Treatment Expectations amended and adopted. Directed ACEP to: oppose CMS mandated reporting standards that require potential harm to patients without the recognition of appropriate physician assessment and evidence-based goal directed care of individual patients; actively communicate to members and the public the dangers of CMS overstep of physician responsibility to patients for quality indicators; and communicate to hospitals the need and options to recognize appropriate physician treatment.

Prior Board Action

April 2019, supported appointing a Sepsis Task Force to develop consensus guidelines for the treatment of sepsis in the emergency department.

Resolution 18(16) Opposition to CMS Mandating Treatment Expectations amended and adopted.

October 2015, approved 2016 Sepsis Measures for CEDR.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 25(19)

SUBMITTED BY: Illinois College of Emergency Physicians
Maryland Chapter
Pennsylvania College of Emergency Physicians
South Carolina College of Emergency Physicians
West Virginia Chapter

SUBJECT: Rational Crystalloid Hydration in Sepsis

PURPOSE: 1) Work with CMS to create a formal caveat to withhold 30cc/kg crystalloid bolus(es) from patients with select comorbidities that put them at higher risk of fluid overload and harm. 2) Affirm with the CMS that the bedside emergency physician may exercise clinical judgement to withhold 30cc/kg crystalloid bolus(es) without penalty in situations where it could be potentially harmful to the patient.

FISCAL IMPACT: Budgeted committee/task force and staff resources.

WHEREAS, Key emergency department evidence improved the care and outcomes of those with sepsis and CMS SEP-1 has helped improve care across the country; and

WHEREAS, Despite new trials showing that early care in sepsis improves outcomes, the exact composition of fluids vs. vasopressors in initial care is unclear and many patients are at risk for harm from fluid therapy; and

WHEREAS, CMS has included appropriate "physician documentation caveats" that allow for clinical exceptions for compliance with CMS Sepsis Bundle compliance (such as "no infection present," etc.); and

WHEREAS, In patients with Sepsis (SIRS signs, Suspected Infection, and Lactate 4 or greater) the CMS Bundle mandates 30cc/kg crystalloid in all patients causing physicians to potentially cause patient harm in those at risk (existing heart failure, renal failure, depressed ejection fraction, etc.); therefore be it

RESOLVED, That ACEP work with CMS to create a formal caveat allowing clinicians to withhold 30cc/kg crystalloid bolus(es) in select patients with presumed sepsis and a higher risk of fluid overload or harm; and be it further

RESOLVED, That ACEP affirm with CMS that the bedside emergency physician's judgement of potential harm be allowed withhold 30cc/kg crystalloid boluses in patients with presumed sepsis without penalty.

Background

This resolution requests ACEP work with the CMS to create a formal caveat allowing clinicians to withhold 30cc/kg crystalloid bolus(es) from patients with comorbidities that put them at a higher risk of fluid overload or harm and to affirm with the CMS that the bedside emergency physician may exercise clinical judgement to withhold 30cc/kg crystalloid bolus(es) without penalty in situations where administration could be potentially harmful to the patient.

ACEP has had numerous discussions with the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), and the measure stewards regarding the merits and deficiencies of the various components of the sepsis metrics. To support the highest quality of sepsis care, ACEP has worked closely with the CMS to develop our own quality measures as part of the Clinical Emergency Data Registry (CEDR). Specifically, the CEDR Qualified

Clinical Data Registry (QCDR) measures are CMS-approved entities that strive to improve healthcare quality. For year 2019, ACEP worked closely with CMS to develop CEDR QCDR measures, ACEP #30 and ACEP #48, that address septic shock, with ACEP #48 including exclusions specific to fluid resuscitation and lactate levels among sepsis patients with renal failure and/or heart failure.

In addition to the CEDR QCDR metrics, to support the highest quality of sepsis care, ACEP also developed the Emergency Quality (E-QUAL) Network Sepsis Initiative and the DART online point-of-care tool to assist members in the identification and treatment of patients who develop sepsis, severe sepsis, and septic shock. ACEP is also currently coordinating a multispecialty panel to develop consensus-based recommendations that address the underlying background, rationale, evaluation, and management of patients with sepsis who present to the emergency department. The deliverables of this project will be a manuscript containing the consensus-based recommendations and an update to the content of the DART online point-of-care tool.

Renowned emergency medicine experts specializing in the identification and treatment of patients with sepsis strongly encourage ACEP members to exercise their clinical judgement to provide care that is in the best interest of their patients regardless of quality measure score. This is true not only for patients with sepsis, but for patients with any condition.

In 2016, the Council and the Board of Directors adopted Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations, which directed ACEP to: 1) work with CMS regarding mandated reporting standards that require potential harm to patients without the recognition of evidence-based care of individual patients; and 2) communicate to members and hospitals the dangers that quality indicators could present to potential patients and the importance of physician autonomy in treatment. A similar resolution was submitted to the American Medical Association (AMA) from ACEP members. It was referred to the AMA Board of Trustees and adopted as policy.

> **Development of Quality Measures with Appropriate Exclusions and Review Processes H-450.927**
>
> 1. Our AMA will advocate for quality measures, including those in the Hospital Inpatient Quality Reporting Program, to have appropriate exclusions to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making, and for denominators of quality measures to be appropriately defined to ensure patients for whom the treatment may not be appropriate are adjusted for or excluded.
>
> 2. Our AMA will advocate for CMS to allow for any proposed quality measures to be reviewed by the appropriate medical specialty societies prior to adoption.

As a matter of principle, most ACEP subject matter experts recommend treating the most urgent life-threatening condition first and then manage other comorbid conditions. However, it is recognized there will be circumstances where comorbid conditions are exacerbated and become urgent and life threatening, as evidenced by the thousands of people who die in the United States each year from both heart failure and end stage renal disease. In most instances, it is only the examining and treating physician who can determine which condition is the most urgent and life threatening. More often than not, that condition would be septic shock.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted. Directed ACEP to: 1) work with CMS regarding mandated reporting standards that require potential harm to patients without the recognition of evidence-based care of individual patients; and 2) communicate to members and hospitals the dangers that quality indicators could present to potential patients and the importance of physician autonomy in treatment.

Prior Board Action

April 2019, supported appointing a Sepsis Task Force to develop consensus guidelines for the treatment of sepsis in the emergency department.

Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted.

October 2015, approved 2016 Sepsis Measures for CEDR.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 26(19)

SUBMITTED BY: Arjun Chanmugam, MD, FACEP
Maryland Chapter
New Jersey Chapter
Ohio Chapter

SUBJECT: EMTALA Professional Liability Coverage

PURPOSE: Support and advocate for federal liability protections when providing EMTALA-related services.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

WHEREAS, The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd)., and its original intent and goals are consistent with the mission of ACEP and the public trust engendered by emergency physicians; and

WHEREAS, EMTALA has become the de facto national health care policy for the uninsured as ninety-two percent of all hospitalizations for the uninsured are directly linked with an emergency department visit; and\

WHEREAS, EMTALA requires Medicare-participating hospitals with emergency departments to screen, stabilize, and manage patients with emergency medical conditions in a non-discriminatory manner, regardless of ability to pay, insurance status, national origin, race, creed, or color; and

WHEREAS, Healthcare Reform and the implementation of the Affordable Care Act (ACA) may affect access to emergency care; however, there have been no significant challenges to the current EMTALA law; and

WHEREAS, Several federal bills promoting professional liability (malpractice) relief for EMTALA related services have been promoted by ACEP; therefore be it.

RESOLVED, That ACEP support and advocate that all EMTALA related services have liability coverage commensurate with that which exists under the Federal Tort Claims Act for National Health Service members.

Background

This resolution calls for ACEP to support and advocate for federal liability protections when providing EMTALA-related services.

The nature of emergency medicine is providing care to patients who have serious injuries or illnesses, with whom the emergency physician has little or no relationship and, at best, a limited ability to access their medical history. For these reasons, emergency physicians and other on-call physicians have much higher liability exposure and subsequent premiums. Providing liability protection to physicians for the federally mandated EMTALA services rendered will help ensure emergency and on-call physicians remain available to treat patients in their communities. Otherwise, the nation will continue to see sharp declines in on-call specialist availability and the relocation of emergency physicians to areas of the country where the liability environment is more favorable.

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law enacted in 1986 that requires hospital emergency departments and its physicians to provide a medical screening exam for all patients, regardless of their insurance status or ability to pay. If an emergency medical condition is discovered, then medical treatment must be provided on-site or the patient is transferred to a facility that could provide the necessary treatment.

For the past several Congresses, ACEP has supported legislation, the "Health Care Safety Net Enhancement Act," which will encourage physicians and on-call specialists to continue their lifesaving work and ensure emergency medical care will be available for patients when and where it is needed. Specifically, the legislation addresses the growing crisis in access to emergency care by providing emergency and on-call physicians who perform EMTALA-related services with temporary protections under the Federal Tort Claims Act. It does so by temporarily deeming these physicians as federal employees covered under the Public Health Services Act for purposes of liability protection only. During the 112th (2012) Congress, the House version of this bill (H.R. 157) was approved by voice vote as an amendment to H.R. 5 in March 2012. The Senate did not take action on H.R. 5 before the end of the session.

As of September 9, 2019, ACEP has secured a House sponsor, Representative Bill Flores (R-TX), to reintroduce the legislation in the 116th Congress (H.R. 3984) and we are working on identifying a Senate sponsor as well.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective G – Pursue meaningful medical liability reform and other initiatives at the state and federal levels.

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials

Prior Council Action

Amended Resolution 22(14) EMTALA-Related Liability Reform adopted. Directed that ACEP support individual states in passing EMTALA-related liability reform that increases the burden of proof and evidentiary standard in cases against those providing EMTALA-related care.

Resolution 16(07) Compulsory Arbitration for EMTALA related medical liability torts not adopted. Called for ACEP to propose and seek support for a federal measure mandating binding arbitration in EMTALA related cases.

Resolution 31(04) Medical Liability Reform – Total Caps not adopted. Directed ACEP to support efforts to attain federal tort reform and support caps on economic and non-economic damages.

Resolution 27(01) Federal Tort Reform not adopted. Directed ACEP to support efforts to attain federal tort reform.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted. Directed ACEP to study causes and scope of professional liability crisis in emergency medicine and develop short- and long-term resolutions, including tort reform.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted. The resolution directed ACEP to take the position that meaningful medical malpractice reform be an essential component of any health care reform measures and directed ACEP's lobbyist to further that position with Congress and via its key contact system.

Amended Resolution 27(87) State Liability and Tort Reform adopted. Directed ACEP to encourage chapters to take an active role in their state medical societies'' liability reform efforts and to act independently where appropriate.

Amended Resolution 42(85) Malpractice Coverage Information adopted. The resolution called for ACEP to urge the membership, through national and state publications, to obtain documentation and information regarding their individual medical liability insurance.

Amended Resolution 27(85) Malpractice Premiums and Tort Legal Reforms adopted. ACEP was directed to cooperate closely with other medical organization in creating strong support for legal tort reforms.

Prior Board Action

June 2018, approved the policy statement "Interpretation of EMTALA in Medical Malpractice Litigation."

April 2017, approved revised policy statement "Reform of Tort Law;" revised and approved April 2011 and August 2009; reaffirmed October 1998; originally approved September 1985.

Amended Resolution 22(14) EMTALA-Related Liability Reform adopted.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted.

Amended Resolution 27(87) State Liability and Tort Reform adopted.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 27(19)

SUBMITTED BY: Sean Ochsenbein, MD, MBA
Nathaniel Westphal, MD

SUBJECT: Ensuring Public Transparency and Safety by Protecting the Terms "Emergency Department" and "Emergency Room" as Markers of Physician-Led Care

PURPOSE: Oppose use of "emergency" or ER by a facility if a physician is not onsite at all times and draft state and federal legislation mandating that those terms indicate physician-led care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The general public expects the highest standard of physician-led care when presenting to an emergency department or emergency room; and

WHEREAS, It is the consensus among the general public that when presenting to an emergency department or emergency room, they will be treated by a physician; and

WHEREAS, ACEP has the obligation to protect the public and ensure emergency departments and emergency rooms provide the high standard of care that patients expect to receive; and

WHEREAS, ACEP has the responsibility to honor this unwritten truth of physician-led care which the public has come to trust in emergency departments or emergency rooms; and

WHEREAS, ACEP's current policy states that any facility that does not meet the definition of an Emergency Department or Freestanding Emergency Department as defined by ACEP, and that advertises itself as providing unscheduled care should not use the word "emergency" or "ER" in its name in any way; and

WHEREAS, ACEP's current policy states that Freestanding Emergency Departments (FSED) including hospital outpatient departments (HOPD), satellite emergency departments (ED), and independent freestanding emergency centers (IFECs) should be staffed by appropriately qualified emergency physicians; and

WHEREAS, ACEP's current policy states that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care; and

WHEREAS, Across the United States advanced practice registered nurses or physician assistants are treating patients in designated sites under the term "emergency department" or "emergency room" without direct, in person, physician oversight; and

WHEREAS, The trend of advanced practice registered nurses or physician assistants may, over time, erode the public trust and expectations regarding the terms "emergency department" or "emergency room" and the care these terms signify; and

WHEREAS. It is ACEP's responsibility to protect the brand of emergency physicians and most importantly to honor the obligation that the public has bestowed upon the specialty of emergency medicine; and

WHEREAS, The branding of our specialty matters and ACEP must protect the terms "emergency department" and "emergency room" to ensure public safety and transparency of care; therefore be it

37 RESOLVED, That if a physician is not onsite at all times in a facility that otherwise meets the definition of an
38 Emergency Department or Freestanding Emergency Department as defined by ACEP, and that facility advertises
39 itself as providing unscheduled care, such facility should not use the word "emergency" or "ER" in its name in any
40 way; and be it further
41
42 RESOLVED, That ACEP will consider it a top priority and will draft legislation for state and federal
43 legislators and such legislation will mandate that the terms "emergency" and "ER" are indicative of physician-led care
44 and should be regulated to ensure public safety and public transparency.

Background

The resolution calls for ACEP to oppose the use of the word "emergency" or "ER" by a facility if a physician is not onsite at all times and to draft state and federal legislation mandating that those terms indicate physician led care.

Recent years have witnessed the proliferation of delivery models and legislative proposals that would address perceived shortages of available board certified, residency trained emergency physicians by loosening requirements for onsite physician supervision and expanding the scope of practice of APRNs and PAs to permit either independent practice or lower levels of mandated supervision. These trends are not unique to emergency medicine and often reflect either efforts to reduce costs based on the argument that physician training is not always required in a practice environment or to expand the professional roles of non-physician health care practitioners. Additionally, proponents of these trends contend that in rural areas onsite physician care is not always available, meaning that the only choice is between nonphysician care and no care at all

ACEP's origins are rooted in the establishment of emergency medicine as a medical specialty, and the College's historical development coincides with the rising availability of residency training and board certification for physicians that would hold themselves out as emergency physicians. Whereas the early decades of ACEP are characterized by expansion of the specialty and of specialized care in contrast to nonspecialist physicians practicing in emergency departments, challenges are now increasingly arising from nonphysician practitioners arguing that their training suffices for an expanded scope of practice to include unsupervised practice. In contrast to this trend, ACEP policy for freestanding emergency departments, including those operated by hospitals, states that any such emergency department "that presents itself as an ED" should be "staffed by appropriately qualified emergency physicians." Given the array of emergent medical conditions that present at emergency departments, whether remote or rural, at any given time, the training and experience of an emergency physician is crucial for a viable, functioning emergency department team.

As stated in ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department," ACEP opposes the independent practice of emergency medicine by NPs and PAs. ACEP has assisted many state chapters as they confronted legislation that legalized the independent practice by NPs. While independent practice for NPs has passed in several states, efforts by National ACEP and the state chapters helped defeat legislation in many states.

Without question, NPs and PAs are valuable members of the emergency care team and are used effectively in many physician-led care models. However, ACEP has always believed that emergency care should be led by emergency physicians. ACEP has never supported the independent practice by NPs or PAs. In 2018, ACEP created a small workgroup composed of several members of the ACEP Board of Directors to discuss issues around the emergency medicine workforce. From the discussions of that group, two task forces were created: the NP/PA Utilization Task Force (NPUTF) and the EM Physician Workforce Task Force (EMPWTF).

ACEP's policy statement "Freestanding Emergency Departments" reinforces that any FSED facility that presents itself as an ED should be staffed by appropriately qualified emergency physicians. Additionally, the policy states that "ACEP encourages all states to have regulations regarding FSEDs that are developed in close relationship with the ACEP chapter in that state."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted. Directed ACEP to explore the feasibility of setting minimum accreditation standards for FEC's.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted. Directed ACEP to study the emergence and proliferation of free-standing EDs and facilities including: applicable federal and state regulatory and accreditation issues; the potential impact on the emergency medicine workforce; the potential fiscal impact on hospital-based EDs; and provide informational resources to the membership.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board. 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.

Substitute Resolution 51(84) Advertising and Public Education of Free Standing Facilities adopted. This resolution called for ACEP to encourage physicians to emphasize in advertising their positive attributes rather than denigrate the capabilities of other providers or facilities.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted. That ACEP develop definitions of various types of ambulatory and emergency care facilities and that these definitions be included in future revisions of the Emergency Care Guidelines.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted. Called for ACEP to set standards of care for facilities that present themselves to be sources of emergency care.

Prior Board Action

April 2019, discussed two options from the task force regarding accreditation of Freestanding Emergency Centers. Approved partnering with the Center of Improvement in Healthcare Quality, which has deeming authority with CMS, to provide accreditation services for FECs.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

September 28, 2018, discussed the feasibility for ACEP to proceed with implementing an accreditation program for freestanding emergency centers. The Board directed the task force to explore models and develop a business plan.

May 2018, accepted the report of the Freestanding Emergency Centers Accreditation Task Force, which included accreditation standards, and requested additional information about The Joint Commission's accreditation of FECs.

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted.

November 2015, reviewed the information paper "Freestanding Emergency Departments and Urgent Care Centers."

June 2014, approved the policy statement "Freestanding Emergency Departments."

July 2013, reviewed the revised information paper "Freestanding Emergency Departments;" originally developed in August 2009.

June 2013, revised the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements: "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted.

Substitute Resolution 51(84) Advertising and Public Education of Free Standing Facilities adopted.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted.

Substitute Resolution 40(79) Freestanding Ambulatory Care Centers adopted.

Background Information Prepared by: Harry J. Monroe, Jr.
Director, Chapter & State Relations

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 28(19)

SUBMITTED BY: Darrell Calderon, MD
Ricardo Martinez, MD, FACEP

SUBJECT: Expanding the Benefits of EMTALA to Ensure the Safety of the Public

PURPOSE: Promote to policymakers that EMTALA should be expanded to urgent care and primary care clinics and further modify the law so that if a patient is required to be sent to the ED, the urgent care and primary care clinic must call ahead to facilitate a transfer, document that the patient is safe for transfer, and facilitate safe transportation or direct admission.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

WHEREAS, Members of the public deserve ease of access and rapid evaluation for acute, unscheduled conditions regardless of their ability to pay; and

WHEREAS, Urgent care and primary care clinics consistently assert that they can evaluate and treat a large number of the patients that are currently seen in emergency departments and at lower costs; and

WHEREAS, Urgent and primary care clinics routinely limit evaluation and care for patients based on the patient's financial status, leaving many patients unevaluated and with potentially unsafe conditions; and

WHEREAS, These practices do not ensure that patients are evaluated in a timely manner by a Qualified Medical Provider (QMP) to confirm that an emergency medical condition (EMC) does not exist; and

WHEREAS, EMTALA was put in place to ensure that patients are at least evaluated by a Qualified Medical Provider to ensure that the patient does not have an EMC and if an EMC is present, the provider needs to take steps to ensure the patient is given proper care; and

WHEREAS, EMTALA was put in place to prevent patient dumping, but current practices of urgent care and primary care clinics serve to overload hospital emergency departments, and create conditions that can affect patient safety and quality of care, and financially overburden emergency departments, hospitals, and the providers who dedicate themselves to care for patients in these facilities; therefore be it

RESOLVED, That in the interest of public health and safety, ACEP promote to policymakers that the benefits of EMTALA should be expanded to urgent care and primary care clinics so that they may contribute to ensuring that the unscheduled care needs of the public are met, better coordinate care with emergency departments, and lower overall costs to the health systems by evaluating and treating those patients that can safely be cared for in their clinics; and be it further

RESOLVED, That ACEP promote the expansion of EMTALA to include that if a patient is required to be sent to the emergency department, the urgent care and primary care clinic must call ahead to facilitate a transfer, document that the patient is safe for transfer, and facilitate safe transportation or direct admission.

Background

This resolution calls for ACEP to promote to policymakers that EMTALA should be expanded to urgent care and primary care clinics and further modify the law so that if a patient is required to be sent to the ED, the urgent care and primary care clinic must call ahead to facilitate a transfer, document that the patient is safe for transfer, and facilitate safe transportation or direct admission.

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.

An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

EMTALA applies when an individual "comes to the emergency department." A dedicated emergency department is defined as "licensed by the State . . . as an . . . emergency department" or "is held out to the public . . . as a place that provides care for emergency medical conditions." This means that hospital-based outpatient clinics are not obligated under EMTALA unless they provide more than one-third of care as unscheduled AND those 1/3 visits are emergency medical conditions as defined by the statute. EMTALA applies to all aspects of emergency care, including specialists, all available tests and procedures, and anything else necessary to determine or stabilize an emergency medical condition.

Hospitals have three main obligations under EMTALA:

1. Any individual who comes and requests examination or treatment of a medical condition must receive a medical screening examination to determine whether an emergency medical condition exists. This cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and stabilizing treatment.
2. If an emergency medical condition exists, treatment must be provided until it is resolved or stabilized. If the hospital does not have the capability to stabilize the emergency medical condition, an "appropriate" transfer to another hospital must be done in accordance with the EMTALA provisions.
3. Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

Additionally, a hospital must report any time it has reason to believe it may have received an individual who has been transferred in an unstable condition in violation of EMTALA.

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 it 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.

Both CMS (hospitals) and the OIG (hospitals and physicians) have enforcement powers regarding EMTALA violations. There is a two-year statute of limitations for civil enforcement of any violation. Penalties may include:

- Termination of the hospital or physician's Medicare provider agreement.
- Hospital fines up to $104,826 per violation.
- Physician fines up to $104,826 per violation, including on-call physicians.
- The hospital may be sued for personal injury in civil court under a "private cause of action"

A receiving facility, having suffered financial loss as a result of another hospital's violation of EMTALA, can bring suit to recover damages. An adverse outcome does not necessarily indicate there is an EMTALA violation; however, a violation can be cited even without an adverse outcome. There is no violation if a patient refuses examination and/or treatment unless there is evidence of coercion.

In recent years, some courts, such as a Rhode Island federal court in the case Friedrich et al v. South County Hospital, have determined that certain urgent care centers (UCCs) must abide by EMTALA regulations. Since EMTALA only applies to Medicare-participating hospitals, for this to be valid, regardless of any other factors, the UCC must be operated by a hospital and use the hospital's Medicare provider number. Furthermore, the UCC must meet the definition of a "dedicated emergency department," which means it meets at least one of three requirements:

1. It is licensed by the state in which it is located as an ED.
2. It is presented to the public as a provider of care for emergency medical conditions (without requiring previously scheduled appointment).
3. During the previous calendar year, it provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions.

ACEP's the policy statement "Freestanding Emergency Departments" states that "ACEP believes that all FSEDs must follow the intent of the EMTALA statute…"

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

Prior Council Action

The Council has discussed and adopted many resolutions regarding EMTALA. However, no resolutions have been adopted that specifically relate to extending EMTALA requirements to primary care and urgent care settings.

Prior Board Action

June 2014, approved the policy statement "Freestanding Emergency Departments."

November 2015, reviewed the information paper "Freestanding Emergency Departments and Urgent Care Centers."

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 29(19)

SUBMITTED BY: Sarah Hoper, MD, JD, FACEP
Lisa Maurer, MD, FACEP
Rachel Solnick, MD
American Association of Women Emergency Physicians Section

SUBJECT: Extending Medicaid Coverage to 12-Months Postpartum

PURPOSE: Support the extension of Medicaid coverage to 12 months postpartum and work with relevant stakeholders to support the extension of Medicaid to 12 months postpartum.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The United States is the only industrialized nation with a rising maternal mortality rate[1]; and

WHEREAS, State maternal mortality review committees report an estimated 60% of maternal deaths may be preventable. A growing number of deaths are linked to emergency department (ED) treatable conditions such as cardiovascular disease, cardiomyopathy, and overdose and suicide, with many of these deaths occurring during the postpartum period[2]; and

WHEREAS, Medicaid is the largest payer of maternity care, covering 42.6% of births[3]; and

WHEREAS, States that have expanded Medicaid experienced a 50% greater reduction in infant mortality than non-expansion states[4]; and

WHEREAS, Pregnancy-related Medicaid eligibility ends 60 days postpartum, and over half [5] of Medicaid beneficiaries experience a coverage gap[6] in the 6 months following childbirth; and

WHEREAS, The postpartum period is a time of unmet maternal health needs[7]; and

WHERAS, A study on a Medicaid population of mothers found high use of the ED (34.9%) with associated hospitalization (6.6%) within 6 months of delivery[8]; and

---

[1] MacDorman MF, Declercq E, Cabral H, Morton C. Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. Obstet Gynecol. 2016;128(3):447-55.
[2] Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs.
[3] Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. Births: Final Data for 2016. National vital statistics reports; vol 67 no 1. Hyattsville, MD: National Center for Health Statistics. 2018. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf
[4] https://ccf.georgetown.edu/2019/05/09/medicaid-expansion-fills-gaps-in-maternal-health-coverage-leading-to-healthier-mothers-and-babies/
[5] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1241
[6] https://www.ncbi.nlm.nih.gov/pubmed/?term=daw+churn
[7] Spelke B and Werner E. The Fourth Trimester of Pregnancy: Committing to Maternal Health and Well-Being Postpartum. R I Med J (2013). 2018 Oct 1;101(8):30-33. v Tully KP, Stuebe AM, and Verbiest SB. The fourth trimester: a critical transition period with unmet maternal health needs. Am J Obstet Gynecol. 2017 Jul;217(1):37-41.
[8] https://www.ncbi.nlm.nih.gov/pubmed/28691865

WHEREAS, Postpartum women experience a significantly increased risk (OR 2.2, 95%CI 1.5- 3.1) of thrombotic events (ischemic stroke, acute myocardial infarction, or venous thromboembolism) up to 12 weeks after delivery (past the 60 days covered by Medicaid)[9]; and

WHEREAS, 13% of pregnancy related maternal deaths occur 42-365 days after delivery[10]; and

WHEREAS, The American College of Obstetricians and Gynecologists is recommending a 3 week and 12 week postpartum follow up appointment rather than a onetime 6 week appointment[11]; and

WHEREAS, Conditions associated with pregnancy such as pregnancy-induced hypertension, gestational diabetes, post-partum depression may drive ED use for these conditions if postpartum mothers lose Medicaid insurance coverage; and

WHEREAS, Legislation in several states, including Texas, Illinois, California, and New Jersey, was introduced in 2019 to extend Medicaid coverage to 12 months postpartum; and

WHEREAS, The American Medical Association adopted a similar resolution at their 2019 annual meeting; therefore be it

RESOLVED, That ACEP support the extension of Medicaid coverage to 12 months postpartum; and be it further

RESOLVED, That ACEP work with relevant stakeholders to support the extension of Medicaid coverage to 12 months postpartum.

Background

The resolution calls upon the College to support the extension of Medicaid coverage to 12 months postpartum and work with relevant stakeholders to support such an extension.

Generally, Medicaid is required to cover pregnant women for 60 days following childbirth. Depending on economic circumstances of the mother, many do not have health insurance coverage beyond that point. Many mothers and newborns require health care for critical health related issues during this first year, and the lack of health care coverage arguably results in delaying access to necessary care.

In June 2019, the American Medical Association House of Delegates adopted Resolution 221 supporting enactment of legislation to extend Medicaid coverage to 12 months postpartum.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care

Objective D – Promote quality and patient safety, including development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources.

---

[9] https://www.nejm.org/doi/full/10.1056/nejmoa1311485

[10] Creanga AA, Syverson C, Seed K, Callaghan WM. Pregnancy-related mortality in the United State, 2011-2013. Obstet Gynecol. 2017;130(2):366-73.

[11] https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care?IsMobileSet=false

Prior Council Action

The Council has discussed and adopted many resolutions related to Medicare, but none specific to extending coverage to 12-months postpartum.

Prior Board Action

None.

Background Information Prepared by: Harry J. Monroe, Jr.
Director, Chapter and State Relations

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 30(19)

SUBMITTED BY: David Callaway, MD, FACEP
Eric Goralnick, MD, MS, FACEP
Richard Kamin, MD, FACEP
Gina Piazza, DO, FACEP
E. Reed Smith, MD, FACEP
Matthew Sztajnkrycer, MD, FACEP
Government Services Chapter
Disaster Medicine Section
EMS-Prehospital Care Section
Tactical Medicine Section

SUBJECT: High Threat Emergency Casualty Care

PURPOSE: That ACEP set as a legislative priority the drafting of and lobbying for legislative language that will enable the development and funding of both National Transportation Safety Board-style "Go Teams" and a database into which gathered information would be entered for research purposes; and, support the development processes of both a National Transportation Safety Board-style "Go Teams" and a database of gathered information for research purposes

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, High threat incidents, including mass shootings, mass stabbings, vehicle-borne attacks, bombings, and other acts of terror, continue to plague our nation and the world; and

WHEREAS, These events cause significant psychosocial, political, and economic impacts on our society and additional physical impacts on involved individual victims and represent disruptions of the public's health, safety, and security; and

WHEREAS, These types of events involve a high-threat incident response that is unique from day-to-day prehospital care and is inherently complex, involving multiple disciplines, acting under extreme stress; and

WHEREAS, Perpetrators have shown the ability to learn our response tactics and to evolve their threats to achieve maximal harm, and we have been continually challenged to make concomitant data-driven improvements in mitigation, preparedness, response, and recovery efforts due to the lack of a standardized, rapid, rigorous data-gathering mechanism and the lack of a data repository; and

WHEREAS, We must create a reliable mechanism(s) to allow us to study the injured and how we prepare for, respond to, and recover from high threat mass casualty incidents to inform and improve our health system and emergency services response from injury prevention throughout the chain of survival; and

WHEREAS, The Department of Defense has made great strides in reducing preventable battlefield deaths through their learning healthcare system and the process of focused empiricism "using the best data available in combination with experience to develop clinical practice guidelines that, through an iterative process, continue to be refined until high-quality data can be generated to further inform clinical practice and standards of care," a model which the National Academy of Sciences, Engineering, and Medicine has recommended be adopted as a best practice in creating a National Trauma Care System; and

WHEREAS, Preliminary work done in the U.S. and internationally by teams like the National Transportation Safety Board's (NTSB) "Go Teams" demonstrates that this nascent best practice is poised to enable improved and more rapid learning from these incidents, along with improved dissemination of lessons-learned; and

WHEREAS, ACEP's EMS Subcommittee on High Threat Emergency Casualty Care and the Disaster Preparedness & Response Committee recommend developing rapidly deployable, multidisciplinary teams of subject

matter experts, with the authority and ability to gather discipline and casualty-specific qualitative and quantitative data in furtherance of developing best practice guidelines based on the "Go-Team" model; and

WHEREAS, The subcommittee also recommends the establishment of a database to house gathered data to facilitate research and to enable rapid dissemination of lessons learned in a secure manner; and

WHEREAS, Both recommendations will require legislation and public-private partnerships; therefore be it

RESOLVED, That ACEP set as a legislative priority the drafting of and lobbying for legislative language that will enable the development and funding of both National Transportation Safety Board-style "Go Teams" and a database into which gathered information would be entered for research purposes; and be it further

RESOLVED, That ACEP support the development processes of both a National Transportation Safety Board-style "Go Teams" and a database of gathered information for research purposes.

Background

The resolution directs ACEP to set as a legislative priority the drafting of and lobbying for legislative language to enable the development and funding of both National Transportation Safety Board-style (NTSB) "Go Teams" and a database into which gathered information would be entered for research purposes. It further directs ACEP to support the development processes of both NTSB-style "Go Teams" and a database of gathered information for such purposes.

Several existing ACEP policies align with the purpose of this resolution. ACEP's policy statement, "Support for National Disaster Medical System and Other Response Teams," states "that every community needs a comprehensive plan for immediate emergency medical care in case its medical care system is overwhelmed or rendered ineffective in a disaster. As a component of this plan, ACEP supports the National Disaster Medical System (NDMS) and encourages further development and funding of the program. ACEP also supports its 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 encourages entities such as health care facilities/systems and EMS services and employers such as medical practice groups to allow, encourage, and support their employees to participate."

ACEP's policy statement, "Disaster Data Collection" also calls for the development of "real-time syndromic surveillance to capture a majority of clinical illnesses and injury patterns on a mass scale…ACEP further supports prospective and retrospective disaster data collection and research which is critical for future disaster preparedness and response."

Additionally, while specific to firearms-related injuries, ACEP's "Firearms Safety and Injury Prevention" policy statement calls for the creation of a confidential national firearm injury research registry while encouraging states to establish a uniform approach to tracking and recording firearm related injuries.

ACEP has also successfully advocated for legislation to help improve mass casualty response and other disaster response efforts, including the Pandemic and All-Hazards Preparedness and Advancing Information Act (PAHPAI) of 2018. PAHPAI also included ACEP-supported legislation, the Military Injury Surgical Systems Integrated Operationally Nationwide to Achieve ZERO Preventable Deaths Act, better abbreviated as the MISSION ZERO Act. Specifically, the MISSION ZERO Act authorizes the Assistant Secretary for Preparedness and Response (ASPR) to award grants that would enable military trauma care providers and trauma teams to provide trauma care and related acute care at civilian trauma centers. This training has the dual benefit of maintaining military surgical battle readiness between wars while at the same time improving civilian access to trauma care.

PAHPAI also authorized the Regional Health Care Emergency Preparedness and Response System. This program, developed by the Assistant Secretary for Preparedness and Response (ASPR) with input from the Trauma Coalition (a broad group of organizations representing the nation's frontline trauma care providers), will improve emergency response by creating regional systems of trauma centers, hospitals, and other public and private entities. Finally, the legislation also included increased funding for the Hospital Preparedness Program (HPP), which supports regional

collaboration by encouraging the development of health care coalitions. The HPP provides funding through cooperative agreements and grants to states, territories, and eligible municipalities to improve the capacity of the health care system to plan for and respond to medical surge events. HPP, the only source of federal funding for health care delivery system readiness, is intended to improve patient outcomes, minimize the need for supplemental emergency funding, and enable rapid recovery. By reauthorizing and the Hospital Preparedness Program with additional funding, Congress has improved the U.S. health care system's ability to save lives during emergencies and disaster events.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 20(13) Disaster Research adopted. Directed ACEP to work with other organizations to develop guidelines for evaluation of new or ongoing projects for disaster preparedness, response, and effectiveness of interventions and outcomes research to identify areas to focus funding. Additionally, work other organizations to increase disaster research funding until guidelines on appropriate funding for research on disaster preparedness, response, and effectiveness of interventions are established.

Prior Board Action

June 2019, approved the revised policy statement, "Support for National Disaster Medical System and Other Response Teams;" revised and approved June 2013 with the current title; revised and approved October 2006; originally approved March 1999 replacing two resolutions that were adopted in 1991 and 1985.

June 2016, approved the revised policy statement, "Disaster Data Collection;" revised and approved August 2007; originally approved October 2000.

Amended Resolution 20(13) Disaster Research adopted.

April 2013, approved the revised policy statement, "Firearm Safety and Injury Prevention;" replacing the "Firearm Injury Prevention" policy statement that was revised and approved in October 2012 and January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 31(19)

SUBMITTED BY: Missouri College of Emergency Physicians
New Jersey Chapter
Ohio ACEP

SUBJECT: Improving Emergency Physicians Utilization of Medication for Addiction Treatment

PURPOSE: Work with DEA and SAMHSA to minimize regulatory barriers for emergency physicians to enact meaningful OUD therapies, establish ED-specific OUD training, and advocate for the elimination of the X-waiver to initiate Medication Assisted Treatment from the ED.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP position to federal Executive and Legislative branch officials.

WHEREAS, The Emergency Department is the primary initial contact point for many individuals who are facing the health consequences of the opioid epidemic; and

WHEREAS, Many individuals present to the Emergency Department seeking some sort of formal assistance with breaking the cycle of addiction; and

WHEREAS, Medication Assisted Treatment has most recently demonstrated considerable benefit for the treatment of opioid addiction and prevention of the medical complications that might arise from continued opioid abuse; and

WHEREAS, Current ability to initiate Medication Assisted Treatment requires 8 hours of learning for qualified healthcare personnel to apply for the Drug Enforcement Agency (DEA) Waiver as mandated federally with oversight by Substance Abuse and Mental Health Services Administration (SAMHSA), directed under the Drug Addiction Treatment Act of 2000 (DATA 2000); and[2]

WHEREAS, ACEP has previously submitted positions opposing medical merit badges; and

WHEREAS, The American College of Medical Toxicology's position statement, endorsed by the American Academy of Clinical Toxicology, the American Academy of Emergency Medicine, and the American College of Emergency Physicians strongly recommend removing the waiver ("X-waiver") requirement for buprenorphine[3]; therefore be it

RESOLVED, That ACEP work directly with the Drug Enforcement Administration and the Substance Abuse and Mental Health Services Administration to minimize barriers for emergency physicians to enact meaningful therapy for patients in a time of opioid crisis in the unique environment in which we work; and be it further

RESOLVED, That ACEP advocate to the Drug Enforcement Administration and the Substance Abuse and Mental Health Services Administration for emergency department specific requirements and curriculum so as to reach the greatest number of patients safely and without onerous barriers; and be it further

RESOLVED, That ACEP advocate for our physicians in emergency department settings who are uniquely trained by our environment to recognize and respond to the complications of opioid addiction and furthermore that ACEP continue to advocate for patients seeking treatment for opioid addiction and/or dependence through the

34 elimination of X-waiver requirements for emergency physicians for treatment that is initiated from an emergency
35 department setting.

References

1. Herring A et al. "Managing Opioid Withdrawal in the Emergency Department With Buprenorphine." *Annals of Emergency Medicine,* 73 (5). 481-7. 4 January 2019.
2. "Buprenorphine Waiver Management." *Substance Abuse and Mental Health Services Administration.* 16 July 2019. https://www.samhsa.gov/medication-assisted-treatment/training -material-resources/buprenorphine-waiver
3. "Coalition to Oppose Medical Merit Badges." American College of Emergency Physicians. 30 March 2017.

Background

This resolution calls for ACEP to work with the DEA and SAMHSA to minimize regulatory barriers for emergency physicians to enact meaningful OUD therapies, establish ED-specific OUD training, and advocate for the elimination of the X-waiver to initiate Medication Assisted Treatment from the ED.

Resolution 23(19) Allow Emergency Physicians to Prescribe Buprenorphine also requests ACEP to advocate for the removal of the X-waiver. The content of the background information is the same for both resolutions.

The immense scope of opioid use disorder and its associated public health impacts have become increasingly evident across all fields of medicine. The size of the crisis prompted the Department of Health and Human Services to declare the opioid crisis a public health emergency in October of 2017. Yet, despite the wide-ranging nature of this issue, nowhere are its impacts clearer than in the Emergency Department (ED). According to the National Survey on Drug Use and Health, in 2015 approximately 3.8 million people misused pain medications and 329,000 people used heroin. An estimated 135,000 of those people tried heroin for the first time during that year. Despite the scale of opioid misuse in this country, the consequences of that misuse are even more profound. Since 2001 there has been a 200% increase in the rate of death from opioids. In 2016 alone nearly two thirds (66.4%) of all drug overdose deaths involved prescription opioids, illicit opioids, or both, an increase of 27.7% from 2015. Put simply, opioid use disorder is widespread, and its associated mortality is getting worse.

Given the impact of opioid use disorder on ED patients, emergency medicine providers are taking the lead on addressing this crisis. Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder.

Medication for opioid use disorder refers to any addiction treatment that includes pharmacologic therapy. In the context of opioid use disorder this includes medications that act as opioid agonists, partial agonists, or antagonists. Popular examples are methadone, buprenorphine, and naltrexone. There is a growing body of literature showing that Medication Assisted Treatment (MAT) for opioid use disorder improves patient outcomes. Data suggest that patients receiving medication for opioid use disorder have decreased fatal overdose compared to with those who receive counseling alone. Additionally, patients maintained on buprenorphine for at least a year are noted to have less ED visits and inpatient hospital stays.

Yale University recently published a randomized controlled study evaluating the viability and efficacy of ED initiated buprenorphine. They determined that not only was it safe to administer buprenorphine to ED patients, but it also improved patient outcomes. Specifically, they found that compared to brief behavioral counseling or usual care, ED patients receiving buprenorphine where significantly more likely to be engaged in addiction treatment 2 months after their ED visit.

Despite the promise of this therapy they are currently significant barriers to ED administration of medication for opioid use disorder. The Drug Addiction Treatment Act of 2000 (DATA 2000) created a special licensing process for prescribing opioid-based addiction treatment. This special license, colloquially referred to as the X -Waiver, requires

physicians to complete an 8-hour training course before they can legally prescribe. This training includes information on identifying appropriate patients for buprenorphine treatment and how to best use this medications within addiction treatment programs. However, the training is not specifically designed with ED providers in mind. Furthermore, the 8-hour training provides a significant barrier for the widespread adoption of medication assisted therapy.

ACEP's policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department" supports all patients being treated appropriately for acute pain with prompt, safe, and effective pain management. The policy statement acknowledges that acute pain management is patient-specific and provides guidance on pharmacological and non-pharmacological pain interventions. This is a joint statement by ACEP, the American Academy of Emergency Nurse Practitioners, and the Emergency Nurses Association. ED physicians will continue to be on front lines of this public health emergency as the nation struggles with opioid use disorder. Given the scale of this problem it is incumbent upon us to use the best treatment available for our patients. While there are many potential solutions to this issue, medication for opioid use disorder is a promising tool, and is the only evidence-based treatment available for the treatment of opioid use disorder. It has proven to be both an effective and safe treatment for ED patients suffering from opioid addiction.

Most recently, ACEP met with the head of Substance Abuse and Mental Health Services Administration (SAMHSA), Assistant Secretary for Mental Health and Substance Use Dr. Elinore McCance-Katz, on May 15, 2019. During our meeting with Dr. McCance-Katz, we discussed issues that are extremely important to emergency physicians and our patients, including the ability to administer buprenorphine in the ED for patients with opioid use disorder and how to improve care for patients with mental health illnesses. ACEP mentioned the resources and tools that we have created to help our physicians and patients, highlighting the EM-specific DATA 2000/Medications for Addiction Treatment waiver training course that is now being offered to our members, as well as new web-based and mobile device applications around opioids and the management and treatment of suicidal patients. One of SAMHSA's major goals is to boost the community resources that are available to help clinicians across specialties treat patients with substance abuse disorders and mental illnesses. We expressed our commitment to helping SAMHSA achieve the goal and identified opportunities to work together going forward.

On July 16, 2019, ACEP member Dr. Eric Ketcham participated in a panel discussion sponsored by Pew Charitable Trusts focused on how to reduce barriers that impede the ability for providers to treat patients with Substance Use Disorder (SUD). Dr. Ketcham emphasized the need to remove the X-waiver training requirement. Dr. Ketcham also discussed the importance of initiating buprenorphine in the ED, and how the X-waiver requirement creates an unnecessary barrier that impedes access to this potentially life-saving medication. Finally, he and other panelists talked about other treatment barriers to SUD, including stigma and misperception, outpatient access issues, and insurance prior-authorization, and how policy makers can best address these impediments.

On July 16, 2019, ACEP member Dr. Eric Ketcham participated in a panel discussion sponsored by Pew Charitable Trusts focused on how to reduce barriers that impede the ability for providers to treat patients with Substance Use Disorder (SUD). Dr. Ketcham emphasized the need to remove the X-waiver training requirement. Dr. Ketcham also discussed the importance of initiating buprenorphine in the ED, and how the X-waiver requirement creates an unnecessary barrier that impedes access to this potentially life-saving medication. Finally, he and other panelists talked about other treatment barriers to SUD, including stigma and misperception, outpatient access issues, and insurance prior-authorization, and how policy makers can best address these impediments. Representative Paul Tonko (D-NY) also was present and kicked off the panel discussion. Representative Tonko is the sponsor of the ACEP-supported H.R. 2482, the "Mainstreaming Addiction Treatment Act," which would remove the X-waiver requirement as well as address other barriers to SUD treatment. ACEP also supports the Senate companion bill, S. 2074, sponsored by Senators Maggie Hassan (D-NH) and Lisa Murkowski (R-AK).

After the panel discussion, Dr. Ketcham and the other panelists met with Admiral Brett Giroir, the Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS). Adm. Giroir's office is looking into possibly reforming the restrictive "three-day" rule for administering buprenorphine. This rule allows non-waivered providers to administer (but not prescribe) buprenorphine to patients for a three-day period. However, the rule forces providers to administer buprenorphine one-day at a time, requiring patients to come back to the ED or other settings each day to

receive treatment. ACEP has long advocated for eliminating this unnecessary hurdle and allowing providers to provide the patient with three-days' worth of treatment during one session. We have previously met with Admiral Giroir and others at HHS to discuss this issue and are encouraged that the Department is considering a policy change.

On August 29, 2019, ACEP responded to an HHS request for information on ensuring appropriate access to opioid treatments. In the response, HHS is urged to do what is in their authority to reduce barriers to the treatment of patients with OUD. ACEP also issued a press release highlighting the major points contained in the letter.

In addition to advocating for Congress to remove the X-waiver and pushing for regulatory changes to the "three-day rule," ACEP also:

- Offers an emergency-medicine specific X-waiver training course (including one being held during *ACEP19* in Denver);
- Provides clinical tools for emergency physicians to improve decision making and clinical practices; and
- Operates the EQUAL Network Opioid Initiative, which engages emergency clinicians and leverages emergency departments to improve clinical outcomes.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP position to federal Executive and Legislative branch officials.

Prior Council Action

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The

resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

February 2018, revised and approved the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

June 2012, approved the Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 32(19)

SUBMITTED BY: Kyle Fischer, MD, FACEP
Maryland Chapter

SUBJECT: Legal and Civil Penalties for the Routine Practice of Medicine

PURPOSE: Oppose state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The routine practice of medicine encompasses nearly all aspects of human life; and

WHEREAS, The doctor-patient relationship frequently addresses complex and difficult medical and social situations; and

WHEREAS, Physicians are often required to address sensitive and controversial subjects with our patients; and

WHEREAS, Physician autonomy is frequently constricted by state and federal legislatures and regulators; and

WHEREAS, One state outlawed doctors' communication with patients regarding firearms (prior to the law being found unconstitutional); and

WHEREAS, Several states created legal penalties for physicians performing abortions; and

WHEREAS, Although physician assisted suicide has been legalized in many states, under most state laws helping someone commit suicide remains a felony; therefore be it

RESOLVED, That ACEP oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Background

This resolution calls for ACEP to oppose all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Physicians increasingly find themselves caught in the crossfire of highly divisive social issues like abortion, physician-assisted suicide, and gun control. In some cases, lawmakers not only dictate what physicians can and cannot do and say with their patients regarding these issues, but they are also imposing harsh penalties on physicians who do not comply.

Several states passed laws this year significantly restricting abortions. Most notably, the new Alabama law specifically makes it a felony for physicians to perform any abortion unless the mother's life is in jeopardy, punishable by up to 99 years in prison. The U.S. Senate considered a measure this year that would have punished

physicians who do not perform life-saving measures to save any infant born alive during an abortion. Failure to render the same degree of care provided during any birth could have resulted in fines and up to five years in prison. Participating in ending the life of a child born alive during an abortion could have brought federal murder charges. The bill failed to pass the Senate, after falling seven votes short of the 60 votes needed to prevent a filibuster. However, 26 states have enacted similar laws requiring physicians to provide medical care and treatment to born-alive infants at any stage of development. Texas passed such a law in June 2019, with physicians who fail to provide that level of treatment facing fines of at least $100,000 and third-degree felony charges that could lead to a prison term of two to ten years.

In 2011, Florida passed a law that prohibited doctors from asking patients about gun ownership unless it was medically necessary or from putting information about gun ownership in a patient's record. The law carried penalties for physicians of up to a $10,000 fine and discipline from the state medical board. The constitutionality of the law was challenged in court, and in 2017, the U.S. Court of Appeals overturned the law, saying it violated physicians' rights to equal protection and free speech.

In 2019, two more states passed laws legalizing physician-assisted suicide. New Jersey and Maine became the eighth and ninth states, respectively (along with the District of Columbia) to legalize the practice. Physicians cannot be prosecuted in these states for prescribing medications to hasten death, within certain parameters. In the vast majority of other states, however, physicians are under the same law as anyone else who assists someone in taking their own life and are subject to a felony prosecution.

ACEP does not have policy addressing laws that criminalize specific physician actions in such cases, but the College has addressed other examples of government interceding to restrict physician autonomy in determining what is best for their patients.

In response to state governments imposing limits on the amount of pain medication that can be prescribed to patients, the Council and the Board of Directors adopted Amended Resolution 17(12) Ensuring Patient Access to Pain Treatment, which directed, in part, that ACEP "work with government and regulatory bodies on the creation of evidence-supported guidelines for responsible emergency physician prescribing that takes into consideration lack of access while respecting the uniqueness of every individual doctor-patient encounter." Additionally, the resolution directed added that "ACEP oppose non-evidence based public or private limits on prescribing opiates, mandatory opioid-related documentation, and mandatory opioid-related CME."

ACEP's policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment" addresses physician autonomy by stating, in part, that ACEP:

- supports ACEP chapters having the autonomy to establish and coordinate evidence-based pain management guidelines that promote access to appropriate pain control within physician clinical judgment;
- supports limiting the initial prescription of an opioid to no more than a 7-day supply, unless in the judgment of the treating physician a longer duration is indicated and rationale is documented;

In 2016, the Council and the Board of Directors adopted Amended Resolution 18 Opposition to CMS Mandating Treatment Expectations that directed ACEP to work with CMS regarding mandated reporting standards that may result in harm to patients without the recognition of evidence-based care of individual patients, and that ACEP actively communicate to members and hospitals the dangers that quality indicators could present harm to potential patients, and the importance of physician autonomy in treatment.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 18(16) Opposition to CMS Mandatory Treatment Expectations adopted. The amended resolution directed ACEP to work with CMS regarding mandated reporting standards that may result in harm to patients without the recognition of evidence-based care of individual patients and that ACEP actively communicate to members and hospitals the dangers that quality indicators could present harm to potential patients, and the importance of physician autonomy in treatment.

Amended Resolution 17(12) Ensuring Patient Access to Pain Treatment adopted. Directed ACEP to work with government and regulatory bodies on the creation of evidence-supported guidelines for responsible emergency physician prescribing that takes into consideration lack of access while respecting the uniqueness of every individual doctor-patient encounter. It also directed that ACEP oppose non-evidence based public or private limits on prescribing opiates, mandatory opioid-related documentation, and mandatory opioid-related CME.

Prior Board Action

February 2018, approved the revised policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012 as "Ensuring Emergency Department Patient Access to Adequate and Appropriate Pain Treatment."

October 2016, Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted.

October 2012, Amended Resolution 17(12) Ensuring Patient Access to Pain Treatment adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 33(19)

SUBMITTED BY: Bret Frey, MD, FACEP
Nevada Chapter

SUBJECT: National Medical Tort Reform as a "CMS Best Practice"

PURPOSE: Work with CMS and other stakeholders to adopt and promulgate tort "best practices" for submission to Congress with a request for action and adopt principles that preserves CMS' budget viability and patients' legal rights.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

WHEREAS, The defensive practice of medicine in the U.S. is estimated at approximately $55 billion – $200 billion; and

WHEREAS, Medical liability direct and indirect costs are an additional estimated $50 billion annually; and

WHEREAS, Medical tort in the United States is adversarial, inefficient, and drives "cost without benefit;" and

WHEREAS, Medical cost control has become a centerpiece of numerous discussions on national healthcare value; and

WHEREAS, Adoption of CMS "best practices," following specialty specific "consensus guidelines" and adherence to "standards of care" have not conferred reliable liability protection; and

WHEREAS, ACEP's policy statement, "Reform of Tort Law," (originally adopted as Resolution 27(85), reaffirmed in 1998, revised in August 2009 and April 2011, and reaffirmed in April 2017) outlines the basics of medical tort reform essential to cost control, including but not limited to, a ceiling on non-economic damages, same-specialty expert witness standard, adoption of health courts, adoption of apology law protections, and safe harbors when adhering to "best practice" guidelines; and

WHEREAS, Medical tort reform is essential to the preservation and long-term viability of Medicare and Medicaid; therefore be it

RESOLVED, That ACEP work directly with CMS and other willing stakeholders to assist in the adoption and promulgation of tort "best practices" for submission to Congress with a request for action; and be it further

RESOLVED, That ACEP adopt principles of national medical tort reform that simultaneously preserves CMS budget viability and essential legal rights of patients.

Background

This resolution calls for ACEP to work with CMS and other stakeholders to adopt and promulgate tort "best practices" for submission to Congress with a request for action and adopt principles that preserves CMS' budget viability and patients' legal rights.

The Centers for Medicare & Medicaid Services (CMS) does not provide recommendations to Congress unless compelled to do so by a specific piece of legislation. Typically, CMS interacts with Congress by providing technical assistance on potential legislation. However, there is a history of legislation being introduced in Congress that would provide medical liability "safe harbor" protections when physicians follow established clinical practice guidelines.

The ACEP-supported legislative proposal, the "Saving Lives, Saving Costs Act," was introduced in the 113th, 114th, and 115th Congresses by Representative Andy Barr (R-KY) in the House and John Barrasso (R-WY) in the Senate. This bill establishes a framework for health care liability lawsuits to undergo review by independent medical review panels when health care professionals (practicing physicians or their agents or employees), providers, or organizations adhere to clinical practice guidelines. The Department of Health and Human Services (HHS) must publish these clinical practice guidelines provided and maintained by national or state medical societies or medical specialty societies designated by HHS. HHS must ensure that guidelines are developed in accordance with certain standards, including standards related to transparency, the composition of the panel, and the review of existing evidence. Professional organizations and participants in guideline development may not be held liable for injury allegedly caused by adherence to a guideline to which they contributed.

The legislative proposals have not advanced beyond introduction in their respective chambers, but their prospects for passing in the current political environment are unlikely.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective G – Pursue meaningful medical liability reform and other initiatives at the state and federal levels.

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

Prior Council Action

Resolution 31(04) Medical Liability Reform – Total Caps not adopted. Directed ACEP to support efforts to attain federal tort reform and support caps on economic and non-economic damages.

Resolution 27(01) Federal Tort Reform not adopted. Directed ACEP to support efforts to attain federal tort reform.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted. Directed ACEP to study causes and scope of professional liability crisis in emergency medicine and develop short- and long-term resolutions, including tort reform.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted. The resolution directed ACEP to take the position that meaningful medical malpractice reform be an essential component of any health care reform measures and directed ACEP's lobbyist to further that position with Congress and via its key contact system.

Amended Resolution 27(87) State Liability and Tort Reform adopted. Directed ACEP to encourage chapters to take an active role in their state medical societies'' liability reform efforts and to act independently where appropriate.

Amended Resolution 42(85) Malpractice Coverage Information adopted. The resolution called for ACEP to urge the membership, through national and state publications, to obtain documentation and information regarding their individual medical liability insurance.

Amended Resolution 27(85) Malpractice Premiums and Tort Legal Reforms adopted. ACEP was directed to cooperate closely with other medical organization in creating strong support for legal tort reforms.

Prior Board Action

April 2017, approved revised policy statement "Reform of Tort Law;" revised and approved April 2011 and August 2009; reaffirmed October 1998; originally approved September 1985.

Amended Resolution 22(14) EMTALA-Related Liability Reform adopted.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted.

Amended Resolution 27(87) State Liability and Tort Reform adopted.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Jeffrey Davis
Regulatory Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 34(19)

SUBMITTED BY: Illinois College of Emergency Physicians
Missouri College of Emergency Physicians
Pennsylvania College of Emergency Physicians
West Virginia Chapter

SUBJECT: Opposing Naloxone Addition to the Prescription Drug Monitoring Program

PURPOSE: Oppose legislation to add naloxone administration to the Prescription Drug Monitoring Program and work with chapters to develop strategies and supporting materials to stop such legislation.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The epidemic of opioid use disorders is a crisis in the United States that daily affects patients presenting to the emergency department; and

WHEREAS, Emergency physicians are leaders in addressing the opioid epidemic by advocating for effective solutions and opposing initiatives that have adverse unintended consequences; and

WHEREAS, Naloxone is a commonly used medication in both the pre-hospital setting and the emergency department to reverse the effects of opioids; and

WHEREAS, The therapeutic use of naloxone to address the effects of opioids extends beyond the resuscitation of patients with unintentional overdose of illicit drugs; and

WHEREAS, Co-prescription of naloxone with opioids is considered a best-practice, but not commonly done despite CDC recommendations; and

WHEREAS, State legislatures, including in Pennsylvania, are considering legislation to add naloxone administration to Prescription Drug Monitoring Program (PDMP) databases; and

WHEREAS, Such legislation to add naloxone administration to the PDMP will have the adverse unintended consequences of labeling patients as addicts based on incomplete or incorrect understanding of the circumstances under which they received naloxone and potentially discourage co-prescription of naloxone; and

WHEREAS, Leaving the decision of whether to report naloxone administration to the PDMP based on emergency physician judgement of the circumstance involved would inevitably lead to the application of biases and prejudices in patient assessments; and

WHEREAS, Widespread dissemination of naloxone has been shown to save lives in the opioid epidemic and should be encouraged; therefore be it

RESOLVED, That ACEP oppose legislation to add naloxone administration to the Prescription Drug Monitoring Program and work with chapters in developing strategies and supporting materials to stop such legislation.

References:

1. Follman et. al., "Naloxone Prescriptions Among Commercially Insured Individuals at High Risk of Opioid Overdose," JAMA Network Open, Volume, 2, Number 5, May 3, 2019:e193209

2. Abouk et. al., "Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose," JAMA Internal Medicine, Published online May 6, 2019. doi:10.1001/jamainternmed.2019.0272

Background

The resolution asks ACEP to oppose legislative efforts to add the administration of naloxone to a Prescription Drug Monitoring Program (PDMP) and to work with chapters in developing strategies and supporting materials to stop such legislation.

Increased access to naloxone has proven to be an integral component in addressing the nation's opioid epidemic. According to CDC estimates, naloxone reversed more than 10,000 opioid overdoses between 1996-2010. The CDC also notes that the number of naloxone prescriptions dispensed doubled from 2017 to 2018.

As the resolution notes, there have been some initiatives at the state level to require naloxone administration to be reported to a respective PDMP. In some states, naloxone dispensation and administration are reported in different manners. Arizona, for example, requires pharmacists to report naloxone doses *dispensed* to the PDMP, but requires EMS and law enforcement to report naloxone doses *administered* to a separate database, the Arizona Prehospital Information and EMS Registry System, or AZ-PIERS. Such a policy is consistent with the joint ACEP/NAEMSP/ACMT policy statement, "Naloxone Access and Utilization for Suspected Opioid Overdoses," which states: "Programs should be developed to track and report distribution and usage of naloxone both by public safety/EMS personnel and bystander/public access individuals."

In Pennsylvania, legislation has been introduced to require naloxone administration to be reported in the state's PDMP, and further, would require reporting of the suspected/confirmed drug involved in the overdose to be reported within 72 hours of the initial reporting of the event. Proponents suggest that identifying controlled substance overdose events will help address the opioid epidemic, as they can inform a treatment plan and give a provider additional information that would otherwise not be available.

Others are concerned that mandatory reporting of naloxone administration to a PDMP would have an adverse effect on care because of potential stigma or bias, such as a patient being pre-judged as an "addict" if naloxone administration appears in their PDMP record without any context as to why naloxone may have been administered. For example, such a proposal could be overly broad and capture overdoses unrelated to the intent of addressing the opioid epidemic, such as accidental or mistaken ingestion of other medications, or could reduce the use or co-prescribing of naloxone to avoid stigma. Additionally, there are concerns that requirements like those in the Pennsylvania example would be burdensome on emergency physicians and EMS teams, as they would be required to provide information, such as a patient's identity or medical details (e.g., toxicology reports), that are often unavailable during the time that emergency care is being delivered.

Per ACEP's policy statement, "Electronic Prescription Drug Monitoring Programs," ACEP "…supports the use of electronic prescription drug monitoring programs (PDMP)…" but that use of these systems should be voluntary.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

The Council has discussed and adopted many resolutions related to PDMPs and Naloxone, but none specific to opposing legislation to add Naloxone administration to the PDMP.

Prior Board Action

January 2017, appoved the revised policy statement, "Electronic Prescription Drug Monitoring Programs;" originally approved October 2001 titled "Electronic Prescription Monitoring."

June 2016, approved the policy statement, "Naloxone Access and Utilization for Suspected Opioid Overdoses." This is a joint policy statement with the National Association of EMS Physicians (NAEMSP) and the American College of Medical Toxicology (ACMT)

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 35(19)

SUBMITTED BY: Georgia College of Emergency Physicians
Missouri College of Emergency Physicians
Ohio Chapter

SUBJECT: Prudent Layperson Visit Downcoding

PURPOSE: Directs ACEP to develop and enact strategies, including legislative solutions, at the federal level to prevent negative clinical or financial impact caused by the lack of reimbursement for emergency medical services by third-party payers. Also calls for ACEP to create meaningful disincentives for third-party payers that disregard the Prudent Layperson Standard to ensure access to and subsequent reimbursement for emergency medical care regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care.

FISCAL IMPACT: Budgeted staff resources and potential unbudgeted costs for outside consultants and lobbyists to implement the advocacy agenda.

WHEREAS, The Prudent Layperson Standard guarantees patients the right to receive treatment in the emergency department if they feel they have a medical emergency; and

WHEREAS, Emergency providers have an unfunded mandate to provide a medical screening exam and evaluate for an emergency condition under the Emergency Medical and Labor Act (EMTALA); and

WHEREAS, Determining whether an emergent condition exists and stabilizing it as required by EMTALA requires a thorough evaluation that may include multiple diagnostics and treatment modalities; and

WHEREAS, The presenting, or chief complaint, is inadequate to determine if a patient has a medical emergency and does not consistently correlate with a non-emergent final diagnosis; and

WHEREAS, according to the Federal Register Final Rule, 2016, the final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis; and

WHEREAS, The Prudent Layperson Standard requires health insurance companies to cover a patient's emergency department (ED) evaluation based on the patient's symptoms and not their final diagnosis; and

WHEREAS, Insurance companies are arbitrarily downcoding ED charts based on a final diagnosis without reviewing the medical record or presenting symptoms or chief complaint; and

WHEREAS, Insurance companies are using both arbitrary diagnosis lists and tools developed for non-billing and coding purposes to downcode ED charts; therefore be it

RESOLVED, That ACEP develop and enact strategies (including legislative solutions) to prevent insurance companies from arbitrarily downcoding charts; and be it further

RESOLVED, That ACEP work to develop and enact policy at the federal level that prevents insurance companies from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Background

This resolution directs ACEP to develop and enact strategies, including legislative solutions, at the federal level to prevent any negative clinical or financial impact caused by the lack of reimbursement for emergency medical services by third-party payers. It also calls for ACEP to create meaningful disincentives for third-party payers that disregard the Prudent Layperson Standard (PLP) to ensure access to and subsequent reimbursement for emergency medical care regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care.

History of Prudent Layperson Federal and State Laws

The first PLP law was enacted in the state of Maryland in 1993. Three years later, the National Association of Insurance Commissioners (NAIC) drafted the Managed Care Provider Network Adequacy and Contracting Model Act (Model Act) which included the PLP standard. This step recognized the need to require the provision of coverage for emergency services based upon presenting symptoms rather than the ultimate diagnosis. The Model Act differs only slightly from the PLP in the Patient Bill of Rights, part of the 2010 Affordable Care Act (ACA) passed by the 111th Congress. The NAIC model includes the appropriate "concept" of a PLP that applies to patients with presenting symptoms rather than subsequent final diagnosis to the emergency department. As of July 1, 2019, 47 states and the District of Columbia have adopted a PLP law covering access to emergency medical care.

Federally, the Balanced Budget Act of 1997 originally implemented the PLP for Medicaid Managed Care and Medicare recipients and was the prequel to the ACA language standard subsequently adopted as the model for all health plans. However, this remains a source of legislative and regulatory controversy across many states. As previously mentioned, the 2010 ACA Bill of Rights adopted PLP language, however individual insurers have continued to try to reduce payments for emergency care they deem to be non-emergent.

Challenging Retrospective Denials and Down Coding

ACEP developed a toolkit in 2018 for third-party stakeholders to begin an ACEP-led outreach to all impacted groups to ensure a coordinated approach and encourage information sharing and a unified message. Congressional and state legislative activity has focused on identifying legislative champions to lead various efforts, such as Congressional pressure on the third-party payers that violate PLP in their state, Congressional pressure on the insurance commissioner within their state to limit enforcement, Congressional outreach to HHS or CCIIO to encourage their action, and a Hill briefing (featuring a panel of emergency physician(s), a consumer representative, and an impacted patient). The toolkit and Congressional pressure in 2018 led to the publication by Senator McCaskill (D-MO) of this report, "Coverage Denied: Anthem BCBS' Emergency Room Initiative," which included data ACEP had compiled and shared with the Senator's office.

ACEP provided data on specific retroactive denials collected from various emergency physician groups to several federal agencies to supplement any investigative work on PLP denials they might have had underway. ACEP continues to advocate for PLP strengthening in federal law as part of our surprise billing advocacy. Finally, ACEP has written letters to CMS and had calls with and sent letters to several states to address various issues with state Medicaid agencies and/or managed care plans' downcoding or retroactively denying claims.

ACEP is working with chapters to identify champions in the state legislatures and/or governors' offices who might have influence with insurance commissioners, develop op-eds in key markets to influence state lawmakers, and encourage impacted constituents to write to their legislators.

To support this work, ACEP staff internally tracks and collects payment denials by third-party payers in states where the policy has taken effect. Billing companies, ED groups, and Academic Chairs in those states were asked to report any data or observations of denials that violate the PLP. ACEP's DC office launched a website to collect patient stories of denials and is currently in the process of redesigning the site to publicize it more broadly.

ACEP will continue to explore legal options to prevent third-party payers from enforcing policies that violate PLP, including possible injunctions. ACEP has filed suit against Anthem Blue Cross Blue Shield of Georgia. The case is still pending.

Current AMA Policy on PLP

An AMA House of Delegates resolution adopted in June 2017 compels the AMA to work with state insurance regulators, insurance companies, and other stakeholders to immediately halt the implementation of policies that violate PLP of determining when to seek emergency care.

The AMA sent a letter in June 2017 asking Anthem to rescind the policy citing federal patient protections under PLP, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage.

ACEP Strategic Plan Reference

Goal 1 Reform and Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system

Fiscal Impact

Budgeted staff resources and potential unbudgeted costs for outside consultants and lobbyists to implement the advocacy agenda.

Prior Council Action

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 38(05) Proper Payment Under Assignment of Benefits adopted. Directed ACEP to advocate for legislation and regulation to ensure that when authorized by the patient, A payer directly reimburses the provider for care.

Amended Resolution 34(02) Funding for EMTALA-Mandated Services adopted. Directed ACEP to collaborate with organizations whose members are affected by EMTALA to lobby Congress to fund EMTALA-mandated services not covered by current funding mechanisms; ask the AMA to make it a legislative priority to ensure that EMTALA-mandated physician services are funded; and provide a report to the 2003 Council on progress to date.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA for emergency departments and that the Board of Directors provide a report on these efforts at the 2001 Leadership/Legislative Issues Conference.

Amended Substitute Resolution 24(98) HMO Practices referred to the Board of Directors. Called for the College to support a requirement that when a patient calls their HMO with questions regarding medical care, that decisions are made by an appropriate licensed professional according to sound triage protocols developed by qualified individuals.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted. Directed ACEP to investigate and report back on the establishment of an ACEP office of EMTALA usage and compliance for the development of continuing programs for comprehensive regulatory monitoring, member and public education and the coordination of legal and regulatory advocacy for an environment which is conducive to appropriate emergency practice.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in state that have the definition in law. Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted. Directed ACEP to continue current efforts with appropriate government agencies and other interested parties regarding the following EMTALA issues: (1) the role that health care insurance entities have played in denying access to emergency care to their beneficiaries, and ensure that those entities come under the jurisdiction of the statute; (2) the distorted interpretation and misuse of the original intent of the statute; and (3) seeking relief from the onerous implications of the law in light of managed care; and report back to the Council at the 1997 meeting.

Resolution 52(95) Managed Care Plans - Access to Urgent/Emergent Care referred to the Board of Directors because of ongoing efforts in support of H.R. 2011. The resolution called for ACEP to urge managed care organizations to adopt a "prudent layperson" definition to ensure access to timely emergency care for all subscribers.

Substitute Resolution 39(90) Amendments to COBRA adopted. Directed the College to expand its position statement on the definition of bona fide emergency to include reference to the fact that medical evaluation is necessary to ascertain if a bona fide emergency exists and is mandated by federal patient transfer laws.

Substitute Resolution 49(86) Patient Transfer adopted. This resolution directed ACEP to develop and make available support materials for chapters to deal with the assessment, management, and transfer of patients and that the College continue to work toward resolution of those elements of COBRA that deal unfairly with emergency physicians.

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted. Directed that as government entities mandate statutory access to emergency services, such statutes ensure a mechanism for optimal physician payment.

Prior Board Action

February 2018, reaffirmed the policy statement "Assignment of Benefits;" reaffirmed April 2012; originally approved April 2006.

January 16, 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). July 17, 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.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

June 2017, approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider.

April 2017, approved the revised policy statement "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005 with the title "Compensation When Services are Mandated;" originally approved September 1992.

April 2017, approved the revised policy statement "Prior Authorization;" revised and approved October 1998; originally approved November 1987.

May 2016, ACEP filed suit against the federal government. Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are "out of network" because of a medical emergency.

April 2016, approved the revised policy statement "Fair Payment for Emergency Department Services;" originally approved April 2009.

Referred Resolution 28(15) Standards for Fair Payment of Emergency Physicians assigned to the ACEP/EDPMA Joint Task Force on Reimbursement.

April 2014**,** revised and approved the policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

Referred Amended Substitute Resolution 24(98) HMO Practices assigned to the Federal Government Affairs Committee and the Emergency Medicine Practice Committee.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted.

Substitute Resolution 39(90) Amendments to COBRA adopted.

Substitute Resolution 49(86) Patient Transfer adopted

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted.

Background Information Prepared by: Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 36(19)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence

PURPOSE: Work with stakeholders to raise awareness and advocate for research funding and legislation to curb gun violence and intimate partner violence.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Tamara O'Neal, MD, was a medical student, resident, and emergency medicine faculty in the state of Illinois and a member of the Illinois College of Emergency Physicians (ICEP); and

WHEREAS, After graduating from the University of Illinois Chicago (UIC) emergency medicine residency program, she remained in Chicago to give back to the community and work with residents at Mercy Hospital on the south side of Chicago; and

WHEREAS, On November 19, 2018, Dr. O'Neal was shot and killed by her former fiancé in the parking lot of the hospital where she worked; and

WHEREAS, Dr. O'Neal was dedicated to the betterment of her community, and was a strong advocate for diversity in medicine as well as the advancement of care for the most underserved patient populations; and

WHEREAS, The presence of a gun in a domestic violence situation increases the risk of homicide by 500% [1]; and

WHEREAS, 65 percent of all murder-suicides involved an intimate partner and of these 96 percent were females killed by their intimate partners and 94 percent involved a gun[2]; and

WHEREAS, A study of intimate partner homicides found that 20% of victims were not the intimate partners themselves, but family members, friends, neighbors, persons who intervened, law enforcement responders, or bystanders[3]; and

WHEREAS, ICEP, along with University of Illinois at Chicago faculty and alumni, helped to support the creation of a research fund in partnership with the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM); and

WHEREAS, Donations to the Dr. Tamara O'Neal Memorial Research Fund will go toward much-needed studies that address the intersectional issues of gun violence and intimate partner violence, especially as it affects people of color; and

---

[1] Campbell JC, Webster D, Koziol-McLain J, et al. Risk factors for femicide in abusive relationships: results from a multisite case control study. *Am J Public Health*. 2003;93(7):1089–1097. doi:10.2105/ajph.93.7.1089

[2] American Roulette: Murder Suicide in the United States. *Violence Policy Center.* Sixth Edition. June 2018. http://vpc.org/studies/amroul2018.pdf

[3] Smith SG, Fowler KA, Niolon, PH. Intimate Partner Homicide and Corollary Victims in 16 States: National Violent Death Reporting System, 2003–2009. *Am J Public Health.* 2014. 104, 461_466. doi:10.2105/AJPH.2013.301582

31 WHEREAS, ICEP successfully pledged to raise $50,000 in donations to the Dr. Tamara O'Neal Memorial
32 Research Fund; therefore be it
33
34 RESOLVED, That ACEP work with stakeholders to raise awareness and advocate for research funding and
35 legislation to curb gun violence and intimate partner violence.

Background

This resolution calls for ACEP to work with stakeholders to raise awareness and advocate for research funding and legislation to curb gun violence and intimate partner violence.

ACEPs legislative and regulatory priorities over the years have included 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. ACEP has worked with the AMA and other stakeholders to address firearm injury prevention and research on this issue.

The College has addressed the issue of firearms multiple times over the years through Council resolutions and policy statements. A compilation of resources for physicians impacted by active shooter mass casualty incidents is available on the ACEP website.

The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants. An Early Career Research Development Grant for $150,000 was awarded to Kristen Mueller, MD from Washington University in St. Louis in June 2019 for "Firearm Injuries and Recidivism at St. Louis Level 1 Trauma Hospitals." AFFIRM contributed $37,500 and EMF contributed $112,000 to fund this grant. A $5,000 Medical Student Research Grant was awarded in June 2019 to Henry Schwimmer, BA from Emory University School of Medicine for "Rural Emergency Department Firearm Assessment, Screening, and Treatment (FAST) Trial." AFFIRM contributed $2,500 and EMF contributed $2,500 for this award.

In June 2019, the Board of Directors approved a survey of the ACEP Council on the firearms research, safety, and policy. The survey is currently underway. It was sent to 432 councillors and 170 responses were received as of August 28, 2019. The survey will close on September 13, 2019. The results will be presented to the Board in October 2019 and at the 2019 Council meeting. The Board has not yet determined whether this survey will be sent to the entire membership.

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.

ACEP's current policy statement "Firearm Safety and Injury Prevention" was developed by a task force that was appointed in 2013. ACEP policies are reviewed on a 5- to 7-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 discussed the revised policy statement in June 2019 and referred it back to the committee for further work.

During the 2017-18 committee year, the PHIPC developed an 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.

In March 2018, ACEP provided a letter of support for the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM.) The letter outlined ACEPs support of 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. In January 2019, the Board of Directors approved a $20,000 donation to AFFIRM.

The Research Committee was assigned an objective in 2014-15 to "Convene a Technical Advisory Group (TAG) of firearm researchers and other stakeholders to develop a research agenda and to consider the use of available research networks (including ACEP's EM-PRN) to perform firearm research." TAG members determined the research agenda would be based on questions relating to suicides, unintentional injuries, mass violence, and peer violence. An article titled "A Consensus-Driven Agenda for Emergency Medicine Firearm Injury Prevention Research" was published in *Annals of Emergency Medicine* in February 2017 outlining this work.

During the 2013-14 committee year, the Research Committee was assigned an objective to make a recommendation to the Board regarding Referred Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs. In June 2014, the Board approved the following recommendations: 1) ACEP and EMF staff convene a consensus conference of firearm researchers and other stakeholders to develop a research agenda and to consider the use of available research networks (including the proposed EM-PRN) to perform firearm research; 2) ACEP and EMF staff to identify grant opportunities and promote them to emergency medicine researchers; 3) EMF to consider seeking funding for a research grant specifically supporting multi-center firearm research; and 4) ACEP to advance the development of the EM-PRN to create a resource for representative ED-based research on this topic and others.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted. Directed ACEP to support Extreme Risk Protection Orders (ERPO) legislation at the federal level; promote and assist

chapters to enact ERPOs by creating a toolkit and other appropriate resources; and encourage and support further research of the effectiveness and ramifications of ERPOs and Gun Violence Restraining Orders (GVROs).

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.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. Directed ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence, devise strategies to help emergency physicians to work with stakeholders to mitigate patient risk of self-directed or interpersonal harm, investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes, and explore similar precedents currently in use.

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.

Amended Resolution 41(04) Assault Weapon Ban adopted. ACEP deplores 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 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.

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

June 2019, discussed proposed revisions to the statement "Firearm Safety and Injury Prevention." The policy statement was referred back to the Public Health & Injury Prevention Committee for further revision.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement "Domestic Family Violence;" reaffirmed June 2013; originally approved October 2007 replacing seven rescinded policy statements.

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).

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed "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.

Substitute Resolution 21(14) Emergency Department Mental Health Exchange adopted.

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.

April 2013, approved the revised policy statement, "Firearm Safety and Injury Prevention;" replacing the "Firearm Injury Prevention" policy statement that was revised and approved in October 2012 and January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Amended Resolution 41(04) Assault Weapon Ban adopted.

November 2000, assigned Resolution 14(00) Childhood Firearm Injuries to the Public Health & Injury Prevention Committee.

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.

Amended Resolution 69(95) Firearm Legislation adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Resolution 47(94) Firearm Classification referred to the Board of Directors.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted.

Substitute Resolution 45(94) Firearm Possession adopted.

Substitute Resolution 44(94) Firearm Legislation adopted.

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 16(93) Possession of Handguns by Minors adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Amended Resolution 14(89) Ban on Assault Weapons adopted.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted.

Substitute Resolution 16(84) Ban on Handguns adopted.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 37(19)

SUBMITTED BY: Larry Bedard, MD, FACEP
Kathleen Cowling, DO, MBA, FACEP
Gregory Gafni-Pappas, DO, FACEP
Jacob Manteuffel, MD, FACEP
James Mitchiner, MD, MPH, FACEP
Robert Solomon, MD, FACEP
Nicholas Vasquez, MD, FACEP
Bradford Walters, MD, FACEP

SUBJECT: Single-Payer Health Insurance

PURPOSE: Support the adoption of a single-payer health insurance program and explore opportunities to partner with other organizations that favor the single-payer approach to providing universal health care to all Americans.

FISCAL IMPACT: Budgeted staff and consultant resources. Potential additional unknown costs to work with other partners or coalitions.

WHEREAS, Despite enactment of the Affordable Care Act (ACA) in 2010, approximately 24 million adult Americans still lack health insurance and approximately 44 million more are effectively underinsured, causing them to forego care or to receive care only at an advanced stage of disease;[1] and

WHEREAS, The ACA has created a complex and inefficient bureaucracy that works through private insurers with high administrative overhead; and

WHEREAS, Single-payer health insurance, often known as "Medicare-for-All", is simply an alternative method of <u>financing</u> the American health care system without disrupting the private practice of medicine; adds simplicity to billing and medical care administration resulting in lower overhead; and has the potential to help American businesses compete globally by reducing their financial obligations for their employees' health care; and

WHEREAS, Separate polls show that most of the general public[2,3] and a majority of physicians[4] support a national single-payer, Medicare-for-All health plan; and

WHEREAS, The ACEP Council adopted Resolution 15(99) Promotion of Health Care Insurance, stipulating that ACEP formulate and implement a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; and

WHEREAS, The ACEP Council adopted Substitute Resolution 31(14) Financing Health Insurance directing ACEP to create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve patient choice, which met and deliberated with no policy having been proposed; and

WHEREAS, ACEP leadership created the Alternative Payment Models (APM) Task Force, which has focused on <u>*payment*</u> models (for physician reimbursement) rather than <u>*financing*</u> models (for American health care overall); therefore be it

RESOLVED, That ACEP support the adoption of a single-payer health insurance program that finances care for all Americans while fostering competition, preserving patient choice, and recognizing the essential value of emergency medicine; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations that favor the single-payer approach to providing universal health care to all Americans.

[1] Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, Feb. 2019), at: https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca.
[2] Keller M. Seventy percent of Americans support 'Medicare for all' in new poll. *The Hill* (August 23, 2018), at: https://thehill.com/policy/healthcare/403248-poll-seventy-percent-of-americans-support-medicare-for-all; Reuters/IPSOS poll, at https://www.reuters.com/investigates/special-report/usa-election-progressives/
[3] Kirzinger A, Muñana C, Lopes L, Hamel L, Brodie M. KFF Health Tracking Poll - June 2019: Health Care in the Democratic Primary and Medicare-for-all, at: https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-june-2019/; https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/
[4] Bluth R. Doctors warm to single-payer health care. *Kaiser Health News* (August 16, 2017), at: https://khn.org/news/doctors-warm-to-single-payer-health-care/

Background

This resolution requests ACEP to support the adoption of a single-payer health insurance program for financing health care and explore opportunities to partner with other organizations that favor the single-payer approach to providing universal health care to all Americans.

As the resolution notes, the Health Care Financing Task Force (HCFTF), established by Amended Resolution 19(16) to study alternative health care financing models, including single payer, delivered its report in Fall 2018. The report notes:

> Although the HCFTF cannot recommend a financing system at this time, a majority of the HCFTF agree that there are elements of [single payer] systems that strongly adhere to the '9 Principles' outlined. Therefore, if ACEP were to advocate for significant health care financing reform in the future, HCFTF members would want some elements of varied SP models to be considered and included in an ACEP-endorsed model.

The task force determined that ACEP should continue to advocate for and propose meaningful ideas for health care financing reform, but at the current time, no one system – single payer, two-tier, or the current health care system – could be espoused over another. The HCFTF concluded "ACEP shall focus on securing access to coverage for our patients and their families for, acute unscheduled care services in any health care financing model, including single payer."

For purposes of this discussion, it is important to recognize that single-payer is not equivalent to universal health care. Universal health care refers to a system in which all citizens have access to health care services, although payment for these services could derive from either a single source or multiple sources. Single-payer, on the other hand, is a health care financing system where all reimbursements derive from one entity.

Further, while the resolution states "Single-payer health insurance, often known as 'Medicare-for-All'…", it should be noted that "single-payer" and "Medicare-for-All" are also considered distinct proposals, even by many proponents. For example, a 2016 poll conducted by Kaiser Family Foundation (KFF) found significant variation in support among Democratic voters for various proposals, including Medicare-for-All (53% very positive), guaranteed universal health coverage (44% very positive), single-payer health insurance (21% very positive), and socialized medicine (22% very positive). However, those variations appear to have diminished within the past few years – according to a 2019 Morning Consult poll, a majority of voters support either Medicare-for-all (53%) or single-payer (51%). Regardless, as the Morning Consult notes, while the terms are often used interchangeably, "there are differences between the two: Single-payer is a sweeping term for a system in which the costs of essential care for all residents are covered by one public system, while a "Medicare for all" program could be single-payer but does not necessarily have to be."

The United States currently operates under a multi-payer system. Individuals and businesses pay taxes to the government, in the form of payroll taxes and income taxes, as well as paying premiums to private insurers. The government then reimburses health care providers who deliver care through one of the public programs, such as Medicare, Medicaid, CHIP or military health care (TRICARE or VA/CHAMPVA). For those who are privately

insured, health care providers seek reimbursement from the respective insurance company. Presently, there are dozens of private health insurance companies and thousands of private health insurance plans offered through state and federal insurance exchanges, public programs and in the private marketplace. Of those who had health insurance in 2010, government programs insured 95 million Americans while private insurance covered 196 million.

In the case of single-payer financing, individuals and businesses would pay taxes to the government. The government would then reimburse health service providers directly for care delivered through a national health insurance program. Although the collection of funds and the process of reimbursement are conducted by one entity, the delivery of care would be through both public and private sources. For example, under the terms of the single-payer system proposed by Physicians for a National Health Program (published in the *Journal of the American Medical Association* in 2003), all residents of the U.S. would be enrolled, and all medically necessary care would be covered. Obviously, the question of what is considered "medically necessary" could be contentious, especially given the recent developments in the State of Washington.

Financing the proposal would be achieved using existing sources of government funding (for public programs) and supplemented with new taxes. According to PNHP, businesses and individuals would pay more taxes, but those taxes would be offset because there would no longer be health insurance premiums.

Hospitals would receive a global budget for operating expenses every month. Medications and supplies would be purchased by the federal government according to a national formulary and using its bulk purchasing power to negotiate the lowest prices for medications and supplies. Physicians would have three reimbursement options: (1) fee-for-service (with a simplified, binding fee schedule); (2) salaried positions in facilities that receive global budget payments (i.e. hospitals); or (3) salaried positions within group practices or HMOs receiving capitation payments.

Two of the more common economic arguments in favor of single-payer are administrative simplification and the ability to control costs. According to a 2003 New England Journal of Medicine study, the U.S. spends more than $294 billion annually on administrative costs, which represents 31% of health expenditures in this country. However, not all administrative costs are harmful or inappropriate, thus diminishing the amount of savings generated by administrative simplification.

With regard to cost control, the U.S. has a fragmented, non-centrally coordinated system where different payers operate by different rules. Some argue that these variances have curtailed efforts to implement effective, systemic cost control measures, such as global budgeting (lump-sum monthly payments for all care provided); price controls; supply controls; reimbursement caps; and overall expenditure targets. Centrally administered plans, such as single-payer, provide policy makers who wish to institute cost controls with a substantial tool for obtaining that objective. Although, implementing that option would be largely dependent on public opinion. Additionally, if cost containment measures are too aggressive, it can lead to an underfunded system with significant wait times for elective procedures, insufficient resources and diminished research and development.

Some argue that the biggest disadvantage to a single-payer system is the threat of underfunding by the government (due to fiscal or policy determinations). A single-payer system is particularly reliant upon a government that is committed to high funding levels to ensure quality of care is not diminished. As the Medicare and Medicaid Trust Funds rapidly approach projected insolvency, questions arise about the federal government's ability to sufficiently provide benefits even under our current system. Another acknowledged disadvantage is that the transition from the current U.S. system to single-payer would be very difficult and disruptive. The ACEP HCFTF also notes several potential tradeoffs with regard to implementing a single-payer system. These include: "restricted availability and lengthy wait times for certain elective procedures, as well as the potential for capitation that could limit reimbursement for providers." Finally, it has been suggested that Americans would have to be willing to accept other certain sacrifices under a single-payer system, such as accepting less choice in their coverage options and a willingness to accept more government control, oversight, and regulations through a single-payer system.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted staff and consultant resources. Potential additional unknown costs to work with other partners or coalitions.

Prior Council Action

October 2018, the Health Care Financing Task Force report served as the foundation for the 2018 Council Town Hall Meeting.

Amended Resolution 19(16) Health Care Financing Task Force adopted. Directed ACEP to establish a Health Care Financing Task Force to study alternative health care financing models, including single-payer, and provide a report to the 2017 Council.

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.

Resolution 26(11) 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 original resolution Supported the adoption of Medicare for everyone and work with organizations that favor this approach to providing health insurance for all Americans. The substitute resolution directed the Board to appoint a taskforce to investigate alternative models of healthcare financing.

Resolution 18(09) Single-Payer Health Insurance not adopted. Directed ACEP to support the adoption of single payer health insurance and work with organizations that favor the single-payer approach.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted. Directed ACEP to support the adoption of single-payer health insurance and work with organizations that favor the single-payer approach. A substitute resolution was adopted, although the title of the resolution was not changed. The substitute resolution directed the Board of Directors to derive a list of essential components to be included in any new healthcare system and create a white paper.

Resolution 21(07) Single-Payer Health insurance referred to the Board of Directors.

Resolution 34(05) Single-Payer Health Insurance referred to the Board of Directors.

Resolution 11(00) Funding the Mandate referred to the Board.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted. Directed the College to develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; make a long-term commitment to work with federal, state, and private agencies to resolve the problem; and provide a progress report at the 2000 Council meeting. This resolution was linked to Resolution 12(99).

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted. It called for ACEP to continue working with the AMA and other leaders on developing and implementing an educational program, on the issue of the medically uninsured and underinsured.

Substitute Resolution 17(98) Responsibilities of On-call Physicians adopted. It called for a study on the ramifications of on-call physicians and EMTALA including reimbursement issues.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted. The resolution asked for swift action to identify any adverse effects on public health, safety, and access to emergency services resulting from the Act that could result in making many persons covered by Medicaid ineligible, thus increasing the number of uninsured, and to seek immediate government action if any of these are jeopardized.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. The resolution called for the increase of federal taxes on handguns and ammunition to support increased coverage for the uninsured.

Amended Resolution 38(94) Single-Payer System adopted. The resolution asked the board to endorse the concept of a single-payer system for the United States, saying it would reduce administrative costs, thereby offsetting the costs of providing expanded coverage to the poor and uninsured.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Resolution 18(92) Effect of Transfer Legislation on Emergency Medical Care referred to the Board of Directors.

Prior Board Action

September 2018, accepted the final report from the Health Care Financing Task Force. The report was distributed to the Council.

Amended Resolution 19(16) Health Care Financing Task Force adopted.

June 2015, reaffirmed the policy statement, "Universal Health Care Coverage;" reaffirmed August 2009; originally approved December 1999.

Substitute Resolution 31(14) Single Payer Health Insurance adopted.

April 2014, approved the revised policy statement "Health Care Cost Assignments by Taxes," replacing the policy statement "Health Promotion Revenues ("Sin Taxes"); reaffirmed October 2006; revised and approved July 2000; originally approved in 1993.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted.

January 2008, discussed whether ACEP should have a more defined position on health care reform, including universal health care coverage. There was consensus that system reform and health care coverage were ACEP's primary goals in the health care debate.

August 2007, agreed with the assessment of the Federal Government Affairs Committee that support of reform principles and involvement in discussions regarding health care reform constitute sound approach to health care reform and thus took no action on Resolution 34(05).

January 2006, endorsed the "Principles of Reform of the U.S. Health Care System" developed by eleven physicians' organizations, including ACEP.

June 2005 discussed whether ACEP should take the lead in advocating for fundamental changes in public financing of health care to provide universal coverage of basic benefits.

Resolution 11(00) Funding the Mandate was assigned to the EMS Committee, Reimbursement Committee, Federal Government Affairs Committee, and the State Legislative/Regulatory Committee. ACEP addressed the resolution through ongoing legislative and regulatory activities, both nationally and at the state level.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.

Substitute Resolution 17(98) Responsibilities of On Call Physicians adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Amended Resolution 38(94) Single-Payer System adopted.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 38(19)

SUBMITTED BY: Kerry Forrestal, MD, FACEP
Mark Goldstein, MD, FACEP
Maryland Chapter
New Jersey Chapter

SUBJECT: Standards for Insurance Denials

PURPOSE: Directs ACEP to work with legislators to enact legislation that 1) makes it illegal for third-party payers to engage in automatic denials of emergency department claims; 2) to deny a claim, a physician who reviews the claim must be ABEM or ABOEM certified and clinically active in a field related to the claim, and 3) work to establish written policies with third-party payers that uphold the legal rights of patients established by EMTALA.

FISCAL IMPACT: Budgeted staff resources and unbudgeted potential fees for outside consultants and lobbyists to implement the advocacy agenda.

WHEREAS, Roughly 278 million Americans rely on public and private health insurance to obtain healthcare for themselves and their families; and

WHEREAS, Patients who have healthcare insurance have a reasonable expectation that their policies will provide the care contracted for; and

WHEREAS, The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd and provides the legal right to be provided a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC) at an accredited Emergency Department; and

WHEREAS, Insurance companies are engaging in an automated process for approval and denial for EMTALA based claims; and

WHEREAS, Insurance companies have also been found to be denying charts that have never been reviewed by a practicing physician; therefore be it

RESOLVED, That ACEP work with legislators to enact legislation that makes it illegal for an insurance company to engage in automatic denials; and be it further

RESOLVED, That in order to deny a claim, a physician (i.e., MD or DO) who is board certified and remains clinically active in a field related to the claim, carefully review the denial, and attest to the cause of the denial with their signature attached to the documentation that shall be provided to the patient; and be it further

RESOLVED, That patients have the legal right under EMTALA to seek emergency care and that their claims shall not be denied by insurance companies and that ACEP work towards getting an affirmation in writing from insurance companies that they will adopt this as policy.

Background

This resolution directs ACEP to work with legislators to enact legislation that makes it illegal for third-party payers to

engage in automatic denials of emergency department claims; to deny a claim, a physician who reviews the claim must be ABEM or ABOEM certified and clinically active in a field related to the claim; and establish written policies with third-party payers that uphold the legal rights of patients established by EMTALA.

History of Emergency Medical Treatment and Active Labor Act (EMTALA) and Prudent Layperson Standard (PLP)

The Emergency Medical Treatment and Active Labor Act (EMTALA) was originally enacted as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, and was subsequently amended in 1986, 1987, 1988, 1989 and 1990. The law requires that hospitals with emergency departments conduct an appropriate medical screening examination on all individuals seeking care in order to determine whether they are experiencing an emergency medical condition. If it is determined that an emergency medical condition exists, the hospital must stabilize the patient's condition if they are able or transfer the individual to another medical facility if they are not able to stabilize the patient's condition. A hospital may not delay the provision of the screening examination in order to inquire about the method of payment or insurance status. There are severe penalties for hospitals and physicians that violate the law, including substantial fines per violation and/or termination from Medicare/Medicaid programs.

The Prudent Layperson Standard (PLP) was first enacted into law in the state of Maryland in 1993. Three years later, the National Association of Insurance Commissioners (NAIC), which adopts model state legislation and regulations relating to virtually all areas of insurance, drafted the Managed Care Provider Network Adequacy and Contracting Model Act (Model Act) which included PLP. This step recognized the need to require the provision of coverage for emergency services based upon presenting symptoms rather than the ultimate diagnosis. The Model Act differs only slightly from PLP in the Patient Bill of Rights, part of the 2010 Affordable Care Act (ACA) passed by the 111th Congress. The NAIC model includes the appropriate "concept" of PLP that applies to patients with presenting symptoms rather than subsequent final diagnosis to the emergency department. Thus, while the language in the NAIC model law is not identical with the officially sanctioned ACEP PLP language that was developed later and incorporated into the definition in the Patient Bill of Rights, it contains the same substance.

Strategies to Uphold Legal Rights Established by EMTALA and PLP

Despite the longstanding legal precedence of protecting patients and physicians from unwarranted third-party payer denials established by EMTALA and PLP, significant numbers of denials as well as the use of non-emergency board certified physicians to conduct claim reviews continue to persist.

ACEP has continued to fight for the inclusion of the EMTALA provision in third-party payer policies, especially those from managed care plans, which have significantly increased their market share since EMTALA was mandated by law. Although PLP laws have largely eliminated the issue of prior authorization denials for emergency services, many third-party payers have continued to make after-the-fact decisions to deny payment for services resulting in loss of revenue for physicians and an unnecessary financial burden on patients.

ACEP also has continued tracking third-party payer denials and has successfully lobbied on behalf of members in states where policies were announced that would have led to a process of automatic denials. Letters have been sent to several third-party payers that make up a large percentage of total market share in the U.S. with varying degrees of success. Most recently, Anthem Blue Cross Blue Shield retracted a policy in 13 states that would have led to retroactive denials after a letter was submitted on behalf of ACEP demonstrating EMTALA and PLP violations.

The College has continued to monitor and influence both the legislative and regulatory process related to EMTALA and PLP. We have successfully lobbied both Congress and the Centers for Medicare and Medicaid Services (CMS) on several issues of importance to emergency medicine, including removing criminal penalties against physicians, adding on-call requirements to the law, instituting whistleblower protections, and PRO review requirements. ACEP regulatory affairs staff have submitted formal comments to CMS and met with them on numerous occasions over the years to discuss the law, the regulations, and enforcement issues.

ACEP has also spent significant financial resources to educate members about EMTALA through *ACEP Now*, *Annals of Emergency Medicine*, as well as educational sessions at ACEP meetings.

ACEP developed recommended legislative language for patient protections for emergency services in 1997 when the Prudent Layperson Standard (PLP) was adopted in the Balanced Budget Act of 1997. The document was significantly updated in 2017 to reflect the new challenges presented by third-party payers.

ACEP Strategic Plan Reference

Goal 1 Reform and Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care

Fiscal Impact

Budgeted staff resources and unbudgeted potential fees for outside consultants and lobbyists to implement the advocacy agenda.

Prior Council Action

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 38(05) Proper Payment Under Assignment of Benefits adopted. Directed ACEP to advocate for legislation and regulation to ensure that when authorized by the patient, A payer directly reimburses the provider for care.

Amended Resolution 34(02) Funding for EMTALA-Mandated Services adopted. Directed ACEP to collaborate with organizations whose members are affected by EMTALA to lobby Congress to fund EMTALA-mandated services not covered by current funding mechanisms; ask the AMA to make it a legislative priority to ensure that EMTALA-mandated physician services are funded; and provide a report to the 2003 Council on progress to date.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed ACEP to solicit member input to formulate EMTALA recommendations to CMS' regulatory advisory committee including physician on-call responsibilities, greater consistency of enforcement, and more effective involvement of peer review organizations

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Reaffirmed that Eds are an essential part of the health care safety net for all populations, including foreign nationals, and in advocacy efforts ACEP recognizes uncompensated care for foreign nationals as one example of the many factors that threaten the health care safety net.

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Directed ACEP to champion the principle that emergency care is an essential public service.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA for emergency departments and that the Board of Directors provide a report on these efforts at the 2001 Leadership/Legislative Issues Conference.

Amended Substitute Resolution 24(98) HMO Practices referred to the Board of Directors. Called for the College to support a requirement that when a patient calls their HMO with questions regarding medical care, that decisions are made by an appropriate licensed professional according to sound triage protocols developed by qualified individuals.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted. Directed ACEP to investigate and report back on the establishment of an ACEP office of EMTALA usage and compliance for the development of continuing programs for comprehensive regulatory monitoring, member and public education and the coordination of legal and regulatory advocacy for an environment which is conducive to appropriate emergency practice.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in state that have the definition in law. Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted. Directed ACEP to continue current efforts with appropriate government agencies and other interested parties regarding the following EMTALA issues: (1) the role that health care insurance entities have played in denying access to emergency care to their beneficiaries, and ensure that those entities come under the jurisdiction of the statute; (2) the distorted interpretation and misuse of the original intent of the statute; and (3) seeking relief from the onerous implications of the law in light of managed care; and report back to the Council at the 1997 meeting.

Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted. Directed ACEP to continue efforts with government agencies and other interested parties regarding EMTALA: 1) the role that insurance entities have played in denying access to emergency care to their beneficiaries and ensure those entities come under the jurisdiction of the statute; 2) the distorted interpretation and misuse of the original intent of the statute; and 3) seek relief from the onerous implications of the law in light of managed care.

Resolution 52(95) Managed Care Plans - Access to Urgent/Emergent Care referred to the Board of Directors because of ongoing efforts in support of H.R. 2011. The resolution called for ACEP to urge managed care organizations to adopt a “prudent layperson” definition to ensure access to timely emergency care for all subscribers.

Amended Resolution 11(92) Payment for Mandated Services adopted. Directed that 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 providers, also mandate an adequate source of funding to ensure appropriate compensation for those services or products; and support legislation to ensure that any governmental agency, legislative body, insurance carrier, third party payer, or any other entity that mandates the provision of medical services or products, also provides for appropriate compensation for that service or product.

Substitute Resolution 39(90) Amendments to COBRA adopted. Directed the College to expand its position statement on the definition of bona fide emergency to include reference to the fact that medical evaluation is necessary to ascertain if a bona fide emergency exists and is mandated by federal patient transfer laws.

Substitute Resolution 49(86) Patient Transfer adopted. This resolution directed ACEP to develop and make available support materials for chapters to deal with the assessment, management, and transfer of patients and that the College continue to work toward resolution of those elements of COBRA that deal unfairly with emergency physicians.

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted. Directed that as government entities mandate statutory access to emergency services, such statutes ensure a mechanism for optimal physician payment.

Prior Board Action

February 2018, reaffirmed the policy statement “Assignment of Benefits;” reaffirmed April 2012; originally approved April 2006.

January 16, 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). July 17, 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.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

June 2017, approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider.

April 2017, approved the revised policy statement "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005 with the title "Compensation When Services are Mandated;" originally approved September 1992.

April 2017, approved the revised policy statement "Prior Authorization;" revised and approved October 1998; originally approved November 1987.

May 2016, ACEP filed suit against the federal government. Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are "out of network" because of a medical emergency.

April 2016, approved the revised policy statement "Balance Billing;" revised and approved 2009 with the current title; reaffirmed October 2008; originally approved October 2002 titled "Prohibition of Balance Billing."

April 2016, approved the revised policy statement "Fair Payment for Emergency Department Services;" originally approved April 2009.

Referred Resolution 28(15) Standards for Fair Payment of Emergency Physicians assigned to the ACEP/EDPMA Joint Task Force on Reimbursement.

April 2014, revised and approved the policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted.

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

Referred Amended Substitute Resolution 24(98) HMO Practices assigned to the Federal Government Affairs Committee and the Emergency Medicine Practice Committee.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted.

Amended Resolution 11(92) Payment for Mandated Services adopted.

Substitute Resolution 39(90) Amendments to COBRA adopted.

Substitute Resolution 49(86) Patient Transfer adopted

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted.

Background Information Prepared by: Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 39(19)

SUBMITTED BY: Joseph J. Calabro, DO, FACEP
Neal Cohen, MD
Michael Gratson, MD, MHSA
Dennis Hsieh, MD, JD
James Maloy, MD
Jacob Manteuffel, MD, FACEP
Therese Mead, DO, FACEP
Sar Medoff, MD, MPP
James Mitchiner, MD, MPH, FACEP
Dan Morhaim, MD, FACEP
Larisa Traill, MD, FACEP
Bradford Walters, MD, FACEP
Nicholas Vasquez, MD, FACEP

SUBJECT: Work Requirements for Medicaid Beneficiaries

PURPOSE: Oppose mandatory work requirements that force Medicaid beneficiaries to prove or keep employment to keep their health insurance benefit.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, 36 states and the District of Columbia have expanded their Medicaid programs under the provisions of the Affordable Care Act; and

WHEREAS, Expanded Medicaid coverage has increased overall access to healthcare, expanded preventive services, improved prescription drug coverage and boosted employment, while creating less financial stress for beneficiaries, increasing reimbursement for hospitals, and improving state tax revenue;[1,2,3,4] and

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) has granted Section 1115 demonstration waivers to nine states (Kentucky, Indiana, Arkansas, New Hampshire, Wisconsin, Michigan, Arizona, Ohio and Utah) to test the effect of mandatory work requirements (with pre-specified exemptions) on the ability to attain and maintain Medicaid eligibility; and

WHEREAS, CMS is reviewing additional Section 1115 proposals submitted by seven other states; and

WHEREAS, There is no evidence to date that Medicaid work requirements have a significant impact on employment or poverty for Medicaid beneficiaries;[5,6,7] and

WHEREAS, Early evidence from Arkansas suggests that Medicaid work requirements have adversely effected coverage, particularly due to confusion about eligibility and reporting requirements;[5,7,8] and

WHEREAS, Medicaid work requirements have the potential to impact states' budgets because of monitoring and enforcement activities, which are not reimbursable by CMS;[9] and

WHEREAS, Any policy that denies or disrupts insurance coverage, and thus creates a barrier to healthcare access outside the Emergency Department (ED), could lead to poor health outcomes for affected individuals and more uncompensated care in the ED;[10,11] therefore be it

RESOLVED: That ACEP oppose mandatory work requirements that force Medicaid beneficiaries to prove they are employed, or seeking employment, to get or keep health insurance.

[1] Rudowitz R, Antonisse L. Implications of the ACA Medicaid expansion: A look at the data and evidence. Kaiser Family Foundation Issue Brief, May 2018. (http://files.kff.org/attachment/Issue-Brief-Implications-of-the-ACA-Medicaid-Expansion-A-Look-at-the-Data-and-Evidence).
[2] Koorstra K. Fiscal Brief: Healthy Michigan Plan savings and cost estimates. Lansing, MI: Michigan House Fiscal Agency, October 30, 2018. (https://www.house.mi.gov/hfa/PDF/Alpha/Fiscal_Briefing_HMP_Savings_and_Cost_Estimates.pdf).
[3] Ayanian JZ, Ehrlich GM, Grimes DR, Levy H. Economic effects of Medicaid expansion in Michigan. *N Engl J Med* 2017; 376:407-410. (https://www.nejm.org/doi/full/10.1056/NEJMp161398).
[4] Sommers BD, Blendon RJ, Orav EJ. Both the 'private option' and traditional Medicaid expansions improved access to care for low-income adults. *Health Affairs* 2016; 35:96-105. (http://content.healthaffairs.org/content/35/1/96.full.html).
[5] Musumeci M, Rudowitz R, Lyons B. Medicaid work requirements in Arkansas: Experience and perspectives of enrollees. Kaiser Family Foundation Issue Brief, December 2018. (http://files.kff.org/attachment/Issue-Brief-Medicaid-Work-Requirements-in-Arkansas-Experience-and-Perspectives-of-Enrollees).
[6] Pavetti L. Work requirements don't cut poverty, evidence shows. Center on Budget and Policy Priorities, Updated June 7, 2016. ("*The large majority of individuals subject to work requirements remained poor, and some became poorer.*") (https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows)
[7] Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Special Report: Medicaid work requirements – results from the first year in Arkansas. *New Engl J Med* 2019 (published online June 19, 2019) (*..in its first six months, work requirements in Arkansas were associated with a significant loss of Medicaid coverage and rise in the percentage of uninsured persons. We found no significant changes in employment associated with the policy…Many Medicaid beneficiaries were unaware of the policy or were confused about how to report their status to the state…"*)
[8] Solomon J. Medicaid work requirements can't be fixed: unintended consequences are inevitable result. Center on Budget and Policy Priorities, January 10, 2019. ("*Paperwork and red tape cause eligible people to lose coverage*.") (https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed).
[9] Randolph M, Udow-Phillips M. Proposed Medicaid work requirements in Michigan. Ann Arbor, MI: Center for Healthcare Research & Transformation, 2018. (https://www.chrt.org/wp-content/uploads/2018/06/FINAL-Work-Req-Fact-Sheet-FINAL-.pdf).
[10] Pines JM, Ladhania R, Black BS, Corbit C, et al. Changes in reimbursement to emergency physicians after Medicaid expansion under the Patient Protection and Affordable Care Act. *Ann Emerg Med* 2019; 73:213-224. ("*…we found that full Medicaid expansion resulted in a more than 6% increase in emergency physician reimbursement per visit in full-expansion states compared with nonexpansion ones."*) (https://www.annemergmed.com/article/S0196-0644(18)31374-X/fulltext)
[11] Haught R, Dobson A, Luu P-H. How will Medicaid work requirements affect hospitals' finances? Commonwealth Fund Issue Brief, March 2019. ("*In states that impose work requirements, fewer covered Medicaid beneficiaries means hospitals will see reduced revenues, increased uncompensated care costs, and smaller operating margins.*") (https://www.commonwealthfund.org/sites/default/files/2019-03/Haught_medicaid_work_requirements_hosp_finances_ib_v2.pdf)

Background

The resolution calls upon the College to oppose mandatory work requirements that force Medicaid beneficiaries to prove or keep employment to keep their health insurance benefit.

Eight states have been approved by the Center for Medicare and Medicaid Services (CMS) for a waiver to permit them to mandate work and reporting requirements as a condition for ongoing Medicaid eligibility, though only Indiana has implemented such a program. Arkansas had implemented a work and reporting mandate in June of 2018, but the state's program was set aside by a federal court in March 2019. Waivers for Kentucky and New Hampshire have also been set aside by the courts. The remaining approved states have not yet implemented their waivers. In addition to the eight approved states, another seven states have waiver applications pending before CMS. Some of these waivers/applications for waiver apply only to the Medicaid expansion population, although 11 would apply to traditional Medicaid.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources and resources.

Prior Council Action

The Council has discussed and adopted many resolutions related to Medicare, but none specific to opposing mandatory work requirements for Medicaid beneficiaries.

Prior Board Action

July 2018, reviewed the information paper "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine."

Background Information Prepared by: Harry J. Monroe, Jr.
Director, Chapter and State Relations

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

2019 Council Meeting
Reference Committee Members

Reference Committee C
Emergency Medicine Practice
Resolutions 40-54

Michael A. Turturro, MD, FACEP (PA) Chair
Sara A. Brown, MD, FACEP (IN)
Angela P. Cornelius, MD, FACEP (LA)
Steven M. Hochman, MD, FACEP (NJ)
Matthew J. Sanders, DO, FACEP (OH)
John C. Soud, DO, (FL)

Margaret Montgomery, RN, MSN
Travis Schulz, MLS, AHIP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 40(19)

SUBMITTED BY: Rural Emergency Medicine Section
Florida College of Emergency Physicians
Idaho Chapter
Nebraska Chapter
West Virginia Chapter

SUBJECT: Advancing Quality Care in Rural Emergency Medicine

PURPOSE: Directs 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.

FISCAL IMPACT: Estimated $15,000 to convene meeting of stakeholder organizations to develop strategies, promote collaborative practice delivery models, and develop a paper.

WHEREAS, All patients, regardless of setting, deserve prompt access to high-quality emergency care, and ACEP emphasizes that emergency care is best provided by physicians who are residency trained in emergency medicine; and

WHEREAS, Data suggests that emergency medicine residency trained/board certified emergency physicians may never be able to fully meet workforce demands in rural areas; and

WHEREAS, The ED workforce in many rural areas may by necessity differ from that in urban areas and is diverse; and

WHEREAS, ACEP supports innovative approaches to raise the level of care, as well as the cognitive and technical skills of all emergency providers; and

WHEREAS, ACEP supports initiatives to improve the quality of emergency care in rural areas and expand the size of the rural emergency care workforce; and

WHEREAS, The recommendations from the Institute of Medicine (IOM) report and the Future of Emergency Medicine Summit include the need for increased collaboration between emergency medicine and primary care specialties and increased links between academic medical centers and rural hospitals; therefore be it

RESOLVED, That ACEP work with identified stakeholder groups and professional organizations, including the American Academy of Family Physicians and the National Rural Health Association, to create effective strategies and to promote emergency medicine practice delivery models that encourage collaboration, increase quality, and reduce costs in rural health care settings; and be it further

RESOLVED, That ACEP identify and promote a variety of existing training opportunities, such as procedural skills, simulation labs, and continuing medical education, to be available to maintain physician and non-physician clinicians' skills and to improve rural emergency medicine care; and be it further

RESOLVED, That ACEP work collaboratively with organizations to develop a rural emergency medicine white paper that identifies best practices, site criteria, supervision requirements, and studies funding mechanisms to

32 promote the development and uniform availability of rural emergency medicine electives within emergency medicine
33 residency training programs; and be it further
34
35 RESOLVED, That ACEP encourage research in rural emergency medicine by identifying funding sources to
36 support research and cost savings in rural emergency medicine and rural healthcare.

Background

This resolution directs the College 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.

According to the 2017 ACEP information paper "Delivery of Emergency Care in Rural Settings," approximately 42% of emergency departments in the U.S. are located in rural counties, accounting for about 17% of all emergency department visits. The unique challenges facing rural emergency medicine are significant and, in many areas, worsening. With low patient volumes and often serving largely impoverished areas, many rural EDs and hospitals face severe financial difficulties. According to the University of North Carolina Center for Health Services Research, 113 rural hospitals have closed since 2010, 16 of them in this year alone.

Rural EDs must also deal with workforce challenges that include a limited number of board-certified emergency physicians choosing to work in rural settings. A 2018 study in the *Annals of Emergency Medicine* showed that emergency physicians make up less than 45% of emergency department clinicians in rural counties, compared to almost 64% in urban counties. 28.3% of rural ED clinicians were non-emergency physicians and 26.8% were advance practice providers (compared to 12% and 24.1%, respectively, in urban EDs.)

These challenges exacerbate the fundamental problem of relatively poor outcomes for rural patients compared to other practice settings. Prolonged transport times to the hospital and typically sicker patient populations than those seen in other settings undermine the effort to save lives in rural America. According to one report, 60% of all U.S. trauma deaths occur in rural areas, even though only 15% of the population lives there.

ACEP has been working on the ongoing problems plaguing rural emergency medicine for many years. In 2003, the ACEP Board of Directors convened 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 the effort. Recommendations from the summit addressed residency training, academic medical centers, advocacy, distribution of the EM workforce, research, and educational programs.

Subsequent actions related to some of the recommendations from the summit included:

- The Residency Review Committee for EM approved program requirements for rural training.
- The American Board of Emergency Medicine and the American Board of Family Medicine developed a combined EM/FM training program.
- ACEP's federal advocacy efforts were successful in obtaining rural GME funding for redistribution of unused GME residency slots via the Medicare Modernization Act; this effort resulted in establishment of new emergency medicine residency programs in rural states such as Nebraska, Utah, and Iowa.

In July 2009, ACEP convened the Future of Emergency Medicine Summit. The summit included representatives from all emergency medicine organizations and other key stakeholders. The purpose of the summit was to build consensus on issues facing emergency medicine, most notably workforce realities, and specifically including rural emergency care.

Following additional discussion on educational opportunities for rural emergency medicine providers, a new Rural Emergency Medicine Task Force was convened in 2014. The task force's recommendations included better defining rural emergency medicine, identifying non-ACEP rural emergency medicine providers, addressing education gaps in rural emergency medicine, supporting and enhancing the development of scientific articles related to rural emergency medicine, and adopting a policy statement supporting the Comprehensive Advanced Life Support program.

In 2017, ACEP developed the policy statement "Definition of Rural Emergency Medicine," which reads: "Rural emergency medicine is urgent or emergent medicine practiced in geographic areas with low population densities and resource constraints, including ready access to more specialized care facilities. Rural emergency departments provide critical services for their communities, including facilitating earlier evaluation and entry into the healthcare system, stabilization and initiation of treatment, and coordinated transfer to a tertiary care facility."

While opposing the required completion of any short course, including Advanced Cardiac Life Support or Advanced Trauma Life Support for board-certified emergency physicians, ACEP has endorsed voluntary use of the Comprehensive Advanced Life Support (CALS) course as an "equally acceptable alternative to other advanced life support and/or trauma life support courses. CALS may be of particular value to those who practice rural emergency medicine as it is more comprehensive than other life support courses." ACEP initiated a pilot project to help expand CALS training opportunities in one rural state.

ACEP's information paper (mentioned previously) "Delivery of Emergency Care in Rural Settings" provides an overview of the challenges facing rural emergency medicine, legislative and funding efforts to support rural hospitals, and the prospect of freestanding emergency departments and telehealth helping to fill the void in better meeting the needs of rural emergency patients. In addition, ACEP's policy statement "Emergency Medicine Telemedicine" states that "ACEP further supports efforts to keep small and rural hospital EDs operational via use of appropriately trained and supervised NPs and PAs with telemedicine support."

For the last several years, including 2019, *Scientific Assembly* has offered educational courses of particular relevance to rural providers. The courses are also available on Virtual ACEP.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety

Fiscal Impact

Estimated $15,000 to convene meetings of stakeholder organizations to develop strategies, promote collaborative practice delivery models and develop a white paper.

Prior Council Action

Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States referred to the Board of Directors. The resolution called in part for ACEP to advocate for the creation of a Critical Access Emergency Center Designation where critical access hospitals no longer exist due to natural disasters or cannot be feasibly maintained.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. The resolution called for ACEP to analyze the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where emergency departments in critical access and rural hospitals have closed.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/ rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas." Reaffirmed in April 2012 and October 2006. Originally approved in June 2000.

January 2018, assigned Referred Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States to the Federal Government Affairs Committee for action.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

January 2016, approved the policy statement "Emergency Medicine Telemedicine."

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

October 2005, adopted Amended Resolution 37(05) Rural Emergency Medicine Workforce.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 41(19)

SUBMITTED BY:

Rural Emergency Medicine Section	Montana Chapter
Young Physicians Section	Nebraska Chapter
Alaska Chapter	Nevada Chapter
Florida College of Emergency Physicians	New Mexico Chapter
Idaho Chapter	West Virginia Chapter
Missouri College of Emergency Physicians	Wyoming Chapter

SUBJECT: Establish a Rural Emergency Care Advisory Board

PURPOSE: Establish an advisory board to monitor, coordinate, and advocate for clinical initiatives and health policies that would improve the delivery of emergency care in rural areas.

FISCAL IMPACT: Unbudgeted costs to include up to one FTE in excess of $100,000 in salary and benefits for identifying and monitoring the impacts of health policy on rural EDs and advocating for improvements to rural health care. Travel and meeting costs for any in-person advisory board meeting. Potential additional advocacy-related costs depending on the level and degree of new advocacy efforts (such as additional lobbying, policymaker education campaigns, meetings in DC, etc.)

WHEREAS, Emergency medicine was founded to improve the access by and delivery of care to the acutely ill wherever and whenever needed; and

WHEREAS, ACEP's mission is to promote the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public; and

WHEREAS, The economics of health care delivery in the United States is rapidly evolving, including drastic shifts within both urban and rural settings; and

WHEREAS, Rural communities are struggling to preserve dwindling access to basic and specialty health care services, including emergency services; and

WHEREAS, Federal legislation can dramatically affect the well-being of communities across the country, especially those in rural areas; and

WHEREAS, ACEP does not have an institutionalized system and resources to monitor the effects of health care legislation in rural areas; and

WHEREAS, Supporting policies for emergency patients in rural environments will improve advocacy and care for all emergency patients; therefore be it

RESOLVED, That ACEP establish an advisory board to monitor, coordinate, and advocate for clinical initiatives and health policies that would improve the delivery of emergency care in rural areas.

Background

This resolution directs the College to establish an advisory board to monitor, coordinate, and advocate for clinical initiatives and health policies that would improve the delivery of emergency care in rural areas.

According to the 2017 ACEP information paper "Delivery of Emergency Care in Rural Settings," approximately 42% of emergency departments in the U.S. are located in rural counties, accounting for about 17% of all emergency department visits. The unique challenges facing rural emergency medicine are significant and, in many areas, worsening. With low patient volumes and often serving largely impoverished areas, many rural EDs and hospitals face severe financial difficulties. According to the University of North Carolina Center for Health Services Research, 113 rural hospitals have closed since 2010, 16 of them in this year alone.

Rural EDs must also deal with workforce challenges that include a limited number of board-certified emergency physicians choosing to work in rural settings. A 2018 study in *Annals of Emergency Medicine* showed that emergency physicians make up less than 45% of emergency department clinicians in rural counties, compared to almost 64% in urban counties. 28.3% of rural ED clinicians were non-emergency physicians and 26.8% were advance practice providers (compared to 12% and 24.1%, respectively, in urban EDs.)

These challenges exacerbate the fundamental problem of relatively poor outcomes for rural patients compared to other practice settings. Prolonged transport times to the hospital and typically sicker patient populations than those seen in other settings undermine the effort to save lives in rural America. According to one report, 60% of all U.S. trauma deaths occur in rural areas, even though only 15% of the population lives there.

For many years, ACEP has advocated for federal legislation and regulation to improve rural emergency care. Following the ACEP Rural Workforce Summit in 2003, ACEP's federal government affairs efforts were successful in obtaining rural GME funding for redistribution of unused GME residency slots via the Medicare Modernization Act; this effort resulted in establishment of new EM residency programs in rural states such as Nebraska, Utah, and Iowa.

For the past several years, ACEP has led the effort to pursue Congressional support for the REACH (Rural Emergency Acute Care Hospital) Act, which would create a rural emergency hospital classification that would allow endangered critical access hospitals to voluntarily convert to rural emergency hospitals and continue providing emergency care. 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 their work in this area.

A separate advisory board as contemplated by the resolution would be unique within the ACEP organizational structure. The proposed advisory board's charge to "monitor, coordinate and advocate for clinical initiatives and health policies" would require effective coordination with existing bodies within the College working on rural health care issues, in particular the federal affairs staff and the Federal Government Affairs Committee.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Unbudgeted costs to include up to one FTE in excess of $100,000 in salary and benefits for identifying and monitoring the impacts of health policy on rural EDs and advocating for improvements to rural health care. Travel and meeting costs for any in-person advisory board meeting. Potential additional advocacy-related costs depending on the level and degree of new advocacy efforts (such as additional lobbying, policymaker education campaigns, meetings in DC, etc.)

Prior Council Action

Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States referred to the Board of Directors. The resolution called in part for ACEP to advocate for the creation of a Critical Access Emergency Center Designation where critical access hospitals no longer exist due to natural disasters or cannot be feasibly maintained.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. The resolution called for ACEP to analyze the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where emergency departments in critical access and rural hospitals have closed.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/ rotations at medical schools and residency programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Prior Board Action

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas." Reaffirmed in April 2012 and October 2006. Originally approved in June 2000.

January 2018, assigned Referred Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States to the Federal Government Affairs Committee for action.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

January 2016, approved the policy statement "Emergency Medicine Telemedicine."

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

October 2005, adopted Amended Resolution 37(05) Rural Emergency Medicine Workforce.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Substitute Resolution 20(01) Medical Education Debt adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 42(19)

SUBMITTED BY: Zach Jarou, MD
John Rogers, MD, FACEP
Emergency Medicine Informatics Section

SUBJECT: Artificial Intelligence in Emergency Medicine

PURPOSE: 1) Develop an information paper on the role and future impact of emergency medicine artificial intelligence (EMAI) through convening a summit or creation of a task force. 2) Add EMAI to ACEP's Strategic Plan. 3) Incorporate a presentation on EMAI as part of the 2020 Leadership & Advocacy Conference 2020 and/or ACEP20.

FISCAL IMPACT: Cost for a summit approximately $25,000 plus staff labor. Cost for a task force approximately $15,000 plus staff labor (depending on the number and site of meetings). Cost for an educational offering approximately $5,000 (estimated speaker fee and travel costs).

WHEREAS, Applications using artificial intelligence (AI) are being developed and implemented for emergency medicine; and

WHEREAS, Emergency physicians should be the principal leaders and stakeholders of new technologies being applied to the practice of emergency medicine; and

WHEREAS, Applications using AI may alter the workforce needs both in terms of number and type of providers; and

WHEREAS, The use of these applications may require specific training before, during, and after residency; and

WHEREAS, These applications may alter physician workflow, and the practice of emergency medicine itself; and

WHEREAS, The general principles, scientific evidence, ethics, liability, and legal questions regarding the use of AI in emergency medicine have yet to be elucidated; and

WHEREAS, Identifying applications that emergency physicians would find helpful would guide the development of these applications; and

WHEREAS, Research and funding to support directed research questions on AI in emergency medicine may be of benefit to the Emergency Medicine Foundation and the academic community; therefore be it

RESOLVED, That ACEP convene an Emergency Medicine Artificial Intelligence (EMAI) Summit and/or a task force; and be it further

RESOLVED, That the purpose of convening an Emergency Medicine Artificial Intelligence (EMAI) Summit is to produce an information paper to include recommendations based on the best available knowledge or opinion on the issues and concerns surrounding artificial intelligence and make recommendations for how the College will continue to be informed and advised on matters related to EMAI; and be it further

RESOLVED, That the Board of Directors consider updating the College's Strategic Plan to include artificial

34 intelligence; and be it further
35
36 RESOLVED, That during the Leadership & Advocacy Conference 2020 and/or ACEP20, a presentation on
37 artificial intelligence in emergency medicine, panel discussion, town hall, or similar session on emergency medicine
38 artificial intelligence be offered.

Background

This resolution calls for ACEP to develop an information paper on the role and future impact of artificial intelligence in Emergency Medicine through convening a summit or creation of a task force, the information paper should contain recommendations for the College to keep informed and advised on matters related to emergency medicine artificial intelligence (EMAI), EMAI to be addressed in ACEP's Strategic Plan, and incorporate a presentation on EMAI as part of the 2020 Leadership & Advocacy Conference and/or ACEP 2020.

Artificial Intelligence (AI) is a term used to describe a computer or similar device that can perform complex tasks generally associated with intelligent beings. These processes may include learning (acquisition of information and rules for using that information), reasoning (using rules to reach conclusions) and self-correction. Often included as AI, machine learning (ML) is somewhat different and is the ability of computers to rapidly analyze large quantities of data and draw relationships that might not be apparent after human analysis. The AMA prefers the term Augmented Intelligence, recognizing that it is not "artificial" but rather the ability of today's computers to analyze an immense amount of data and filter out unnecessary or duplicative information rapidly. In addition, AI can use this data analysis to make connections that might escape the human brain.

AI is already impacting our world outside of medicine. In fact, medicine may be lagging behind other industries. For example, your online buying habits are filtered and analyzed almost instantaneously, and you are provided with additional options that reflect those purchases. In addition, you may be prompted for future purchases based on prior patterns.

AI is part of medicine today. In the 1970s and 80s, physicians at the University of Pittsburgh attempted to design a computer program that would establish a differential diagnosis for patients based upon their presentation and some laboratory input. Their aim was to ensure that all possible causes, common and rare, of a patient's illness were considered, and to provide direction for physicians caring for particularly difficult cases. Their product, INTERNIST-1 took decades of literature review and establishing ranking algorithms for each symptom/sign/laboratory finding as it related to each disease (an effort requiring approximately 15 person-years). While INTERNIST-1 proved to be accurate when a patient had a single disease, it did not work well on complex cases and involved the manual entry of a large amount of data for each patient, making it far too cumbersome to be useful.

AI has many applications for medicine and for emergency medicine. Many of these are demonstration projects but show promise for future widespread applications. AI can do a lot to improve physician performance and efficiency but will never replace the physician.

AI can handle well-defined repetitive tasks, especially when those tasks have defined inputs and binary (yes/no) outputs. There are now AI products that analyze photos of skin lesions and determine malignancy with greater specificity and sensitivity than dermatologists. For the ED there are applications for AI interpretation of rashes.

AI is excellent at predictive modeling. Numerous systems exist to predict readmissions, and the quantity and physical location of EMS calls. They can predict the need for admission for infants with bronchiolitis, adults with cervical spine injury, renal colic, and patient mortality in sepsis. It can be trained to interpret x-rays and images, often with greater accuracy than a radiologist.

AI has proven superior to humans in patient monitoring. Computers do not get "alarm fatigue" or take breaks. They may also assist with decision making, by making decision trees and care algorithms available at the appropriate "just in time" moment.

AI can also help with staffing and flow in the ED. Using years of data, it can predict patient influx and staffing shortages. It can provide more accuracy to triage decisions and deployment of staff/beds in the ED and hospital. Future applications of AI may reduce medication errors and reduce the incidence of falls and other patient safety concerns. AI shows promise in diagnosing and predicting mental illness, providing counseling via a robot and connecting individuals to services and resources.

Physicians will never be replaced by AI; it is there to augment our practice and patient care. AI cannot provide empathy or compassion. It cannot learn the Art of Medicine. It cannot be a doctor. It also takes a learned doctor to make sense of the data derived by AI. AI also relies on aggregated data, which may or may not apply to a specific patient. However, clearly AI will change the role of a physician.

ACEP currently does not have any policy statements or information papers addressing the role or future development and integration of AI in the emergency setting. The AMA has both policy and information papers on AI.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in the different environments across the acute care continuum.

Fiscal Impact

Cost for a summit approximately $25,000 plus staff labor.
Cost for a task force approximately $15,000 plus staff labor (depending on the number and site of meetings).
Cost for an educational offering approximately $5,000 (estimated speaker fee and travel costs).

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Sandy Schneider, MD, FACEP,
Associate Executive Director, Clinical Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 43(19)

SUBMITTED BY: Illinois College of Emergency Physicians
Maryland Chapter
Missouri College of Emergency Physicians
Pennsylvania College of Emergency Physicians
South Carolina College of Emergency Physicians
West Virginia Chapter

SUBJECT: Droperidol is Safe to Use in the ED

PURPOSE: Develop a policy statement and a clinical policy to guide members on the safe and effective use of droperidol for various indications in the ED based on existing medical evidence.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency physicians have encountered barriers in incorporating droperidol into their practice, including severe restrictions and overt prohibition; and

WHEREAS, Patients who present with agitated delirium to the emergency department (ED) can be undergoing life-threatening medical or psychiatric concerns; and

WHEREAS, Treatment of these patients can be challenging for the emergency physician; and

WHEREAS, There is growing evidence that the use of droperidol for the treatment of agitated delirium is safe and efficacious; and

WHEREAS, There is a wealth of literature on the safe use of droperidol for other indications in the ED including, but not limited to nausea, vomiting, and migraine headache; and

WHEREAS, Other emergency medicine organizations have published clinical policies on the safe use of droperidol in the ED; therefore be it

RESOLVED, That ACEP create a policy statement regarding the safety and effectiveness of the use of droperidol for various indications in the ED; and be it further

RESOLVED, That ACEP develop a clinical policy to guide its members on the safe and effective use of droperidol for various indications in the ED based on existing medical evidence.

References

1. https://www.acepnow.com/article/a-5-step-approach-to-the-agitatedpatient/?singlepage=1
2. Calver L, Page CB, Downes MA, et al. The Safety and Effectiveness of Droperidol for Sedation of Acute Behavioral Disturbance in the Emergency Department. Annals of EM. 2015; 66: 3. 230–238
3. AAEM Clinical Policy: Safety of Droperidol Use in the Emergency Department. Accessed 6/11/19. https://www.aaem.org/UserFiles/file/Safety-of-Droperidol-Use-in-the-ED.pdf

Background

This resolution calls for ACEP to develop a policy statement and a clinical policy to guide members on the safe and effective use of droperidol for various indications in the ED based on exiting medical evidence.

On December 5, 2001, the FDA issued a “black box” warning on droperidol. Droperidol had previously been used in

EDs for a variety of reasons, including for patients experiencing acute psychotic illnesses. The warning was issued because of a risk of torsades de pointes induced by QT prolongation.[2] Many experts, both in the ED and in other specialties, believe that the black box warning was issued based on poor evidence and effectively removed a safe and effective drug from use.

Much of the recent literature points to droperidol being safe and effective, with instances of arrythmia and/or other adverse effects being low. The Cochrane Database of Systematic Reviews updated a 2004[1] systematic review in 2016. Looking only at randomized controlled trials, the authors found that droperidol demonstrated a reduced risk of needing additional medications and there was no evidence that droperidol caused cardiovascular arrhythmia[3.] The authors concluded that the evidence against use of droperidol in the ED was based on personal experience rather than the evidence in the current literature[3.]

A 2014 study in *Prehospital Emergency Care* looked at the data for 532 agitated patients, 289 receiving haloperidol and 132 receiving droperidol. The authors found there was no significant difference found in adverse events between haloperidol and droperidol.[5]

As recently as 2018, a study in *Tzu-Chi Medical Journal* found that droperidol is effective and safe to use to treat patients with nausea/vomiting, acute psychosis, and migraine in the ED.[4]

ACEP has a clinical policy on Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department and an information paper Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature. However, because of the black box warning, neither goes into detail regarding droperidol.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None.

Prior Board Action

January 2017, approved the revised clinical policy "Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department;" originally approved September 2005.

October 2014, reviewed the information paper "Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature."

Background Information Prepared by: Mandie Mims, MLS
Clinical Practice Manager

Margaret Montgomery, RN, MSN
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 44(19)

SUBMITTED BY: Indiana Chapter
New Jersey Chapter
Missouri College of Emergency Physicians
Ohio Chapter

SUBJECT: Independent ED Staffing by Non-Physician Providers

PURPOSE: 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.

FISCAL IMPACT: Budgeted staff resources and up to $20,000 (unbudgeted) for dissemination of materials to communities and governmental agencies.

WHEREAS, There is a continued nationwide trend to expanding the scope of non-physician providers[i], specifically nurse practitioners (NP) and physician assistants (PA), to include independent practice of medicine; and

WHEREAS, There exists significant education and training differences between board certified emergency physicians and non-physician provider training;[ii,iii] and

WHEREAS, Some emergency departments have implemented staffing models with independent practicing, non-physician providers without the oversight of a board certified emergency physician or any emergency physician; and

WHEREAS, This creates a patient safety issue due to the lack of training, experience and oversight of these practitioners;[iv] and

WHEREAS, Emergency medicine deals with time critical disease processes that requires rapid intervention and procedures to prevent loss of life, which cannot be provided via off site supervision; and

WHEREAS, ACEP values the contributions by NP and PA practitioners to the care of emergency patients in a team-based environment, with direct supervision by physicians; therefore be it

RESOLVED, That ACEP review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" and be it further

RESOLVED, That ACEP develop tools and strategies to identify and educate communities, local, state, and the federal government regarding the importance of emergency physician staffing of emergency department; and be it further

RESOLVED, That ACEP oppose the independent practice of emergency medicine by non-physician providers; and be it further

RESOLVED, That ACEP develop and enact strategies, including legislative solutions, to ensure that the practice of emergency medicine includes mandatory on-site supervision by an emergency physician.

Background

This resolution calls on ACEP to review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." In addition, it asks for ACEP to develop tools and strategies to identify and then educate communities and government at all levels on the importance of emergency physician staffing of emergency departments. It asks that ACEP oppose the independent practice of emergency medicine by non-physician providers and develop strategies including legislative solutions to require on-site supervision of non-physicians by an emergency physician.

ACEP is already reviewing the 2013 policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." The revisions to the policy statement will be presented to the ACEP Board of Directors for approval at their meeting on October 24, 2019. ACEP already opposes the independent practice of emergency medicine by NPs and PAs (policy since 2001). ACEP already has a task force (details below) that is making recommendations for scope of practice and supervision requirements for NPs and PAs.

ACEP has assisted many state chapters as they confronted legislation that legalized the independent practice by NPs. While independent practice for NPs has passed in several states, efforts by National ACEP and the state chapters helped defeat legislation in many states.

Without question, NPs and PAs are valuable members of the emergency care team and are used effectively in many physician-led care models. However, ACEP has always believed that emergency care should be led by emergency physicians. ACEP has never supported the independent practice by NPs or PAs. In 2018, ACEP created a small workgroup composed of several members of the ACEP Board of Directors to discuss issues around the emergency medicine workforce. From the discussions of that group, two task forces were created: the NP/PA Utilization Task Force (NPUTF) and the EM Physician Workforce Task Force (EMPWTF).

The EMPWTF is examining the physician workforce supply and demand for the future. The EMPWTF is supporting a comprehensive study by Ed Salsberg, a noted national authority on physician workforce. ACEP invited all major emergency medicine organizations to participate and support this study. ABEM, AOBEM, ACOEP, EMRA, and SAEM chose to participate. AACEM, AAEM, AAEM/RSA, SAEM/RAMS declined. Although the focus of the EMPWTF is physician workforce, AAENP and SEMPA are participating.

The NPUTF is also multiorganizational, with all major emergency medicine organizations participating including AACEM, AAEM, AAEM/RSA, AAENP, ACEP, ACOEP, CORD, EMRA, ENA, SAEM, SAEM/RAMS, and SEMPA. The primary purpose of the NPUTF is to define the scope of practice and need for supervision for NPs and PAs who practice in the emergency setting. The NPUTF objectives are:

- *Objective 1: Overview of Current NP/PA Training* – The group is conducting an extensive review of current training requirements and options. This includes new options for on-line training (primarily for NPs) with special emphasis on the amount of general and emergency care specific exposure.
- *Objective 2: State of EM/APP Supervision* – The group is initially looking at current levels of supervision, including what is legally permitted and what is done in practice. They have prepared a survey and are attempting to obtain policies from various institutions.
- *Objective 3: Reimbursement Issues Surrounding the Use of NPs and PAs* – They plan a brief paper on the incentives, costs, and productivity data of PAs and NPs vs MDs. They are examining the cost of onboarding and retention patterns of the various providers. They will also cover requirements for chart co-signing and the medical-legal exposure associated with that practice.
- *Objective 4: EM/NP/PA Workforce Issues – The group is examining the distribution of the APP* workforce.
- *Objective 5: ACEP Policies* – The group is reviewing all ACEP's policies and positions regarding the use of NPs and PAs and determining if these should be recommended for revision. They are also reviewing policies of other organizations. They have noted that all policies are silent on the use of telehealth.
- *Objective 6: Current/Existing Policies/Procedures/Guidelines from Outside Groups* – USACS has provided their extensive guidelines; however, the group reports resistance by other large employers to release their policies. They are reaching out to the medical directors through ACEP's sections.

For the past year, the NPUTF has been preparing their report and recommendations. The report and recommendations will be provided to the ACEP Board of Directors for approval at the October 24, 2019 Board meeting. Once approved by the ACEP Board, it will be distributed to the other participating organizations for approval and endorsement. The report will then be submitted to *Annals of Emergency Medicine* for publication consideration.

ACEP's current policy statement, first created in 2001, "Providers of Unsupervised Emergency Department Care," clearly states that ACEP believes that the independent practice of emergency medicine is best performed by specialists who have completed American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certification, or have successfully "completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited emergency medicine residency, and is in the process of completing ABEM or AOBEM examinations." Additionally, the policy includes the statement that "ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care" and ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists." The NPUTF is reviewing the policy statement and will provide their recommendations to the Board in October.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." In that policy statement, ACEP asserted that:

- PAs and APRNs do not replace the medical expertise and patient care provided by emergency physicians.
- PAs and APRNs working in EDs should have or acquire specific experience or specialty training in emergency care and should receive continuing education in providing emergency care.
- Credentialing procedures for PAs and APRNs in the ED must be specifically stated and approved by the facility governing body with input from the medical staff and must meet the requirements of the federal or state jurisdictions in which they practice.
- PAs and APRNs must be appropriately certified by their respective certifying bodies.
- Due to variations in state laws and regulations, it is imperative that emergency physicians, PAs and APRNs are aware of their scope of practice as well as physician supervision responsibilities and requirements.
- The PAs and APRNs scope of practice must be clearly delineated and must be consistent with federal and state laws and regulations.
- PAs and APRNs working in EDs should participate in a supervised orientation program, including demonstrating knowledge of specific ED policies and procedures and the requisite knowledge base to function safely and appropriately in the ED.
- The medical director of the ED or a designee has the responsibility of providing the overall direction of activities of the PA or APRN in the ED. In EMS, this is the role of the physician EMS medical director.
- PAs may function in various capacities and with varying degrees of supervision. However, as dependent practitioners, they must always function with a supervisory agreement with a physician.
- APRNs supervisory requirements (collaborative agreements) vary and independent practice is authorized in some states.
- ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care.
- Each supervising physician should retain the right to determine his/her degree of involvement in the care of patients provided by PAs and APRNs in accordance with the defined PA or APRN scope of practice, state laws and regulations, and supervisory or collaborative agreement. When such is required, the supervising physician for each PA or APRN encounter should be specifically identified.
- The ED medical director should define the number of PAs and/or APRNs whose clinical work can be simultaneously supervised by one emergency physician, guided by ED clinical needs and state laws.
- ED medical directors are encouraged to develop guidelines for PAs and APRNs outlining the types of conditions PAs and APRNs may or may not routinely evaluate and treat:
    - With indirect supervision: Verbal supervising physician consultation and/or chart review/signature.
    - With direct supervision: In conjunction with a supervising physician physically attending to the patient, providing face-to-face time.
- PAs and APRNs must be aware of and participate in performance improvement activities of the ED or EMS agency.

- The ED medical director should be responsible for ongoing professional practice evaluation of each PA and APRN utilizing focused professional practice evaluation, as appropriate.
- PAs and APRNs may fulfill clinical and administrative roles in which they will supplement and assist emergency physicians.
- Multiple staffing models utilizing PAs and APRNs exist. It is the responsibility of the ED medical director to identify the most appropriate staffing model to achieve operational efficiency, while maintaining clinical quality.

Over the past decade, there has been tremendous growth in the number of NPs and PAs, both in the ED and in medicine in general. Often used and referred to as a single group (Advanced Practice Providers or APPs), their background and training are very different, and their skill set, at least initially in the ED, may vary. NPs are required to be RNs first and then complete a master's degree in nursing (depending on the program, this may take 1.5-4 years). In general, 500 hours of faculty-supervised clinical hours are required. Some programs permit some of the curriculum to be taken on line. There is no specific emergency medicine NP; most are family nurse practitioners, although some may have a focus on acute care. Physician assistants generally are required to have two years of college coursework, with emphasis in the sciences, although most have a bachelor's degree. Most programs are three years and include 2,000 hours of clinical rotation.

Both NPs and PAs have the option of certification in emergency medicine. Specific post-graduate courses exist for both groups to get additional training in emergency medicine. However, all NPs and PAs can work in any area of healthcare by their license, and can, and often do, move from specialty area to specialty area with no requirement by the state for additional training. Certification in emergency medicine is a valuable credential but should never be used to support independent practice. The Society for Emergency Medicine Physician Assistants (SEMPA) was created in 1990. It is currently managed as an independent organization by ACEP. The American Academy of Emergency Nurse Practitioners (AAENP) is a newer and smaller organization. Both provide educational opportunities for their members and have a certification program to demonstrate competence in emergency medicine. To sit for the exam, AAENP requires an initial family NP program, with an additional 2,000 hours of emergency practice in the past five years, with at least 100 hours of continuing education in emergency medicine, with 30 of those hours specifically on procedural skills. Alternatives to these requirements include completion of a graduate or post-graduate training program in emergency medicine or an emergency medicine fellowship. SEMPA has a similar program.

NPs are considered licensed independent practitioners by the Health Resources and Services Administration (HRSA); however, state law determines whether they can practice independently. Many states recognize them as independent licensed practitioners (AK, AZ, CO, CT, HI, ID, IA, ME, MD, MT, NE, NV, NH, NM, ND, OR, RI, SD, VT, WA, WY, and Washington, DC). In all other states, NPs must work under the supervision of or in collaboration with a physician. PAs are required to have a formal connection to physicians; however, there is movement within the American Academy of Physician Assistants to advocate for more autonomy. SEMPA does not support the independent practice of PAs.

There are about 250,000 NPs and 140,000 PAs in the US. There are no good data on the number of NPs and PAs who practice in the ED. Many may practice in the ED for part of their work and then in an office or clinic setting. However, from the Clinical Emergency Data Registry and E-QUAL data, we know that about 10% of providers' participants are either PAs or NPs. That number appears to be similar in urban and rural areas. In general, most APPs in EDs work adjacent to or directly supervised by physicians but there is increasing use of APPs independently staffing EDs, with or without telemedicine oversight.

It should be noted that several other "non-physicians"' practice in the ED. This diverse group includes dentists, oral surgeons, psychologists, podiatrists, psychiatric social workers, and many more. Many of these provide consultation and direct patient care in the ED. Sexual Assault Nurse Examiners are trained RNs who provide services in some settings as well as collect forensic specimens. Increasingly, consultations in the ED are provided by NPs and PAs who work for other specialties. Some may direct patient care in the ED. Practice by these non-physicians is governed by local hospital policy. ACEP has not created a specific policy statement for these individuals when they provide services in the ED.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted staff resources and $20,000 to convene a task force (already appointed and in progress). Up to $20,000 (unbudgeted) for dissemination of materials to communities and governmental agencies.

Prior Council Action

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care and survey states and hospitals on where independent practice by NPs is permitted.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. Directed ACEP to work with NP and PA organizations to establish a curriculum and clinically-based ED educational training program and encourage certifying bodies to develop certifying examinations for competencies in emergency care.

Prior Board Action

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

September 2018, accepted the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations to proceed with the NP/PA Utilization Task Force and the Emergency Medicine Workforce Task Force.

June 2013, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by 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 2011, adopted a motion to take no further action on referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development. In January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. A task force was appointed to review the available information and provide a recommendation to the Board regarding ACEP's potential involvement in the development of specialized training curricula for PAs and NPs that work in the ED.

May 2001, accepted the report of the Staffing Task Force.

The MLP/EMS Task Force recommendations were presented to the Board September 1999. The Board approved dissemination of the results of the surveys.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Clinical Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

---

[i] Scope of Practice Policy: Nurse Practitioners Overview. http://www.scopeofpracticepolicy.org/practitioners/nurse-practitioners/
[ii] American Association of Family Physicians: Scope of Practice Kit: What is a Physician? https://www.aafp.org/dam/AAFP/documents/advocacy/workforce/scope/Restricted/ES-statescopeofpracticekit-051513.pdf
[iii] Primary Care Coalition: Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners. https://www.tafp.org/Media/Default/Downloads/advocacy/scope-education.pdf
[iv] McCleery E, Christensen V, Peterson K, et al. Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses. 2014 Sep. In: VA Evidence Synthesis Program Evidence Briefs [Internet]. Washington (DC): Department of Veterans Affairs (US); 2011-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK384613/

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 45(19)

SUBMITTED BY: International Emergency Medicine Section
Social Emergency Medicine Section

SUBJECT: Medical Neutrality

PURPOSE: Make a public statement in support of medical neutrality.

FISCAL IMPACT: Budgeted committee, section, and staff resouces.

WHEREAS, Medical neutrality describes the ethical obligation of medical professionals to treat the sick and injured without discriminating on the basis of religion, race, or political affiliation; and

WHERAS, Medical neutrality is a universal principle which applies in both times of armed conflict, as enshrined in international humanitarian law, and in times of peace, as enshrined in the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social, and Cultural Rights (ICESCR), and the Convention Against Torture (CAT); and

WHEREAS, Emergency physicians and our prehospital colleagues, being uniquely situated to provide life-saving care in times of conflict, have a special responsibility to defend medical neutrality; therefore be it

RESOLVED, That ACEP make a public statement in support of medical neutrality.

Background

This resolution calls on ACEP to make a public statement in support of medical neutrality. Medical neutrality primarily refers to a principle of noninterference with medical services in times of armed conflict and civil unrest. Medical neutrality is often interpreted as practicing medicine impartially and with immunity from attack, for both providers and patients, during times of conflict. Medical neutrality has drawn its tenets from international law, medical professional codes of ethics, as well as humanitarian law. The 1864 Geneva Convention established principles of neutrality for medical personnel, establishments and units providing relief to the wounded. It stated: "Inhabitants of the country who bring help to the wounded shall be respected and shall remain free," and that "Wounded or sick combatants, to whatever nation they may belong, shall be collected and cared for." The later 1949 Geneva Convention, which replaced the Convention of 1864, also established rules for the protection of people not participating in fighting as well as those unable to fight; specifically calling for provisions that would give protection to the wounded and sick, as well as to medical and religious personnel. Additional protocols were added to address non-international armed conflicts as well as wars of national liberation. Currently, there are 194 nations that have ratified the Geneva Conventions. The International Covenant on Economic, Social, and Cultural Rights (ICCPR) and the International Covenant on Civil and Political Rights were both signed and ratified during the United Nations (UN) 1966 General Assembly. The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment was signed and ratified by the UN in 1984. In 2016, the UN adopted Resolution 2286, which condemned attacks and demanded compliance with the Geneva Convention.

In 2012, the World Health Assembly (WHO) adopted Resolution 65.20 that called on WHO to provide global leadership in collecting and reporting information on healthcare attacks. The WHO created the Attacks on Health Care Initiative to collect evidence on attacks and promote best practices for preventing them. As part of the initiative, they

monitor secondary internet sources for attacks and work with partners on the ground in conflict and emergency-affected countries to gather relevant information.

The United States Medical Neutrality Protection Act of 2013, referred to the House Foreign Affairs and Judiciary Committees, required the Secretary of State to annually compile a list of foreign governments that the Secretary determined to have engaged in violations of medical neutrality. Some examples of violations included: militarized attacks on health care facilities, health care service providers or individuals receiving medical treatment; destruction of medical supplies; and deliberate blocking of access to health care professionals. The bill prohibited assistance to governments that violated medical neutrality and also directed diplomatic and consular missions to investigate all reports of violations. After its introduction to the House on May 16, 2013, it was referred to the Subcommittee on Immigration and Border Security.

The World Medical Association (WMA) policy on international ethics states that a "physician shall give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care," and "always bear in mind the obligation to respect human life." The AMA policy statement, *Medical Neutrality H-520.998,* supports global medical neutrality for all health care workers, the sick and wounded. The ACEP *Code of Ethics for Emergency Physicians* calls on emergency physicians to "respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care." ACEP adopted the revised policy statement "Non-Discrimination and Harassment" in June 2018. In February of 2019, ACEP signed on to the Colombo Declaration, which condemned attacks on health care facilities, workers, and vehicles in conflict zones.

Documented violations of medical neutrality have occurred, and continue to occur, throughout the world. One study found that while the likelihood of violence against health care workers increased as conflict increased, there was no correlation between attacks on civilians and health/aid workers thus suggesting that health care workers are overtly targeted. According to WHO data, there were a total of 388 attacks on health care workers, resulting in 322 deaths and 425 injuries, in 19 countries across the globe in 2018 alone. The International Committee of the Red Cross (ICRC) conducted a two-and-a-half-year analysis looking at reports of violations in countries where they had operations and found 655 violent incidents in 16 countries. While the short-term consequences of violations of medical neutrality have been cited (i.e. lack of access to essential health services, reduced capacity to address infectious disease, loss of facilities, large-scale exodus of health care workers from a conflict area), the WHO states that the full extent of the impacts of attacks on health care is not yet known. Attacks on health care are increasingly used strategically during times of conflict but are rarely prosecuted nationally. Additionally, some governments might also criminalize the provision of medical care to those injured and seen as the opposition.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. Directed the College to oppose all forms of discrimination against patients and that ACEP oppose employment discrimination in emergency medicine.

Prior Board Action

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

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 with the current title June 1997; originally approved January 1991 titled "Ethics Manual."

October 2015, approved the revised policy statement "Emergency Physicians Rights and Responsibilities;" revised and approved April 2008 and July 2001; originally approved September 2000.

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

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

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 46(19)

SUBMITTED BY: Kerry Forrestal, MD, MBA, FACEP
Erik Schobitz, MD, FACEP
Maryland Chapter
New Jersey Chapter

SUBJECT: Mental Health Care for Vulnerable Populations

PURPOSE: Support increasing the capacity of mental health facilities to provide care for children with special needs and support policies that allow pediatric patients to be admitted to a conventional mental health facility to receive treatment while also remaining in the queue for a bed at a neuropsychiatric facility.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Children with special needs, such as those who have lower functioning autism or other neurological impairments plus mental health issues will, on occasion, require hospitalization for medication stabilization; and

WHEREAS, There are extremely limited neuropsychiatric beds available to place these children: in Maryland, as an example, there is one hospital with four beds that will care for adults and children with combined neurological and psychiatric issues, this in a state with a population of over 6 million residents; and

WHEREAS, These vulnerable children are forced to wait in Emergency Departments after being medically cleared for admission for placement in one of these scarce beds; and

WHEREAS, This boarding situation puts patients, families, and staff at risk of assault; therefore be it

RESOLVED, That ACEP support increasing the capacity of current conventional mental health facilities to provide care for children with special needs; and be it further

RESOLVED, That ACEP support policies that allow a pediatric patient to be admitted to a conventional mental health facility and receive treatment while remaining "on the list" for a bed at a neuropsychiatric facility.

References

1. According to Becker's Hospital Review 8/2016 – Total US psychiatric inpatient beds declined 13% from 2010-2016.
2. Becker's Hospital Review also notes that according to some estimates, the US needs 123,300 more inpatient psychiatric beds to alleviate the current shortage.
3. The CDC in 2018 noted a 15% increase in prevalence of autism nationally over the previous biannual review. Autism Speaks notes the prevalence is now 1/59 children by age 8 will be diagnosed as autistic.

Background

This resolution calls for ACEP to support increasing the capacity of mental health facilities to provide care for children with special needs and to support policies that allow pediatric patients to be admitted to a conventional mental health facility to receive treatment while also remaining in the queue for a bed at a neuropsychiatric facility.

The nation's dwindling mental health resources present significant challenges for emergency department (ED) physicians. Over the past several decades, there has been a movement towards treating patients with mental illness or

intellectual and developmental disabilities (I/DD) in the community instead of in inpatient facilities. Several factors, such as advacements in therapeutic and pharmacologic treatments (i.e., development of first-generation antipsychotics in the late 50s and early 60s), political and federal priorities (i.e., NIMH's push for community health centers under Dr. Robert Felix), as well as societal pressures and outcry over the conditions of state run facilities in the 40s and 50s precipitated the de-institutionalism of mental health care that occurred during most of the 60s. The National Association of State Mental Health Program Directors report notes a decline of 77.4% beds for inpatient psychiatric patients since 1970. The Agency for Healthcare Research and Quality states that "From 1970 to 2000, public psychiatric hospital beds dropped from 207 to 21 beds per 100,000 persons." Unfortunately, to this day, the availability of psychiatric beds is limited and community care remains fragmented and difficult to access.

Patients with mental health complaints and/or intellectual and developmental disabilities (I/DD) are increasingly presenting to EDs for care. The prevalence of U.S. children with diagnosis of a developmental disability is 6.99%, according to the CDC. Approximately 7% of pediatric emergency department visits are for mental health or behavioral emergencies. However, little is known about patients with I/DD presenting to the ED because the patient population with intellectual or developmental disabilities is rarely studied in emergency departments. Additionally, there are state-to-state variations in statutes directing the treatment of individuals with I/DD.

Psychiatric bed availability varies widely. Beds exist in a variety of settings, from specialized private or public hospitals, units in general hospitals, psychiatric-specific inpatient units, VA centers and more. Each of these facilities might have different admission and insurance requirements or other restrictions, such as acuity, age, uncertainty with "medical clearance," etc. Insurance authorization allowing psychiatric patients to be admitted to the hospital from the ED can often take extensive amounts of time, contributing to boarding and further burdening the ED. Additionally, many psychiatric facilities do not fall under EMTALA and can, therefore, legally refuse admission. One study found that out of seven psychiatric hospitals available for pediatric patients in Houston, Texas, none would accept patients with severe intellectual disabilities or autism. As noted previously, with the decrease in available beds and increasing demand, psychiatric facilities are frequently at capacity and often have no place for additional patients. Some facilities might exclude patients because of inadequate staffing, or lack of advanced equipment/training needed for care (i.e., tracheostomy care, etc.). Many psychiatric facilities may also lack the ability to provide basic medical care for patients with insulin-dependent diabetes, dialysis-dependent renal failure, unresolved cellulitis, or pregnancy. Without the ability to care for such patients, facilities may refuse transfer even if they have capacity. While some states have instituted real-time, psychiatric bed registries, this is not a common practice across the U.S.

Compounded with a shortage of available beds is a severe shortage of mental health care providers in the workforce. In 2016, the US Department of Health and Human Service (HHS), the Health Resources and Services Administration (HRSA), the Bureau of Health Workforce, and the National Center for Health Workforce Analysis produced a report addressing the supply and demand of behavioral health practitioners. It projected a shortage of behavioral health workers by 2025 along with an increasing national demand from patients. Another study looking at national trends in ED visits for youth with mental health concerns found that only 16% of patients in the ED were seen by a mental health provider during their visit. According to the American Academy of Child and Adolescent Psychiatry (AACAP), as of April 2019 there are 8,300 practicing child and adolescent psychiatrists in the United States with an estimated 15 million children and youth in need of services. A 2015 workforce study done by the American Academy of Pediatrics (AAP) and the Child Neurology Society (CNS) found that of the child neurologists surveyed, the majority of division directors believed that their current staffing levels were inadequate and they perceived an increasing volume and complexity of referrals. A growing subspecialty of pediatrics, developmental-behavioral pediatrics (DBP), had less than 800 AAP board-certified DBPs by the end of 2016.

Emergency departments can be overwhelming for children with autism. Additionally, children with autism might have unusual reaction to medication and elevated behavioral responses to routine procedures. ACEP's policy statement "Pediatric Mental Health Emergencies in the Emergency Department" states that, "The American College of Emergency Physicians supports the following actions: advocacy for increased community mental health resources and linking them to the medical home, EDs, and inpatient psychiatric hospitals, as well as improved pediatric mental health tools for the ED, increased mental health insurance coverage, adequate reimbursement at all levels; acknowledgment of the importance of the child's medical home and their role in managing crisis events, development of community paramedicine programs for accurate assessment and triage of behavioral health crisis, and promotion of education and research for mental health emergencies." It also says that, "EDs should safely, humanely, and in a

culturally sensitive manner manage patients with exacerbations of known diagnosed mental illnesses as well as those with developmental delay, autistic spectrum disorders, ADHD, or those in behavioral crisis," and that, "Pediatric mental health emergencies are best managed by a skilled, multidisciplinary team approach, including specialized screening tools, pediatric-trained mental health consultants, the availability of pediatric psychiatric facilities when hospitalization is necessary, and an outpatient infrastructure that supports pediatric mental health care, including communication back to the primary care physician and timely and appropriate ED referrals to mental health professionals."

ACEP's policy statement "Boarding of Pediatric Patients in the Emergency Department" states, "Recognizing that a major contributor to boarding admitted pediatric patients in the ED is the delay in transfer of care and placement to inpatient units after the decision to admit, hospital and inpatient processes must be improved to speed transfer of admitted patients out of the ED." Additional policy statements, such as "The Role of Emergency Physicians in the Care of Children" call for "...optimal access to facility and specialists," while the policy statement "Pediatric Readiness in the Emergency Department" (joint policy statement with the American Academy of Pediatrics and the Emergency Nurses Association) calls for written policies, procedures and protocols in the ED for: social and behavioral health issues; children with special health care needs including developmental disabilities; written pediatric interfacility transfer procedures and/or agreements that include psychiatric emergencies. ACEP conducted an all-member poll in April 2014 on ED trends and the poll included questions on psychiatric patients. Another membership poll on psychiatric boarding was disseminated in 2016.

ACEP frequently collaborates with the American Academy of Pediatrics (AAP) on joint policy statements and development of resources and tools for emergency physicians. One such tool is the Emergency Information Form (EIF) for Children with Special Health Needs. This form is intended to summarize a child's complicated medical history when they present with an acute health need without their pediatrician or parent. Along with the EIF, ACEP and AAP developed a fact sheet and policy statements to better help physicians treat and manage children with special needs, such as those with ASD. ACEP is also developing a bedside, point-of-care tool that will outline evidence-based clinical content for the care of patients with autism spectrum disorder. The tool will be submitted to the ACEP Board of Directors in October 2019 for review.

Recent efforts to address mental health have also occurred. During the 2019 Leadership & Advocacy Conference, ACEP advocated on the Hill for mental health policy changes, calling for innovations within mental health care itself and improved access to care. ACEP members urged lawmakers to co-sponsor the "Improving Mental Health Access from the Emergency Department Act." In 2017, ACEP called on lawmakers to express support for H.R. 3931, the "Excellence in Mental Health and Addiction Treatment Expansion Act," which would provide outpatient services and make inpatient psychiatric beds more readily available. In 2016, ACEP advocated for legislation that provided additional resources for patients with serious mental illness. H.R. 2646, the "Helping Families in Mental Health Crisis Act of 2015," called for expansion of the mental health workforce and for mental health parity in health plans. Later, the 21st Century Cures Act, passed into law in December 2016, included a number of provisions around mental health, including Section X "Strengthening Mental and Substance Use Disorder Care for Children and Adolescents" as well as language from the H.R. 2646 bill that ACEP had promoted.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Goal 2 Enhance Membership Value and Member Engagement
Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 40(18) Care of Individuals with Autism Spectrum Disorder in the ED adopted. Directed ACEP to develop educational materials for emergency physicians to improve the treatment and management of patients with Autism Spectrum Disorder in the ED.

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted. The resolution directed ACEP to develop a psychiatric boarding toolkit.

Amended Resolution 14(16) Development and Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs adopted. Called for the development and application of throughput quality data measures and dashboard reporting for behavioral health patients boarded in EDs.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted. Directed ACEP to work with the US Department of Health and Human Services, US Public Health Service, The Joint Commission and other appropriate stakeholders to determine action steps to reduce ED boarding and crowding.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to seek out and work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Additionally directed ACEP to promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted. Directed ACEP to convene a work group of appropriate stakeholders to explore and identify additional resources, technologies, and best practices that promote quality patient care for timely evaluation and disposition of behavioral health patients and provide a report to the 2013 Council.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted. Directed ACEP to meet with the American Psychiatric Association and other stakeholders to create a standard for the medical stability of psychiatric patients that includes the conclusions from the 2006 ACEP "Clinical Policy: Clinical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department."

Substitute Resolution 28(06) Psychiatric Bed Availability adopted. Directed that ACEP work with appropriate organizations to study the impact of psychiatric bed availability on emergency departments and EMS, seek solutions to problems identified, and bring the issue to the AMA House of Delegates at the 2007 annual meeting.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted. This resolution called on ACEP to develop talking points to respond to issues related to psychiatric and substance use patients in the ED.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted. This resolution called on ACEP to support legislation around psychiatric involuntary transfers.

Prior Board Action

Resolution 40(18) Care of Individuals with Autism Spectrum Disorder in the ED adopted.

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted.

September 2018, approved the revised policy statement, "Pediatric Mental Health Emergencies in the Emergency

Department;" reaffirmed April 2012; originally approved April 2006 titled, "Pediatric Mental Health Emergencies in the Emergency Medical Services System."

September 2018, approved the revised policy statement, "Boarding of Pediatric Patients in the Emergency Department;" originally approved January 2012.

June 2018, approved the revised policy statement "Pediatric Readiness in the Emergency Department" with the current title; revised and approved April 2009; originally approved December 2000 titled "Guidelines for Care of Children in the Emergency Department."

June 2017, approved the Quality & Patient Safety Committee's recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in Emergency Departments. The Clinical Emergency Department Registry (CEDR) currently has dashboard functionality and the ED throughput measures are included in the registry and reportable to CMS for the Quality Payment Program (QPP). CMS currently collects data on CMS OP-18c measure for arrival to ED departure time for psychiatric and mental health patients and CMS ED-2c measure for admit decision to ED departure time for psychiatric and mental health patients.

January 2017, approved the "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department." Replaced the 2006 clinical policy with the same title. The 2006 clinical policy replaced the 1999 "Clinical Policy for the Initial Approach to Patients with Altered Mental Status."

June 2016, reviewed the updated the information paper "Emergency Department Crowding High-Impact Solutions."

Amended Resolution 14(16) Development and Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs adopted.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted October 2015.

October 2015, reviewed the information paper "Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department."

October 2014, reviewed the information paper, "Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature."

June 2013, reaffirmed the policy statement, "The Role of Emergency Physicians in the Care of Children;" reaffirmed October 2007; revised and approved June 2001 and January 1996; originally approved September 1989.

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted.

January 2008, approved the survey on Psychiatric Bed Availability for distribution to the Emergency Department Directors Academy e-list.

Substitute Resolution 28(06) Psychiatric Bed Availability adopted.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted.

June 1984, approved the policy statement "The Emergency Physician's Role in Behavioral Emergencies."

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING.RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 47(19)

SUBMITTED BY: Indiana Chapter

SUBJECT: Prevention of Self -Harm & Accidental Injury by Internet Challenges and Social Media Posts

PURPOSE: Work with the CDC to study, track, and trend statistical data about accidental self-harm promoted by social media posts, develop guidelines for recognition of self-harm content, develop programs to advance awareness among adolescents, and promote legislation that protects patients from self-harm and prohibits posting of self-harm challenge content and videos on social media sites and the internet.

FISCAL IMPACT: Undetermined amount of staff resources.

WHEREAS, The American College of Emergency Physicians represents the interests of emergency physicians who provide healthcare access for all persons residing in America; and

WHEREAS, The American College of Emergency Physicians advocates for measures to protect the patients we serve and promote wellness and harm prevention; and

WHEREAS, The American College of Emergency Physicians understands the powerful influence and easy accessibility of information posted on the internet and social media sites which promote self-harm and pose challenges; and

WHEREAS, The American College of Emergency Physicians realizes the dangerous and potentially fatal effects of mimicking these challenges resulting in self-harm and death, especially for our most vulnerable adolescent population; and

WHEREAS, Social media sites have a moral obligation to monitor posts which could be harmful to their viewers; therefore be it

RESOLVED, That ACEP study, track, and trend statistical data regarding accidental self-harm promoted by social media posts in collaboration with the Centers for Disease Control; and be it further

RESOLVED, That ACEP develop guidelines for the recognition of self-harm content and develop programs to advance awareness amongst adolescents; and be it further

RESOLVED, That ACEP promote legislation that protects patients from self-harm materials and prohibits the posting of self-harm challenge content and videos on social media sites and the internet.

Background

This resolution calls for ACEP to work with the CDC to study, track and trend statistical data regarding accidental self-harm promoted by social media posts, develop guidelines for recognition of self-harm content, develop programs to advance awareness among adolescents, and promote legislation that protects patients from self-harm and prohibits posting of self-harm challenge content and videos on social media sites and the internet.

To date, ACEP has not addressed self-harm and accidental injury caused by internet challenges and social media posts.

An article in Archives of Disease in Childhood, "Prevalence and associated harm of engagement in self-asphyxial behaviors ("choking game") on young people: a systematic review" notes that this behavior is not new and was described in the British Medical Journal in 1951. The CDC defines the "choking game" as "self-strangulation or strangulation by another person with the hands or with a noose to achieve a brief euphoric state caused by cerebral hypoxia." The "choking game" is most frequently related to a social media challenge, fitting in with a social group and experimentation.

A 2008 CDC Morbidity and Mortality Weekly Report, "Unintentional Strangulation Deaths from the 'Choking Game' Among Youths Aged 6-19 Years- United States, 1995-2007" noted that death certificates lack the detail necessary to distinguish choking-game deaths from other unintentional strangulation deaths and utilized LexisNexis to search newspaper reports and choking-game-awareness websites to identify deaths. This report was the first attempt to assess the incidence of deaths as a result of the "choking game" in the US. It is difficult to track statistics because cases can be reported as suicides.

YouTube and other websites provide information and songs about the choking game. A 2014 Lifetime Movie titled "The Choking Game" was based on a young adult novel, "Choke," published in 2012. There are websites and webpages focused on providing information (the choking game has a variety of names), describing the "game" and identifying signs and symptoms that could indicate that an adolescent is participating in this risky behavior.

There are numerous social media challenges including: The Blue Whale challenge that persuades teens to accept 50 challenges over 50 days that can include self-mutilation, running away from home, a last challenge to commit suicide to end the game; car surfing where the teen "surfs" on the roof, bumper, or hood of a moving vehicle; Tide pod ingestions; and the cinnamon challenge that dares participants to swallow a tablespoon of cinnamon in one minute without drinking any liquid to wash it down.

The Public Health & Injury Prevention Committee (PHIPC) was assigned an objective for the 2017-18 committee year to "review the literature and research on contagion-related suicide risk for teens." The committee developed the information paper "Suicide Contagion in Adolescents: The Role of the Emergency Department."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Undetermined amount of staff resources.

Prior Council Action

The Council has discussed and adopted resolutions related to suicide, but none on the subject of self-harm and accidental injury as a result of internet challenges and social media posts.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. Directed that ACEP research the feasibility of identifying and risk-stratifying patients at high risk for violence; devise strategies to help emergency physicians work with stakeholders to mitigate patients' risk of self-directed or interpersonal harm; and investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes and explore similar precedents currently in use.

Prior Board Action

September 2018, reviewed the information paper ""Suicide Contagion in Adolescents: The Role of the Emergency Department"

November 2015, reviewed the information paper, "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 48(19)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: Promotion of Maternal and Infant Health

PURPOSE: Collaborate with ACOG to promote maternal and infant health in rural areas and provide educational materials for emergency physicians on how to provide care consistent with best practices for these vulnerable populations.

FISCAL IMPACT: Budgeted staff resources and $20,000 for creation of a point of care tool.

WHEREAS, Many hospitals across the country have inadequate or no obstetric coverage and the percentage of rural counties with hospital-based obstetric services declined from 55% to 46% between 2004 and 2014,[1,2] with less-populated rural counties experiencing more rapid declines[3,4]; and

WHEREAS, Pregnant patients in rural settings may need to travel long distances for obstetric care; and

WHEREAS, Pregnant patients may present to an emergency department with an obstetrical complaint or complication; and

WHEREAS, These rural patients are more likely to have a preterm delivery; therefore be it

RESOLVED, That ACEP attempt to collaborate with the American College of Obstetricians and Gynecologists to promote maternal and infant health; and be it further

RESOLVED, That ACEP work with the American College of Obstetricians and Gynecologists and other stakeholders to provide educational materials, such as toolkits, to emergency physicians regarding how to provide care that is up-to-date and consistent with best clinical practices for these vulnerable populations.

References

[1]Access to Obstetric Services in Rural Counties Still Declining with 9 percent losing services 2004-14
Health Affairs, September 2017
[2]Eroding Access and Quality of Childbirth care in Rural US Counties, JAMA 2018
[3]The neglected challenge: Saving America's rural ob care
https://www.contemporaryobgyn.net/maternal-mortality-special-reports/neglected-challenge-saving-americas-rural-ob-care
[4]Kozhimannil KB, Hung P, Henning-Smith C, Casey MM, Prasad S. Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States [published online March 8, 2018.] *JAMA* . doi: 10.1001/jama.2018.1830.

Background

This resolution calls for the College to collaborate with the American College of Obstetrics and Gynecology to promote maternal and infant health in rural areas and to provide educational materials such as toolkits for emergency physicians regarding how to provide care consistent with best practices for these vulnerable populations.

ACEP is already working on educational materials with the American College of Obstetrics and Gynecology (ACOG). ACOG has recently received a grant from the CDC to develop educational materials for non-OB physicians to reduce maternal morbidity and mortality. ACOG reached out to ACEP as their initial organization and we will be

working with them over the next one to two years to create appropriate content. Additionally, ACOG has expressed interest in ACEP creating a point of care tool for the website and app that would cover maternal and post-partum complications.

The American Academy of Family Physicians has created a course on Advanced Life Support in Obstetrics that is available to all physicians. Several emergency physicians who practice in a rural or low-resourced setting have taken this course

Many rural healthcare facilities have been under pressure for many years to keep their doors open. Disparities in healthcare for rural versus urban communities is reflected in national-level data. ACOG noted in their Committee Opinion in February 2014 titled "Health Disparities in Rural Women" that "In 2008, only 6.4% of obstetrician-gynecologists practiced in a rural setting. By 2010, 49% of the 3143 U.S. counites (home to 10.1 million women or 8.2% of all women), lacked an obstetrician-gynecologist." The report outlines recommendations to reduce rural health disparities but notes that rural communities are diverse and local solutions are needed to address local issues. In 2015, CDC data showed a maternal mortality rate of 18.2 per 100,000 live births in a metropolitan area versus 29.4 deaths per 100,000 live births in most rural areas. CDC figures reflect the same trend for infant mortality rates.

ACOG developed a Committee Opinion on Hospital-Based Triage of Obstetric Patients but these recommendations are for collaboration of hospital-based obstetric units and the emergency department within the same facility.

At *ACEP19* there are several courses that address pregnancy and trauma in pregnancy. Two sessions of "Emergency Vaginal Delivery Lab" are offered with one session each of these two courses: "Late Pregnancy and Postpartum Emergencies" and "Trauma in Pregnancy." The lab on vaginal deliveries will discuss the management of the complications associated with an emergency delivery, identifying necessary equipment, and identifying patients who cannot be transferred to labor & delivery.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Goal 2 Enhance Membership Value and Member Engagement
Objective C – Provide robust communications and educational offerings, including novel delivery models.

Fiscal Impact

Budgeted staff resources and $20,000 for creation of a point of care tool.

Prior Council Action

None.

Prior Board Action

January 2019, reaffirmed the joint policy statement, "Death of a Child in the Emergency Department." A joint policy statement of the ACEP, American Academy of Pediatrics (AAP), and the Emergency Nurses Association (ENA.) Revised by AAP April 2014, ENA October 2012 and ACEP March 2013. Reaffirmed in October 2008 by ACEP and AAP. Approved June 2002 by AAP. Originally approved February 2002.

April 2018, approved the policy statement "Interpretation of EMTALA in Medical Malpractice Litigation."

October 2016, approved clinical policy "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy."

April 2014, approved revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved October 2007, June 2004, and June 2001 with current title; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

April 2012, approved the revised Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy. Originally approved September 2002.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 49(19)

SUBMITTED BY: Arizona College of Emergency Physicians, District of Columbia Chapter, Idaho Chapter, Illinois College of Emergency Physicians, Maryland Chapter, New Jersey Chapter, Pennsylvania College of Emergency Physicians, West Virginia Chapter

SUBJECT: Protecting Emergency Physician Compensation During Contract Transitions

PURPOSE: Adopt a new policy statement addressing continuity of fair compensation including monetary payments and malpractice coverage during times of contract transitions.

FISCAL IMPACT: Budgeted staff and committee resources to develop and disseminate a policy statement.

WHEREAS, Emergency physicians providing medical services in hospitals may be employed by separate corporate entities or staffing groups who contract with the said hospital for those services; and

WHEREAS, Emergency physicians may not have input into the contract negotiations between the said hospital and staffing group; and

WHEREAS, During times of transitions in staffing group contracts, emergency physicians have been asked to work unpaid to complete their professional responsibilities; and

WHEREAS, The ACEP policy statement "Emergency Physician Rights and Responsibilities"[2] states that emergency physicians "should be accorded due process before any adverse final action with respect to employment or contract status" and "both independent contractors and physician employees should be represented in the contract negotiation process between hospitals and those payers providing reimbursement for emergency services;" and

WHEREAS, The ACEP policy statement "Compensation Arrangements for Emergency Physicians"[3] states "Exploitation of emergency physicians by other emergency physicians or health care entities is improper;" therefore be it

RESOLVED, That ACEP adopt the following statement and disseminate its content to its members and other parties: "It is the position of the American College of Emergency Physicians that emergency physicians who provide services to patients during a time of contract transitions should be fully compensated for their professional efforts without delay, barrier, or requirement to continue employment with a specific party. This compensation should include monetary compensation as well as uninterrupted provision of malpractice coverage. Parties involved in contract transitions, including contract management groups and the hospitals and health systems involved, have a responsibility to meet these obligations immediately and not use such a transition as leverage in the contract process."

References

1. https://www.phillytrib.com/metros/montgomery_county/er-doctors-go-unpaid-atroxborough-other- hospitals-in-changeover/article_9f25e8f2-a33d-5f4e-97377a812ff0cc7b.html
2. ACEP Policy: Emergency Physician Rights and Responsibilities. Accessed on 6/10/19. https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-andresponsibilities/
3. ACEP Policy: Compensation Arrangements for Emergency Physicians. Accessed on 6/10/19. https://www.acep.org/patient-care/policy-statements/compensationarrangements-for-emergency- physicians/

Background

This resolution calls for ACEP to adopt a new policy statement specifically addressing continuity of fair compensation, including monetary payments and malpractice coverage, during times of contract transitions. It further speaks against using the transition period for leverage in negotiating new contract terms. The authors cite two examples from 2018 to support the need for this policy statement. The concepts addressed in the proposed policy can be found in other ACEP resources, but not stated as succinctly as in this language.

ACEP's policy statement "Emergency Physician Rights and Responsibilities" explains that emergency physicians typically work under a contractual arrangement to provide staffing. Relevant points include:

- Emergency physicians should be reasonably compensated for clinical and administrative services and such compensation should be related to the physician's qualifications, level or responsibility, experience, and quality and amount or work performed.
- Emergency physicians should be accorded 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.
- Emergency physicians, both independent contractors and physician employees, should be represented in the contract negotiation process between hospitals and those payers providing reimbursement for emergency services. Emergency physicians are entitled to fair rights and reimbursement pursuant to such contract agreements.
- Emergency physicians should not be required to agree to any unreasonable restrictive agreement that limits the right to practice medicine for a specified period of time or in a specific area after the termination of employment or contract to provide services as an emergency physician. Such restrictions are not in the public interest.

ACEP's policy statement "Compensation Arrangements for Emergency Physicians" includes two relevant points:

- Regardless of the compensation method or practice arrangement, emergency physicians are entitled to fair and equitable compensation, taking into account their experience and added value to the practice, market conditions, and other appropriate circumstances.
- Exploitation of emergency physicians by other emergency physicians or health care entities is improper.

ACEP's policy statement (not referenced in the resolution) "Emergency Physician Contractual Relationships" also contains a relevant point:

- 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.

The "Emergency Physician Contractual Relationships" policy statement has an associated Policy Resource & Education Paper (PREP) that explains some of the background and foundation of the policy statement.

In 2017, the Contract Transitions Task Force developed the information paper "Emergency Department Physician Group Staffing Contract Transition" that includes this information:

> "The contract should have clear language detailing the rights and responsibilities of the party after the decision to terminate is made. Typically, both parties have the same obligations and rights until the termination date. Contracts should specify an orderly transition, and both parties should agree to work collaboratively towards that future transition. Whether there are certain ethical obligations on all parties (beyond the contract) is perhaps debatable, but continuity of patient care, patient safety and community safety, and any medical student/resident vital patient care or educational programs should be paramount.

> There are certain rights and obligations that must continue after termination. For example, sharing billing information, HIPAA compliance, and addressing final payments and/or accounts receivable should be specified in the contract."

The information paper also references malpractice coverage in the event of contact termination.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective E.5. – Monitor and support chapter efforts to pursue legislative and regulatory initiatives that ensure fair payment.

Objective G.6. – Review and update as needed ACEP resources, including educational offerings that provide information to members to help minimize their liability risks. Collate the resources and promote to members.

Goal 2 Enhance Membership Value and Member Engagement
Objective H.3. – Develop a collection of resources for each of the stages in a physician's career – first job, moving, maternity, leadership and advancement, planning for retirement, retirement.

Fiscal Impact

Budgeted committee and staff resources to develop and disseminate a policy statement.

Prior Council Action

The Council has discussed and adopted many resolutions regarding ED contracts. Resolutions relevant to this resolution are:

Resolution 45(17) Group Contract Negations to End-of-Term Timelines referred to the Board of Directors.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans and contract groups.

Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Prior Board Action

July 2018, reviewed the Policy Resource and Education Paper (PREP) "Emergency Physician Contractual Relationships. The PREP is an adjunct to the policy statement "Emergency Physician Contractual Relationships."

June 2018, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1982 titled "Contractual Relationships Between Emergency Physicians and Hospitals."

May 2018, reviewed the revised "Emergency Department Physician Group Staffing Contract Transition" information paper. First draft reviewed June 2017, second draft reviewed March 2018. The final version of the information paper also included the tenets of Referred Resolution 45(17) Group Contract Negotiations to End-of-Term Timelines.

January 2017, issued a public statement on rapid transitions of ED contracts.

January 2017, discussed concerns regarding the residency program at Summa Health.

April 2015, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" reaffirmed October 2008; revised and approved April 2002; revised and approved June 1997; reaffirmed April 1992; originally approved June 1988.

October 2015, approved the revised the policy statement "Emergency Physician Rights and Responsibilities;" revised April 2008, July 2001; originally approved September 2000.

Resolution 45(17) Group Contract Negations to End-of-Term Timelines assigned to the Contract Transitions Task Force.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted.

Amended Resolution 49(94) Information on Contract Issues adopted.

Background Information Prepared by: David A. McKenzie, CAE
Reimbursement Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 50(19)

SUBMITTED BY: Social Emergency Medicine Section
New York Chapter

SUBJECT: Social Work in the Emergency Department

PURPOSE: 1) Promote the inclusion of social workers and/or care managers within the ED team. 2) Educate hospitals on the need to include social workers in team-based care. 3) Compile best practices on ED care models that include social workers and care managers and create resources to assist members in implementing these models.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, Social determinants including, among many others, food insecurity, substance use disorders, homelessness, and socioeconomic status, greatly impact patients' health and the outcomes of their ED care; and

WHEREAS, Optimal care of Emergency Department (ED) patients mandates attention to social determinants of health; and

WHEREAS, Payment models are transforming to consider patient outcomes and these outcomes are intrinsically tied to their social determinants; and

WHEREAS, Centers for Medicare and Medicaid Services Conditions of Participation discharge planning rules have been updated to reflect the need to consider discharge planning for patients treated in the emergency department; and

WHEREAS, Emergency physicians are tasked with focusing on the prompt evaluation and medical treatment of ED patients; and

WHEREAS, A holistic approach to patients and their social determinants requires a team-based approach including, but not limited to, social workers and care managers; therefore be it

RESOLVED, That ACEP promote the consistent inclusion of social workers and/or care managers in the team of clinicians caring for patients in the ED; and be it further

RESOLVED, That ACEP educate hospitals on the need to include social workers and/or care managers on ED care teams; and be it further

RESOLVED, That ACEP compile information on best practices related to ED care models that include social workers and care managers and create resources to assist members in implementing multidisciplinary care models.

Background

This resolution requests ACEP to promote the inclusion of social workers and/or care managers within the ED team, educate hospitals on the need to include them in team-based care, compile best practices on ED care models that include social workers and care managers, and create resources to assist members in implementing these models.

Emergency departments are often referred to as the "front porch" of the medical system or called the "safety net/de facto" system for the medically underserved. As a result of EMTALA, EDs provide care for all individuals, regardless of socioeconomic status. EDs also see a growing demand for serving lower socioeconomic patients with unmet social needs. The ICD-10-CM codes (Z55-Z65) now include categories of potential health hazards related to a patient's socioeconomic or psychosocial environment, and other factors that can influence their health status.

Team-based, multi-disciplinary care is becoming increasingly common within health care as more emphasis is placed on improving patient quality and outcomes. Since the Institute of Medicine report, *To Err is Human*, stimulated discussion on how to improve patient safety and quality across the delivery system, the need for better coordination and collaboration has continued to drive the conversation. Multi-disciplinary teams and collaborative care models often include clinicians, nurses, and social workers or care managers. Emergency department social workers are typically tasked with facilitating linkages and identifying resources across organizational systems to improve the care of an individual. They might also provide mental health services, serve as a cultural liaison, educator, discharge planner, assessor, or crisis intervention specialist. They also frequently work with vulnerable populations, such as child/elder abuse victims or victims of sexual assault. The Bureau of Labor Statistics states that there were 707,400 social workers in the US in 2018. Of those, approximately 180,000 were involved in the health care setting. Job growth for social workers is expected to outpace other occupations, particularly in the health care setting, partially due to the aging populations. Demand for mental health and substance use disorder social workers is also expected to increase as more people seek treatment or are diverted into treatment programs. Case management services might also be carried out by a community health worker, nurse or care coordinator. Case management typically includes assessing for unmet needs and aiding in delivering or coordinating services with other agencies.

Despite the movement towards more multi-disciplinary teams, and the inclusion of social workers as part of many ED-care teams, not all hospitals have social workers available. The Deloitte Center for Health Solutions surveyed 300 hospitals and health systems and found that while the majority (88%) were committed to addressing social determinants of health and were screening patients for social needs, 72% of hospitals had not made any investments into meeting these needs, with the limited activity that was occurring fragmented and ad hoc. The U.S. spends less on social services than other developed nations, ranking 22 out of 37 nations. The American Hospital Association launched The Value Initiative in 2017 to address population health and social determinants of health to reduce cost and improve the quality of care provided by hospitals and health systems in the future.

Some argue that including social workers in the ED may reduce overall hospital costs by reducing unnecessary admissions or reducing the length of stay. One study examining ED visit reduction programs found that only case management consistently reduced ED use when compared to other strategies, such as patient education, etc. Other arguments for the use of social workers are for: improving quality of communication, increased patient satisfaction, and less burden on ED physicians to address social needs or services. One study found that social workers reduced the demands on clinicians to arrange for home health care, nursing home placement, and other social-services. Some argue that the costs of providing social work might eventually be met with ED efficiency gains (reduced admissions, clinician time, etc.). One literature review found that interventions in care coordination, income support, nutrition, housing, and community outreach had positive impacts on health improvements or health care spending reductions.

Some argue that the inclusion of social workers in the ED detracts from the overall mission of the emergency care system in treating the acute and critically ill or injured. Barriers to including social workers as part of the ED team could include the prohibitive cost to the hospital or institution, but also other challenges, such as lack of local or community resources, limited workforce, narrow scope of practice, and reduced coverage and access (e.g., M-F, 9:00 am – 5:00 pm hours).

ACEP's policy statement "Emergency Department Planning and Resource Guidelines," states that emergency departments "must provide the staff and resources necessary to evaluate all individuals presenting to the emergency department" and that ED personnel must establish effective working relationship with other health care providers and entities with whom they must interact, such as social service resources. It also states that emergency medical care must be available to all members of the public and that a smooth continuum should exist between prehospital and ED providers to follow up care.

ACEP's policy statement "Optimizing the Treatment of Pain the Patients with Acute Presentations" states that in

addition to contemporaneous pharmacologic intervention, "other pathways such as referral for long term pain management, case management or referral to social service for clinicals and/or center" should be considered." Additionally, it encourages the use of "social service interventions" for patients at risk of addiction.

The ACEP website includes many Transitions of Care Resources, including a Rapid Integration of Care Toolkit.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective A – Promote/Advocate for efficient, sustainable and fulfilling clinical practice environments.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted. Directed ACEP to pursue reimbursement strategies to promote coordination of care, effective ED information sharing, and performance incentives for case management of high utilizers.

Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted. Directed that ACEP develop a rapid integration of care toolkit to focus on transitions of care and care coordination, provide best practices based upon hospital type and location, tools/resources for the design and implementation of rapid integration of care programs, and measures to report success of efforts.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted. Directed ACEP to define the role of emergency medicine in transitions of care for emergency medicine patients; to participate in all significant forums of discussion with regulatory entities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, The Joint Commission, National Quality Forum, related to performance parameters and proposed standards for emergency medicine transitions of care; to monitor and have input into any reimbursement issues tied to transitions of care, including performance incentives and accountable care organization collaboration; and to identify resources and educational materials to improve transitions of care for emergency patients.

Substitute Resolution 34(07) Patient Support Services Addressing the Gaps adopted. Stated that the College supports that hospitals develop resources to improve emergency department patients' access to outpatient community health and support services.

Prior Board Action

June 2019, approved the policy statement "Safe Discharge from the Emergency Department."

April 2019, approved the revised policy statement "Patient Support Services;" reaffirmed June 2013; originally approved October 2007.

January 2019, reaffirmed the policy statement "EMTALA and On -call Responsibility for Emergency Department Patients;" revised and approved June 2013, April 2006 replacing policy statements titled "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).

April 2017, approved the revised policy statement "Optimizing the Treatment of Pain the Patients with Acute Presentations;" replaced the 2009 policy statement with the same title.

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 with the current title June 1997; originally approved January 1991 titled "Ethics Manual." Part II D defines the role of the emergency physicians with society.

April 2016, approved the policy statement "Human Trafficking." States that EDs include approaches to interfacing with outside entities such as social service organizations to care for patients.

October 2015, Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted.

October 2014, reviewed the Rapid Integration of Care Toolkit.

April 2014, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved October 2007, June 2004, and June 2001 with current title; reaffirmed September 1996; revised

Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted.

October 2012, reviewed the information paper, Transitions of Care Task Force Report. The information paper recommended strategies for emergency medicine. The 2012 Council Town Hall meeting focused on Transitions of Care and highlighted aspects of the task force report.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted.

Substitute resolution 34(07) Patient Support Services Addressing the Gaps adopted.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 51(19)

SUBMITTED BY:

Alexander Chiu, MD, MBA, FACEP	Hawaii Chapter
Mark E. Escott, MD, MPH, FACEP	Iowa Chapter
Adam Ash, DO, FACEP	Nebraska Chapter
Joo Yup Shaun Chun MD, FACEP	New Jersey Chapter
David Ernst, MD, FACEP	New York Chapter
Alina Ershova BA	Virginia College of Emergency Physicians
Hartmut Gross, MD, FACEP	West Virginia Chapter
William Holubek, MD, FACEP	Critical Care Section
Nizar Kifaieh, MD, MBA, FACEP	EMS-Prehospital Care Section
Arkansas Chapter	Wilderness Medicine Section
District of Columbia Chapter	

SUBJECT: Stimulating Telemedicine Researchers and Programs

PURPOSE: 1) Promote telehealth research, maintain a database of telehealth programs and interested researchers; 2) allocate lobbying resources to increase federal funding for telehealth research in emergency medicine; and 3) work with outside organizations to coordinate research awareness and lobbying efforts to increase the number of quality research studies in emergency telehealth.

FISCAL IMPACT: Budgeted staff resources for advocacy activities and maintenance of a database of telehealth programs and researchers. Additional dedicated lobbying efforts could be needed for telehealth research funding and coordinating telehealth lobbying efforts with other organizations, depending on the workload. May require an additional staff person or increased costs for consultant lobbying activity, which could exceed $100,000. Any additional costs are not currently included in the budget.

WHEREAS, ACEP represents emergency physicians practicing in all emergency care environments; and

WHEREAS, Telemedicine is currently a valuable tool for providing patient care by emergency physicians under a variety of circumstances that include consultant access and direct-to-patient care; and

WHEREAS, ACEP represents emergency physician's equitable reimbursement and evidence-based practice for providing patient care through its lobbying and public awareness; and

WHEREAS, Reimbursement policies for telemedicine services provided by emergency medicine providers created by CMS and third-party payers are developed primarily based on research data centered around outcomes, quality, access, and cost; and

WHEREAS, In 2016, the ACEP Emergency Telemedicine Section, having been awarded an ACEP Section Grant to develop a Telehealth Focused Practice Guideline document, performed a systematic review of two bibliographic databases (PubMed/Medline and EMBASE) from 1974 to September 2016 which revealed that the quality of studies suffered from small patient populations and were underpowered, showing low number of relevant studies and a lack of patient outcomes in the realm of emergency physicians as providers of telemedicine; and

WHEREAS, ACEP telehealth literature search found a lack of both unbiased, high-quality literature and low-quality literature involving the use of telemedicine in emergency medicine; and

WHEREAS, In 2019 the Agency for Healthcare Research and Quality (AHRQ) published a systematic review to

identify and summarize the evidence of telehealth consultations, found telehealth evidence insufficient, and called for further telehealth research emphasizing rigor and standardized outcome comparisons; and

WHEREAS, A grant search was performed using resources and medical librarians at NYITCOM and Health/ Hospitals System and search engines www.AHRQ.org, www.spin.infoedglobal.com, www.Grants.gov, and other relevant search engines and the search included both new grant funding opportunities and projects which were funded; and

WHEREAS, A total of 417 grant funding opportunities were selected for review of possible restriction (examples of restriction include telehealth and veteran patients or telehealth and breast cancer) and 413 of the 417 funding opportunities were found to have restrictions on telehealth research; and

WHEREAS, Per clinical policies, ACEP requires thousands of high-quality studies and meta-analyses to produce Level A Clinical Recommendations and Level B Clinical Recommendations for a high or moderate degree of clinical certainty; and

WHEREAS, given the grant search and clinical policy literature requirement, there is a *lack* of dedicated federal and other financial resources available to support research in emergency telehealth to reach generally accepted principals for emergency telehealth patient care that reflect a high or moderate degree of clinical certainty; and

WHEREAS, A simple database of high-quality researchers interested in telemedicine research and telemedicine programs would create no material cost to ACEP and would be a cost-effective way to coordinate experienced researchers with emergency telehealth programs delivering care to large samples of patients; and

WHEREAS, The American Telemedicine Association (ATA), in their 2019 strategy statement, has agreed to work with other organizations in the improvement of telemedicine; and

WHEREAS, The ATA Health, Technology, and Distance Learning SIG has agreed during its 2019 strategic goals meeting to promote telehealth research awareness, increase telehealth quality research studies, and increase funding opportunities in telehealth with the same methods presented in this resolution; therefore be it

RESOLVED, That ACEP promote telehealth research awareness to its members, maintain a database of telehealth programs and interested researchers, and make introductions between interested parties; and be it further

RESOLVED, That ACEP allocate lobbying resources at the federal level for promoting the increase of federal funding toward telehealth research in emergency medicine; and be it further

RESOLVED, That ACEP work with outside organizations, such as the American Academy of Emergency Medicine, the Society for Academic Emergency Medicine, American Telemedicine Association, Healthcare Information and Management Systems Society, and others to coordinate research awareness and lobbying efforts to increase the number of quality research studies in emergency telehealth.

*Additional authorship by: Ummul Asfeen, BS; Edward Cho, DO, MPH; Meaghan Donnelly MS BS; Brianna Ferrarie; Mark Kindschuh, MD, MBA; John Rimmer, DO; Jonathon Savage, DO, FAAEM; Christian Daniel Espana Schmidt, MD; Wehbeh, MD; and Tucker Woods, DO.

Background

This resolution calls for ACEP to promote telehealth research, maintain a database of telehealth programs and interested researchers, allocate lobbying resources to increase federal funding for telehealth research in emergency medicine, and work with outside organizations to coordinate research awareness and lobbying efforts to increase the number of quality research studies in emergency telehealth.

The rapid development and deployment of telehealth services is significantly impacting various aspects of the U.S. healthcare system. According to a 2016 report by the U.S. Department of Health and Human Services (HHS), more than 40% of hospitals in the U.S. and more than 60% of all healthcare institutions were using telemedicine.

While the growth of telehealth has been impressive, it has nonetheless been slowed by reimbursement and interstate licensing issues. State laws regulating private payer reimbursement for telemedicine vary, but the majority now have parity laws that require insurers to reimburse for care provided via telemedicine in the same way it reimburses for in-person care. While Medicare reimburses for some telehealth services, it does not pay for telehealth services provided for emergency care.

Despite these reimbursement challenges, the use of telehealth in emergency care is growing as well through a variety of applications, including remote consults with psychiatrists and other specialists, providing rural patients access to emergency physicians when their hospital has none available, and health systems conducting centralized virtual visits for lower acuity patients presenting to their EDs.

Research of some applications of telehealth demonstrates that telehealth can enhance access to care, reduce costs, and/or improve outcomes. A 2019 report by the Agency for Healthcare Research and Quality (AHRQ) reported that "results vary by setting and condition, with telehealth consultations producing generally either better outcomes or no difference from comparators in settings and clinical indications studied." Regarding emergency care, the report noted that:

- "Specialty telehealth consultations likely reduce patient time in the emergency department."
- "Telehealth consultations in emergency services likely reduce heart attack mortality."

However, the AHRQ report also noted limitations in available research that preclude a more thorough examination of the impacts of telehealth, stating that "more detailed telehealth consultation costs and outcomes data would improve modeling assumptions." The limited amount of research on telemedicine was also noted in an information paper developed by members of the ACEP Emergency Telehealth Section. The purpose of the 2016 project was to review currently available literature that reported on emergency telehealth or telehealth applied in acute unscheduled care "to evaluate current research and to suggest the future directions of telehealth research. It was discovered that there is a lack of established specialty guidelines or evidence to support reaching certain conclusions in the reviewed literature."

ACEP has supported efforts to increase funding for emergency telehealth research. In response to a request for information from the Congressional Telehealth Caucus earlier this year, ACEP submitted a comment letter specifically requesting additional federal funding for telehealth research in emergency medicine. The comment letter stated in part that "additional data on quality, cost, access, and outcomes are needed to help both CMS and third-party payers evaluate and establish appropriate reimbursement for these services." ACEP has lobbied for increased federal funding for additional research to support emergency medicine. ACEP's efforts were instrumental in the 2012 creation of the Office of Emergency Care Research (OECR) within the National Institutes of Health. While OECR does not fund research projects, its mission includes coordinating emergency care research funding opportunities within the National Institutes of Health, matching researchers with funding opportunities, and helping to train new emergency care researchers.

Additional recent ACEP advocacy efforts related to telehealth include a comment letter this year to the Federal Communications Commission (FCC) regarding its proposed Connected Care Pilot Program, in which ACEP encouraged the FCC to expand the scope of the project to support high quality, cost-effective telehealth programs in the emergency department setting that allow greater access to an emergency physician in inner city or rural EDs. Over the past two Congresses, ACEP has promoted the CONNECT for Health Act to expand the use of telehealth and remote patient monitoring services in Medicare. In 2017, ACEP advocated (unsuccessfully) through the Current Procedural Terminology (CPT) Editorial Panel Process to get ED evaluation and management (E/M) codes, observation codes, and critical care codes added to the list of recognized telehealth codes.

ACEP has also developed an alternative payment model called the Acute Unscheduled Care Model, in which participating emergency physicians would become eligible to receive reimbursement for providing telehealth services under the model. The model was recommended for implementation by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and awaits further action by the HHS Secretary.

ACEP's Emergency Telehealth Section established a task force of section members to work, in part, on telehealth research issues. Through the work of the task force, the section applied for an ACEP section grant this year to develop an emergency telehealth research repository that would include a library of citations to published literature on

emergency telehealth and a searchable database of ongoing research in the field. The project would also provide a mechanism to facilitate connections between researchers interested in finding collaborators. The section's proposed project was not selected for a grant. Members of the section task force are working on a potential proposal to the Society for Academic Emergency Medicine about the possibility of creating a joint online emergency telehealth research repository with ACEP.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted staff resources for advocacy activities and maintenance of a database of telehealth programs and researchers. Additional dedicated lobbying efforts could be needed for telehealth research funding and coordinating telehealth lobbying efforts with other organizations, depending on the workload. May require an additional staff person or increased costs for consultant lobbying activity, which could exceed $100,000. Any additional costs are not currently included in the budget.

Prior Council Action

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Prior Board Action

June 2016, approved the policy statement "Ethical Use of Telemedicine in Emergency Care"

January 2016, approved the policy statement "Emergency Medicine Telemedicine."

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

Resolution 36(14) Development of Telemedicine Policy for Emergency Medicine adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 52(19)

SUBMITTED BY: Edward Shaheen, MD, FACEP
Emergency Telehealth Section

SUBJECT: Telehealth Emergency Physician Inclusion

PURPOSE: Specifies that all ACEP policies apply to all emergency physicians regardless of whether their services are provided in-person or remotely unless specifically stated that they only apply to in-person emergency services.

FISCAL IMPACT: None

WHEREAS, ACEP has established policies to apply to the practice of emergency medicine in many settings; and

WHEREAS, The practice of medicine changes with time and advancements in medicine and technology; and

WHEREAS, Technology has enabled emergency physicians to provide their services in ways not predicted or envisioned in the past and it is important to consider these technological advancements; and

WHEREAS, Many emergency physicians currently provide telehealth services; and

WHEREAS, ACEP leaders recognize that more emergency medicine will be provided outside of the traditional emergency department and much of this via telehealth; and

WHEREAS, The wording of ACEP policies do not specifically identify emergency physicians who provide their services remotely via telehealth, electronically, drones, or other means known today or that will come in the future and it is important for there to be no misinterpretation as to whom ACEP policies apply; and

WHEREAS, One such example of how current ACEP policy may be interpreted as not applicable to emergency physicians who provide their services and/or expertise via telehealth is the "Disaster Medical Response" policy statement that states "the American College of Emergency Physicians (ACEP) 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.;" and

WHEREAS, ACEP current and future policies could be interpreted to not include services provided by emergency physicians that are not performed or provided in-person; and

WHEREAS, Emergency physicians who provide their services, regardless of whether in-person or not in-person, should be treated equally, held to appropriate standards, and given equal protection; therefore be it

RESOLVED, That unless a policy statement specifically indicates that it only applies to in-person emergency services, ACEP extend all ACEP policies that include or refer to emergency physicians to specifically apply to all emergency physicians regardless of whether their services are provided remotely or in-person.

Background

This resolution calls for all ACEP policies that apply to emergency physicians to apply to all emergency physicians regardless of whether their services are provided in-person or remotely unless specifically stated that they only apply to in-person emergency services.

The rapid development and deployment of telehealth services is significantly impacting various aspects of the U.S. healthcare system. According to a 2016 report by the U.S. Department of Health and Human Services (HHS), more than 40% of hospitals in the U.S. and more than 60% of all healthcare institutions were using telemedicine. Use of telehealth in emergency care is growing as well through a variety of applications, including remote consults with psychiatrists or other specialists not available on site, providing rural patients access to emergency physicians when their hospital has none available, and health systems conducting centralized virtual visits for lower acuity patients presenting to their EDs.

ACEP's policy statement "Emergency Medicine Telemedicine," addresses several issues regarding telemedicine in the emergency department setting, and states that "the use of telemedicine is quickly increasing in emergency departments throughout the United States, and emergency physicians are well suited to the provision of this care."

ACEP's policy statement "Definition of an Emergency Physician" does not distinguish by site of service or other practice differences, stating only that "an emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians."

The policy statement "Definition of Emergency Medicine" addresses different practice settings, including telemedicine, stating that "emergency medicine is not defined by location, but may be practiced in a variety of settings including hospital-based and freestanding emergency departments (EDs), urgent care clinics, observation medicine units, emergency medical response vehicles, at disaster sites, or via telemedicine."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

None

Prior Council Action

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Prior Board Action

April 2017, reaffirmed the policy statement "Definition of an Emergency Physician;" originally approved June 2011.

June 2016, approved the policy statement "Ethical Use of Telemedicine in Emergency Care"

January 2016, approved the policy statement "Emergency Medicine Telemedicine."

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.

June 2015, approved the revised policy statement "Definition of Emergency Medicine." Revised April 2008, April 2001. Reaffirmed October 1998. Revised April 1994 with current title. Originally approved March 1986 as "Definition of Emergency Medicine and the Emergency Physician."

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

Resolution 36(14) Development of Telemedicine Policy for Emergency Medicine adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 53(19)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Supporting Vaccination for Preventable Diseases

PURPOSE: Support the elimination of non-medical exclusions for vaccines and make a public statement of support for the safety and efficacy of vaccines in preventing disease.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Vaccination has proven to be a safe and effective public health measure decreasing and reducing the burden of disease on patients and communities; and

WHEREAS, Anti-vaccination groups have grown in resources, prominence and influence; and

WHEREAS, The World Health Organization has listed vaccine hesitancy and pandemic flu as two of its top 10 global health threats in 2019[1]; and

WHEREAS, Emergency physicians are uniquely positioned to interact with a wide variety of patients and vulnerable populations; and

WHEREAS, Emergency physicians are equipped to serve as educators, advocates, and facilitators for those best served by vaccinations; therefore be it

RESOLVED, That ACEP support the elimination of non-medical exclusions for vaccines; and be it further

RESOLVED, That ACEP make a public statement of support for the safety and efficacy of vaccines in preventing disease.

Background

This resolution calls for the College to support the elimination of non-medical exclusions for vaccines and to make a public statement of support for the safety and efficacy of vaccines in preventing disease. This resolution is similar to Resolution 53(19) Vaccine Preventable Illnesses Toolkit. Much of the background information is the same for both resolutions.

ACEP has long had policies recognizing that vaccines effectively and significantly reduce the spread of vaccine-preventable infectious diseases, including the 2015 policy statement "Immunization of Adults and Children in the Emergency Department" and the 2019 policy statement "Reporting of Vaccine-Related Adverse Events."

The Centers for Disease Control and Prevention have resources available for Health Care Providers, including but not limited to:

- Vaccination Schedules - https://www.cdc.gov/vaccines/schedules/hcp/index.html

[1] "Ten Threats to Global Health in 2019" https://www.who.int/emergencies/ten-threats-to-global-health-in-2019. Accessed June 7, 2019

- Vaccine Administration Protocols - https://www.cdc.gov/vaccines/hcp/admin/admin-protocols.html
- Patient Education Resources - https://www.cdc.gov/vaccines/hcp/patient-ed/educating-patients.html

Additionally, the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) have a large number of free resources regarding immunizations on their respective websites. These can be accessed at:

- AAFP Immunization Center: https://www.aafp.org/patient-care/public-health/immunizations.html
- AAP Immunization Center: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/Pages/Immunizations-home.aspx

California recently enacted Senate Bill 276, which will prevent fake medical exemptions and require oversight of the medical exemption process. https://sd06.senate.ca.gov/news/2019-09-09-governor-signs-sb-276-law. The bill will require physicians to submit information to California Department of Public Health (CDPH), including the physician's name and license number and the reason for the exemption, which CDPH will check to ensure they are consistent with the Center for Disease Control's guidelines or stand of care. The physician must also certify that they have examined the patient in person.

The College does not have a policy that specifically addresses the elimination of non-medical exclusions for vaccines. The AMA recently modified their policy," Nonmedical Exemptions from Immunizations." The AMA policy clearly states nonmedical exemptions endanger the health of unvaccinated individuals and the public at large and calls for advocacy and support for legislation that eliminates nonmedical exemptions. Additionally, the American Academy of Pediatrics 2016 Policy on Medical Versus Nonmedical Immunization Exemptions for Child Care and School Attendance also recommends that all states and the District of Columbia use their public health authority to eliminate nonmedical exemptions from immunization requirements.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

January 2019, approved the policy statement, "Reporting of Vaccine-Related Adverse Events."

June 2015, approved the revised policy statement, Immunization of Adults and Children in the Emergency Department; revised and approved January 2008, replacing "Immunizations in the Emergency Department" approved in 2002, "Immunizations of Pediatric Patients approved in 2000, and "Immunization of Adult Patients" approved in 2000.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 54(19)

SUBMITTED BY: New York Chapter

SUBJECT: Vaccine Preventable Illnesses Toolkit

PURPOSE: Develop resources for physicians to help with early identification, diagnosis, and recommendations for limiting spread of illness previously rare because of vaccinations and issue a statement supporting vaccinations as a safe and effective method to prevent disease and improve population health in all individuals who can be vaccinated.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, There have been multiple outbreaks of vaccine preventable illnesses; and

WHEREAS, There is a low adult vaccination coverage rate and some parents delay or refuse vaccines for their children; and

WHEREAS, Vaccine success has resulted in fewer doctors and other providers have experienced the serious and potentially life-threatening consequences of vaccine preventable illnesses; therefore be it

RESOLVED, That ACEP develop resources for physicians to help with the early identification, diagnosis, and recommendations for limiting spread of illness previously rare due to vaccination; and be it further

RESOLVED, That ACEP make a statement supporting vaccinations as a safe and effective method to prevent disease and improve population health in all individuals who medically can be vaccinated.

Background

This resolution calls for the College to develop resources for physicians to help with the early identification, diagnosis, and recommendations for limiting spread of illness previously rare due to vaccination and issue a statement supporting vaccinations as a safe and effective method to prevent disease and improve population health in all individuals who medically can be vaccinated. This resolution is similar to Resolution 52(19) Supporting Vaccination for Preventable Diseases. Much of the background information is the same for both resolutions.

ACEP has long had policies recognizing that vaccines effectively and significantly reduce the spread of vaccine-preventable infectious diseases, including the 2015 policy statement "Immunization of Adults and Children in the Emergency Department" and the 2019 policy statement "Reporting of Vaccine-Related Adverse Events."

The Centers for Disease Control and Prevention have resources available for Health Care Providers, including but not limited to:

- Vaccination Schedules - https://www.cdc.gov/vaccines/schedules/hcp/index.html
- Vaccine Administration Protocols - https://www.cdc.gov/vaccines/hcp/admin/admin-protocols.html
- Patient Education Resources - https://www.cdc.gov/vaccines/hcp/patient-ed/educating-patients.html

Additionally, the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) have a large number of free resources regarding immunizations on their respective websites. These can be accessed at:

- AAFP Immunization Center: https://www.aafp.org/patient-care/public-health/immunizations.html

- AAP Immunization Center: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/Pages/Immunizations-home.aspx

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

January 2019, approved the policy statement, "Reporting of Vaccine-Related Adverse Events."

June 2015, approved the revised policy statement, Immunization of Adults and Children in the Emergency Department; revised and approved January 2008, replacing "Immunizations in the Emergency Department" approved in 2002, "Immunizations of Pediatric Patients approved in 2000, and "Immunization of Adult Patients" approved in 2000.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Memorandum

To: 2019 Council

From: Dean Wilkerson, JD, MBA, FACEP
Executive Director and Council Secretary

Date: September 17, 2019

Subj: Compensation Committee Report

The Compensation Committee has not yet developed their recommendations for Board member and officer stipends for FY 2019-20. The committee will hold a meeting in Denver on Sunday, October 27, to discuss their recommendations. The committee's recommendations will be discussed by the Board at their meeting on October 30. 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	$139,933
President-Elect	$101,759
Chair	$ 33,713
Vice President	$ 33,713
Secretary-Treasurer	$ 33,713
Immediate Past President	$ 33,713
Speaker	$ 33,713
Vice Speaker	$ 17,371
Non-Officer Board Members	$ 10,428

HEADQUARTERS
Post Office Box 619911
Dallas, Texas 75261-9911

4950 W Royal Ln
Irving, TX 75063-2524

972-550-0911
800-798-1822
www.acep.org

BOARD OF DIRECTORS
Vidor E. Friedman, MD, FACEP
President
William P. Jaquis, MD, FACEP
President-Elect
Stephen H. Anderson, MD, FACEP
Chair of the Board
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Vice President
Mark S. Rosenberg, DO, MBA, FACEP
Secretary-Treasurer
Paul D. Kivela, MD, MBA, FACEP
Immediate Past President
James J. Augustine, MD, FACEP
L. Anthony Cirillo, MD, FACEP
John T. Finnell II, MD, MSc, FACEP
Alison J. Haddock, MD, FACEP
Christopher S. Kang, MD, FACEP
Kevin M. Klauer, DO, EJD, FACEP
Aisha T. Liferidge, MD, MPH, FACEP
Debra G. Perina, MD, FACEP
Gillian R. Schmitz, MD, FACEP

COUNCIL OFFICERS
John G. McManus, Jr, MD, MBA, FACEP
Speaker
Gary R. Katz, MD, MBA, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Dean Wilkerson, JD, MBA, CAE

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Board of Directors Position and Vote
Amended Resolution 11(15) Ethical Violations by Non-ACEP Members

The 2015 Council and the Board of Directors adopted Amended Resolution 11(15):

> RESOLVED, That ACEP shall extend the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" to include non-ACEP members whose actions involve ACEP members; and be it further
>
> RESOLVED, That ACEP's current 'Procedures for Addressing Charges of Ethical Violations and Other Misconduct' shall be modified to reflect that any disciplinary actions taken by ACEP and involving non-ACEP members will be reported to the expert's own professional society and may be reported to the expert's state licensing board for further action; and be it further
>
> RESOLVED, That ACEP shall create a summary to be distributed to expert witnesses in cases involving ACEP members putting those experts on notice that:
>
> The expert's testimony is subject to review by ACEP and ACEP's Ethics Committee.
>
> 1. Regardless of the expert's specialty or professional society membership, if the expert's testimony is found to be unethical, the expert will be subject to:
> a. Admonishment by ACEP.
> b. Public reporting of such admonishment in an appropriate ACEP publication.
> c. Reporting of such admonishment to any professional society or medical organization to which the expert belongs.
> d. Reporting of such admonishment to the expert's state medical licensing board.

The resolution was assigned to the Ethics Committee and the Medical-Legal Committee. The committees had differing viewpoints about the resolution and presented their recommendations to the Board in June 2016. The Ethics Committee recommended that the Board rescind their previous decision to adopt the resolution and overrule it. The Medical-Legal Committee recommended assigning a task force to implement the resolution. The Board of Directors assigned a workgroup of ACEP members, members of the Ethics and Medical-Legal committees, and staff to consider ways in which expert witness testimony by non-members could be reviewed and potentially admonished by the College. The workgroup examined the issue but was unable to agree upon a process by which ACEP could admonish testimony given by non-member physicians because non-members have not agreed to abide by the rules set forth in ACEP's *Code of Ethics* or *Expert Witness Guidelines*.

The group was also tasked with contacting other medical societies to inquire as to how they have addressed the problem of egregious expert witness testimony. During the 2015 Council meeting, testimony was presented stating that anesthesiology and neurology censure non-members for unethical testimony; however, informal surveys of these and other medical societies, all of whom reported that while they have instituted procedures for reviewing testimony given by their own members, they have no plans to expand their procedures to include non-members, primarily because of liability concerns.

The Ethics Committee, ACEP's Executive Director, General Counsel, and outside legal counsel strongly recommended against implementation of this resolution because of potential legal ramifications to the College, as well as outstanding obstacles surrounding implementation of the policy.

The damage caused by false and misleading expert witness testimony, whether provided by an ACEP member or non-member, is a real problem that must be addressed. However, rather than attempt to censure or admonish a non-member physician for such testimony, a viable solution is to introduce state legislation regarding witnesses testifying in cases concerning the practice of emergency medicine to have the following qualifications: 1) Board certification and licensure in the state in which testimony will be presented; and 2) substantial professional experience in emergency medicine within the last five years.

On January 30, 2019, the Board of Directors approved the following recommendations:

1. Rescind the motion to adopt Amended Resolution 11(15) Ethical Violations by Non-ACEP Members.
2. Overrule Amended Resolution 11(15) Ethical Violations by Non-ACEP Members

The Board also reviewed model state legislation that requires expert witnesses to be licensed in the state in which they are providing testimony as well as maintain expertise in emergency medicine. The Board requested that the State Legislative/Regulatory Committee review the model legislation and determine if any modifications were needed.

The Board acknowledged that egregious expert witness testimony by non-members is a major concern for emergency physicians and that a multi-faceted approach to address the problem is needed. The Board requested: 1) that staff follow up to determine if the American Medical Association has policy stating that expert witness testimony constitutes the practice of medicine and should be subject to peer review; 2) ACEP's standard of care review process be promoted to the membership through the various communication vehicles, such as *ACEP Now, EM Today,* and the website; and 3) that the Medical-Legal Committee and the Ethics Committee provide a recommendation to the Board on further actions that can be taken to address egregious expert witness testimony by non-members.

As directed in the Bylaws, the position and vote of each Board member are provided to the Council:

Board of Directors Position and Vote

Stephen Anderson, MD, FACEP
On advice of ACEP legal counsel, and the ability to accomplish the intent of the resolution through other mechanisms, I voted to overrule the resolution.

James Augustine, MD, FACEP
On the issue of overrule, my position is based on advice of legal counsel.

L. Anthony Cirillo, MD, FACEP
I vote to overrule the Council resolution on ethics violations of non-members on the advice of ACEP's General Counsel.

J.T. Finnell, MD, FACEP
Upon advice of ACEP's counsel and the recommendations by the Ethics Committee, I voted to overrule Amended Resolution 11(15).

Vidor Friedman, MD, FACEP
I voted to overrule the resolution on advice of ACEP legal counsel.

Alison Haddock, MD, FACEP
My decision was made based on the advice of ACEP in-house counsel and outside legal counsel.

Jon Mark Hirshon, MD, FACEP
I voted to overrule the resolution on advice of ACEP legal counsel and the significant fiduciary risk for the organization with the understanding that we will work to find alternate means to address this important issue.

William Jaquis, MD, FACEP
I am overruling this resolution. After review with ACEP counsel, this resolution is not actionable by the Board or the College in its current format.

Christopher Kang, MD, FACEP
Over the past three years, several internal College subject matter experts – Ethics Committee, Medical-Legal Committee, General Counsel, with concurrence by outside counsel, and the Executive Director – researched the intent and operationalization of the adopted resolution. They concur in opposition for several reasons on multiple levels, including scope, precedent, logistics, and liability, the latter which would likely increase the vulnerability and accountability of other non-member emergency physicians to the College and the vulnerability and accountability of emergency physicians to other specialties/organizations. Several other potential courses of action have been identified that could further prioritize the concerns articulated through the resolution.

Paul Kivela, MD, FACEP
I voted to overrule the resolution on advice of ACEP legal counsel and the ability to accomplish the intent of the resolution through other mechanisms.

Kevin Klauer, MD, FACEP
I advocated for overrule of Amended Resolution 11(15) based on the recommendation of the General Counsel and outside counsel opinion.

Aisha Liferidge, MD, FACEP
I voted to overrule the resolution on the basis of legal counsel and inability to implement as written.

Debra Perina, MD, FACEP
I voted to overrule the resolution based on the advice of legal counsel. As this resolution is currently crafted, the potential for excessive liability to the organization to sanction nonmembers could (and likely would) create significant legal and financial burden that would likely affect our organization, all our membership, negatively

Mark Rosenberg, MD, FACEP
I am concerned about unintended consequences as expressed by ACEP legal counsel.

Gillian Schmitz, MD, FACEP
I voted to overrule as I am concerned about unintended consequences of the resolution and agree with recommendations made by general counsel.

Action Taken Since January 2019

- The draft model state legislation was discussed by the State Legislative/Regulatory Committee. The revised model legislation was approved by the Board in June 2019 (Attachment A).

- It was determined that the AMA has policy stating that expert witness testimony constitutes the practice of medicine and should be subject to peer review.
  https://policysearch.ama-assn.org/policyfinder/detail/expert?uri=%2FAMADoc%2FHOD.xml-0-1842.xml

- August 2019, distributed the model state legislation on expert witness testimony to chapters

- The Ethics Committee and the Medical-Legal Committee developed the following recommendations that will be presented to the Board in October 2019:

  - Finalize recommended steps for ACEP to pursue to ensure expert witnesses from other specialties who provide egregious testimony against emergency physicians are held accountable, other than the ACEP Ethics Review process, which can only sanction ACEP members. (Special request by the Board of Directors – January 2019)
    1. Confer with the AMA Section Council on Emergency Medicine the possibility of securing AMA support in addressing egregious cross-specialty expert witness testimony.
    2. Assign an objective to the Ethics Committee to develop new policy or revise the existing ACEP policy on expert witness testimony to explicitly oppose cross-specialty testimony for the standard of care. This would entail not only that other specialties should not testify against emergency physicians, but that emergency physicians should not testify against physicians in other specialties.
    3. Upon adoption of a new policy, distribute to other specialties with a request that they consider adopting similar policy.
    4. Continue to promote to chapters model state legislation on expert witness testimony that includes a requirement that experts practice in the same specialty as the defendant.

  - Discuss ways to promote awareness and adoption of ACEP's "Expert Witness Guidelines for the Specialty of Emergency Medicine" to reduce egregious testimony.
    1. Intensify communication to members through various channels to raise awareness of ACEP's expert witness guidelines and reaffirmation statement: *EM Today, ACEP Now*, website, and social media.
    2. Assign an objective to the Medical-Legal Committee to develop an information paper for members involved in lawsuits outlining the standards they should expect from expert witnesses, including that they follow ACEP guidelines and sign the reaffirmation statement. Disseminate the information paper to chapters and post on the ACEP website.
    3. Under the direction of the Medical-Legal Committee, redesign the Ethics/Legal section of the ACEP website to include a standalone page dedicated to tools and resources for physicians who are being sued. Provide clarity and detail for each resource. Identify gaps and develop additional resources as necessary. Promote the information to chapters and the membership. Add a link to the expert witness reaffirmation

from the “Expert Witness Guidelines for the Specialty of Emergency Medicine” policy statement. Add a “quick link” to Professional Liability or Medical-Legal or Expert Witness under Topics on the website.

- Discuss ways to enhance the egregious testimony review process and advance the effort to reduce egregious testimony.
  1. Assign an objective to the Medical-Legal Committee to review and revamp the Standard of Care Review Process. Identify and address barriers to member usage, including streamlining reporting and review processes to facilitate member submissions.
  2. Intensify communication to members through various channels to raise awareness of ACEP’s ethics complaint review process.

Expert Witness Testimony
Model State Legislation

I. Definitions

A. “Board certified physician” means for purposes of this section a physician licensed to practice medicine in this state that has met the requirements for certification by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine.
B. "Emergency medical condition” means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or the health of an unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.
C. "Emergency medical services" means services required for the diagnosis and treatment of an emergency medical condition.
D. “Freestanding emergency department” means a facility that provides emergency medical services as provided under the laws of this state and that is structurally separate and distinct from a hospital.

*DRAFTING NOTE: small states with limited access to expert witness availability might wish to delete or modify the “in this state” same state licensure requirement.

II. Qualifications for Expert Testimony

A. In any action for damages involving a claim of negligence against a physician providing emergency medical services in a general acute care hospital emergency department or in a freestanding emergency department, the court shall admit expert medical testimony only from board certified physicians licensed in this state who have had substantial professional experience within the last five years while assigned to provide emergency medical coverage in a general acute care hospital emergency department or in a freestanding emergency department.
B. For purposes of this section, “substantial professional experience” shall be determined by the custom and practice of the manner in which emergency medical coverage is provided in general acute care hospital emergency departments or freestanding emergency departments in the same or similar localities where the alleged negligence occurred.

III. Enforcement

A. Notwithstanding any other provision regarding the licensure of physicians, expert witness testimony provided under this section shall be considered the practice of medicine and is subject to sanctions and peer review processes established by the Medical Board.
B. The Medical Board shall adopt regulations establishing sanctions for physicians that provide testimony that fails to meet evidence-based standards.
C. The Medical Board shall establish a medical review process that utilizes an expert witness committee program to investigate complaints filed with the Board related to expert testimony provided under the requirements of this section.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Memorandum

To: 2019 Council

From: Dean Wilkerson, JD, MBA, FACEP
Executive Director and Council Secretary

Date: September 17, 2019

Subj: Resolution 16(18) No More Emergency Physician Suicides

The 2018 Council and the Board of Directors adopted Resolution 16(18) No More Emergency Physician Suicides:

> RESOLVED, That ACEP study the unique, specialty-specific factors leading to depression and suicide in emergency physicians; and be it further
>
> RESOLVED, That ACEP formulate an action plan to address contributory factors leading to depression and suicide unique to our specialty and provide a report of these findings to the 2019 Council.

The resolution was assigned to the Well-Being Committee to seek input from the Academic Affairs Committee (for the resident perspective) and the Wellness Section. The committee is working on the action plan and additional background information, including:

- Reviewing the ICPH 2017 qualitative paper of stories told by survivors of suicide.
- Considering distributing a quantitative survey (+/- space for participants to provide contact information for semi-structured interviews) to attendees of the *ACEP19* didactic session "Physician Do No Harm – A Comprehensive Look at Physician Suicide Workshop." This session will be held on Monday, October 28, 2019
- Developed content and resources for distribution during National Suicide Awareness week, September 8-14, 2019.

The ACEP website includes links to suicide prevention resources.

https://www.acep.org/how-we-serve/sections/wellness/suicide-prevention-awareness/

https://www.acep.org/life-as-a-physician/wellness/wellness/wellness-week-articles/physician-suicide/

https://www.acep.org/patient-care/smart-phrases/suicide-prevention/

HEADQUARTERS
Post Office Box 619911
Dallas, Texas 75261-9911

4950 W Royal Ln
Irving, TX 75063-2524

972-550-0911
800-798-1822
www.acep.org

BOARD OF DIRECTORS
Vidor E. Friedman, MD, FACEP
President
William P. Jaquis, MD, FACEP
President-Elect
Stephen H. Anderson, MD, FACEP
Chair of the Board
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Vice President
Mark S. Rosenberg, DO, MBA, FACEP
Secretary-Treasurer
Paul D. Kivela, MD, MBA, FACEP
Immediate Past President
James J. Augustine, MD, FACEP
L. Anthony Cirillo, MD, FACEP
John T. Finnell II, MD, MSc, FACEP
Alison J. Haddock, MD, FACEP
Christopher S. Kang, MD, FACEP
Kevin M. Klauer, DO, EJD, FACEP
Aisha T. Liferidge, MD, MPH, FACEP
Debra G. Perina, MD, FACEP
Gillian R. Schmitz, MD, FACEP

COUNCIL OFFICERS
John G. McManus, Jr, MD, MBA, FACEP
Speaker
Gary R. Katz, MD, MBA, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Dean Wilkerson, JD, MBA, CAE

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Town Hall Meeting
Friday, October 25, 2019
Hyatt Regency at Colorado Convention Center
Centennial Ballroom, 3rd Floor
12:45 pm – 1:45 pm

Growth of the ACEP Council

Moderator: Michael McCrea, MD, FACEP

Discussants: Paul Pomeroy, MD, FACEP
Arlo Weltge, MD, FACEP

Session Format: The Town Hall Meeting is open to everyone attending the Council meeting. Seating is open without restriction to the Council floor. Each discussant will represent their assigned position and respond to questions posed by the moderator and the participants. The audience is invited – *and expected* – to express uninhibited opinions and to ask challenging questions of the presenters.

Description: A lively discussion of the Growth of the ACEP Council Task Force Report (Attachment A) and five scenarios for consideration by the Council:

1. No changes to current councillor allocation method as delineated in the Bylaws:
   - one councillor per chapter and one additional councillor for every 100 members
   - one councillor each for AACEM, ACOEP, CORD, and SAEM
   - eight councillors for EMRA
   - one councillor for each chartered section (with at least 100 section dues-paying and complimentary candidate members)
2. Capping the maximum number of councillors at 35. Alternatively, the maximum number could be changed to some number less or more than 35. (CA currently has 33 councillors. This option allows for continued growth for 2 more years and does not remove the current number of councillors.)
3. Two councillors per chapter and additional councillors for each 200 members. This scenario would be a drastic change. Using the 2019 membership numbers, would result in a net reduction of 127 councillors (Attachment B). Alternatively, the number at which additional councillors are allocated could be changed.
4. One councillor per chapter with one additional councillor at 100 members and one additional councillor for each additional 200 members. This scenario is also a drastic change. Using 2019 membership numbers, would result in net reduction of 152 councillors (Attachment C). Alternatively, the number at which additional councillors are allocated could be changed.
5. Each chapter allocated two councillors and additional councillors based on their percentage of total ACEP members and removing section councillors. Draft Bylaws language is also provided for consideration (Attachment D). An explanation of the calculation for 418 councillors is provided as Attachment E. Alternatively, this number can be changed as recommended by Council.

Objective: Determine the will of the Council regarding the method of councillor allocation and whether a Bylaws amendment should be submitted to the 2020 Council.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: Council Steering Committee

From: Michael McCrea, MD, FACEP
Chair, Growth of the ACEP Council Task Force

Date: April 30, 2019

Subj: Growth of the ACEP Council Task Force Report

The 2018 Council and the Board of Directors adopted Amended Resolution 13(18) Growth of the ACEP Council:

> RESOLVED, That the Council direct the Council officers to appoint a task force of councillors to study the growth of the Council and determine whether a Bylaws amendment should be submitted to the 2019 Council addressing the size of the Council and the relative allocation of councillors.

Per the Bylaws, the composition of the Council currently includes:

- one councillor per chapter and one additional councillor for every 100 members
- one councillor each for ACOEP, AACEM, CORD, and SAEM
- eight councillors for EMRA
- one councillor for each chartered section (minimum 100 dues-paying and complimentary candidate members)

The resolution was submitted by the Steering Committee because of concerns that, at the current rate of growth, in the not too distant future, the size of the Council will exceed the available space and logistical support that is currently available at the hotel facilities, potentially forcing the Council meeting and ancillary events into a convention center facility that may not be convenient or conducive to the Council activities. Additionally, the human, technical, and financial resources needed to implement the Council meeting increases as the size of the Council grows. The Steering Committee discussed various options that could be considered for limiting the number of councillors, such as a maximum number per component body and changing the number of additional members required before an additional councillor is allocated. There was consensus that the Council should discuss the growth of the Council and determine whether such action should be studied and/or pursued.

Between 1999-2017, the Council has grown an average of 2.81% per year, which is an average of nine additional councillors per year. The total number of councillors allocated for 2019 is 433, an increase of 12 councillors, or 2.85%. The size of the Council continues to expand each year as the membership grows and the number of sections increase.

There was significant testimony in favor of the resolution with an amendment changing the word "limiting" in the original resolution to "addressing." It was acknowledged that the intent was to focus on the operational issues associated with the growth of the Council and the language should be amended to support a broader perspective. It was also mentioned that ACEP needs a logical plan to manage growth, including addressing the possible impacts that unfettered growth would have for the Council and College. It was acknowledged that a study was a reasonable next step.

HEADQUARTERS
Post Office Box 619911
Dallas, Texas 75261-9911

4950 W Royal Ln
Irving, TX 75063-2524

972-550-0911
800-798-1822
www.acep.org

BOARD OF DIRECTORS
Vidor E. Friedman, MD, FACEP
President
William P. Jaquis, MD, FACEP
President-Elect
Stephen H. Anderson, MD, FACEP
Chair of the Board
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Vice President
Mark S. Rosenberg, DO, MBA, FACEP
Secretary-Treasurer
Paul D. Kivela, MD, MBA, FACEP
Immediate Past President
James J. Augustine, MD, FACEP
L. Anthony Cirillo, MD, FACEP
John T. Finnell II, MD, MSc, FACEP
Alison J. Haddock, MD, FACEP
Christopher S. Kang, MD, FACEP
Kevin M. Klauer, DO, EJD, FACEP
Aisha T. Liferidge, MD, MPH, FACEP
Debra G. Perina, MD, FACEP
Gillian R. Schmitz, MD, FACEP

COUNCIL OFFICERS
John G. McManus, Jr, MD, MBA, FACEP
Speaker
Gary R. Katz, MD, MBA, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Dean Wilkerson, JD, MBA, CAE

The task force held four conference calls and various options were discussed:
1. no changes to current councillor allocation method as delineated in the Bylaws
2. cap the number of councillors (determine the maximum number and the formula to use)
3. determine a minimum number of councillors per component body
4. increase the number from 100 for additional councillors
5. limit alternate councillors to the same number as allocated councillors
6. change the formula for additional councillors

The task force agrees that participation in the Council is an important leadership experience, particularly for young physicians. The personal relationships and interactions enhance the leadership experience and cannot be attained through electronic communications only. The task force discussed the size of the Council in terms of efficiency and effectiveness and did not focus solely on the financial aspects (cost) of the annual meeting or the growth in the size of the Council.

The task force discussed the potential of capping the number of alternate councillors. The Bylaws do not specify that alternates cannot exceed the number of allocated councillors. It was noted that some chapters use the alternate councillor experience for leadership development purposes. Most component bodies do not have more alternates than councillors and some have difficulty in filling their councillor allocation. There was no consensus from the task force to submit Bylaws language to specify a 1:1 ratio for councillors and alternate councillors.

It was noted that the U.S. House of Representatives has a fixed number (435) of representatives despite any increases in population. There were concerns that a cap on the number of councillors could dilute the voice of smaller chapters.

The task force discussed section representation in the Council and whether they need a councillor every year, particularly if there are no resolutions that pertain specifically to a section's interests. Options discussed were rotating years that sections are represented in the Council, maintain representation and limit voting to resolutions that are pertinent to the section, limit voting privileges to 20 sections that have the most members, and removing councillor allocations for all sections. It was acknowledged that it would be difficult and controversial to remove representation and/or voting rights from sections.

The task force reviewed candidate members and how they affect the Council composition. All candidate members, including medical students, are included in the total membership numbers to determine councillor allocation. States with multiple medical schools are able to recruit more members, while some states have only one or no medical schools. It was noted that it could be viewed negatively, or disingenuous, to exclude certain members. There was no consensus to remove candidate members from the councillor allocation formula.

On the last conference call, the task force reviewed four scenarios:
1. Capping the maximum number of councillors at 35. CA currently has 33 councillors. This option allows for continued growth for 2 more years and does not remove the current number of councillors. Alternatively, the maximum number could be changed to some number less or more than 35.
2. Two councillors per chapter and additional councillors for each 200 members. This scenario would be a drastic change. Using the 2019 membership numbers, would result in a net reduction of 127 councillors. Alternatively, the number at which additional councillors are allocated could be changed.

3. One councillor per chapter with one additional councillor at 100 members and one additional councillor for each additional 200 members. This scenario is also a drastic change. Using 2019 membership numbers, would result in net reduction of 152 councillors. Alternatively, the number at which additional councillors are allocated could be changed.
4. Each chapter allocated two councillors and additional councillors based on their percentage of total ACEP members and removing section councillors. Subsequently, Dr. Pomeroy drafted Bylaws language for consideration. An explanation of the calculation for 418 councillors is also provided. Alternatively, this number can be changed as recommended by the Steering Committee.

The task force recommends that the growth of the Council be the focus of the Town Hall meeting with options for the Council to consider.

Task Force Members
Michael McCrea, MD, FACEP (chair)
Jim Antinori, MD, FACEP (UT)
Jennifer Casaletto, MD, FACEP (NC)
Marco Coppola, DO, FACEP (GS)
Scott Pasichow, MD (EMRA)
Charles Pattavina, MD, FACEP (ME)
Melissa Platt, MD, FACEP (KY)
Paul Pomeroy, MD, ,FACEP (MI)
Brad Walters, MD, FACEP (MI)
Arlo Weltge, MD, FACEP (TX)

COUNCILLOR ALLOCATION

Attachment B

Component Body	2018 Allocation	Membership as of 12/31/18	2019 Allocation	2020 Allocation	Plus/Minus from 2019
Alabama	3	320	4	3	-1
Alaska	1	101	2	2	
Arizona	8	745	8	5	-3
Arkansas	2	176	2	2	
California	30	3217	33	18	-15
Colorado	8	668	7	5	-2
Connecticut	6	504	6	4	-2
D.C.	4	284	3	3	
Delaware	2	178	2	2	
Florida	20	2050	21	12	-9
Georgia	9	825	9	6	-3
Government Services	15	1269	13	8	-5
Hawaii	2	173	2	2	
Idaho	2	167	2	2	
Illinois	13	1309	14	8	-6
Indiana	7	624	7	5	-2
Iowa	3	229	3	3	
Kansas	3	250	3	3	
Kentucky	4	342	4	3	-1
Louisiana	5	429	5	4	-1
Maine	3	226	3	3	
Maryland	8	661	7	5	-2
Massachusetts	10	945	10	6	-4
Michigan	20	1961	20	11	-9
Minnesota	7	704	8	5	-3
Mississsippi	2	225	3	3	
Missouri	6	603	7	5	-2
Montana	1	95	1	2	1
Nebraska	2	154	2	2	
Nevada	3	289	3	3	
New Hampshire	2	162	2	2	
New Jersey	9	926	10	6	-4
New Mexico	2	199	2	2	
New York	28	2872	29	16	-13
North Carolina	11	1009	11	7	-4
North Dakota	1	53	1	2	1
Ohio	15	1536	16	8	-8
Oklahoma	4	320	4	3	-1
Oregon	5	471	5	4	-1
Pennsylvania	17	1718	18	10	-8
Puerto Rico	2	138	2	2	
Rhode Island	3	226	3	3	
South Carolina	5	502	6	4	-2
South Dakota	1	72	1	2	1
Tennessee	5	452	5	4	-1
Texas	22	2140	22	12	-10
Utah	4	319	4	3	-1
Vermont	1	89	1	2	1
Virginia	10	902	10	6	-4
Washington	8	779	8	5	-3
West Virginia	3	226	3	3	
Wisconsin	6	508	6	4	-2
Wyoming	1	48	1	2	1
Chapter Totals	**374**	**35,390**	**384**	**257**	**-127**

Allocates 2 councillors to every chapter. Additional councillor added at 200, 400, 600, etc.

COUNCILLOR ALLOCATION

Attachment C

Component Body	2018 Allocation	Membership as of 12/31/18	2019 Allocation	2020 Allocation	Plus/Minus from 2019
Alabama	3	320	4	3	-1
Alaska	1	101	2	2	
Arizona	8	745	8	5	-3
Arkansas	2	176	2	2	
California	30	3217	33	17	-16
Colorado	8	668	7	4	-3
Connecticut	6	504	6	4	-2
D.C.	4	284	3	2	-1
Delaware	2	178	2	2	
Florida	20	2050	21	11	-10
Georgia	9	825	9	5	-4
Government Services	15	1269	13	7	-6
Hawaii	2	173	2	2	
Idaho	2	167	2	2	
Illinois	13	1309	14	8	-6
Indiana	7	624	7	4	-3
Iowa	3	229	3	2	-1
Kansas	3	250	3	2	-1
Kentucky	4	342	4	3	-1
Louisiana	5	429	5	3	-2
Maine	3	226	3	2	-1
Maryland	8	661	7	4	-3
Massachusetts	10	945	10	6	-4
Michigan	20	1961	20	11	-9
Minnesota	7	704	8	5	-3
Mississsippi	2	225	3	2	-1
Missouri	6	603	7	4	-3
Montana	1	95	1	1	
Nebraska	2	154	2	2	
Nevada	3	289	3	2	-1
New Hampshire	2	162	2	2	
New Jersey	9	926	10	6	-4
New Mexico	2	199	2	2	
New York	28	2872	29	15	-14
North Carolina	11	1009	11	6	-5
North Dakota	1	53	1	1	
Ohio	15	1536	16	9	-7
Oklahoma	4	320	4	3	-1
Oregon	5	471	5	3	-2
Pennsylvania	17	1718	18	10	-8
Puerto Rico	2	138	2	2	
Rhode Island	3	226	3	2	-1
South Carolina	5	502	6	4	-2
South Dakota	1	72	1	1	
Tennessee	5	452	5	3	-2
Texas	22	2140	22	12	-10
Utah	4	319	4	3	-1
Vermont	1	89	1	1	
Virginia	10	902	10	6	-4
Washington	8	779	8	5	-3
West Virginia	3	226	3	2	-1
Wisconsin	6	508	6	4	-2
Wyoming	1	48	1	1	
Chapter Totals	**374**	**35,390**	**384**	**232**	**-152**

Allocates one councillor per chapter. Additional councillor at 100 members. Additional councillor added at 300, 500, 700, etc.

Proposed Changes to the ACEP Bylaws Article VIII – Council

The Council is an assembly of members representing ACEP's chartered chapters, sections, the Emergency Medicine Residents' Association, 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 **or non-voting representatives** to terms not to exceed three years. Any limitation on consecutive terms are the prerogative of the sponsoring body. **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.** [The last 2 sentences moved from current Section 1 paragraph 2.]

Section 1 - Composition of the Council

A. The number of councillors of the College shall be specified as 418. 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.

B. Fixed allocations of councillors or non-voting representatives shall be as follows:

1. Each chartered chapter shall have ~~a minimum of one~~ **two** councillor**s** as representative of the members of each 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 allocation 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 chanters or sections of the College.~~

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. Each chartered section shall be entitled to one ~~councillor as~~ representative of all 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. **That representative shall have floor privileges but no voting privileges.**

8. Past Presidents, Past Speakers, and Past Chairs of the Board shall have floor privileges but no voting privileges unless credentialed as a councillor or alternate councillor by a sponsoring body.

C. Variable allocation of councillors for chapters:

Additional councillors for each chartered chapter shall be determined biennially based on the percentage of the chapter's members in relation to the total ACEP chapter membership (based on the membership rolls of the College on December 31 of the preceding year) times the number of non-fixed councillor seats. ~~However, a~~ **A** member holding membership simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one chapter. [Last sentence moved from current Section 1, paragraph 1.]

D. Miscellaneous

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.

CALCULATIONS FOR THE EVENTUAL FIXED MEMBERSHIP OF THE ACEP COUNCIL

1. Each chapter is allocated 2 representatives: 53 chapters X 2 = 106 members. Four other EM organizations with current Council membership each allocated one representative. Sections would no longer have representation on the Council. They are special interest groups with a singular purpose not relevant to College governance and also have the potential for continuing growth. EMRA would maintain their current number of 8. The total number of all of the above is 118.

2. Use 300 as an ideal total number for remaining councillor to reapportion to chapters based on membership. Thus, the fixed number of councillors would be 418.

3. The remainder (300) is divided proportionately among the chapters based on their share of the total College membership (excluding international members). Thus, if California has 10% of the College membership, they would receive 10% of the remainder. This would be done every 2 years with a recalculation of the percentage of the total US College membership to determine the number of councillors **(in addition to the baseline of 2 Councillors per chapter).** The calculation is done by dividing the number of chapter members by the **total US membership of ACEP** and multiplying the result by 300. This will, in most cases result in a fractional remainder which can then be rounded up or down.

   Example: 12/31/2018 membership for CA is 3,217 which is divided by 35,390 (total ACEP membership for the same date) = .0909. Multiplying by 300 = 27.27 and would be rounded down to 27. California would thus have 27 +2 Councillors = 29. That is a reduction of 4 councillors from their current allocation of 33 councillors for the 2019 meeting.

   For a small (fewer than 100 members) chapter the calculation would be (using S. Dakota as an example) 72 members divided by 35.390 = .002. Multiply by 304 = .6 and would be rounded up to 1 (one) in addition to their baseline of 2 representatives = 3 total councillors. For chapters that do not reach .50%, such as ND and WY, an additional councillor would not be allocated.

   This scheme represents a mix of the methods currently in use for the US Congress. Every chapter gets two representatives regardless of size (as in the US Senate) and additional representatives based on their percentage of the total College membership (the House of Representatives). The US House of Representatives has a fixed number of members and the allocation is changed every 10 years based on the US census numbers for each state.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Memorandum

To: 2019 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 28, 2019

Subj: Action on 2017 Resolutions

The 2017 Council considered 62 resolutions: 39 were adopted, 5 were not adopted, 5 were withdrawn, 11 were referred to the Board of Directors, and 2 were referred to the Council Steering Committee.

The attached report summarizes the actions taken on the 2017 resolutions adopted by the Council and those that were referred to the Board and to the Council Steering Committee.

HEADQUARTERS
Post Office Box 619911
Dallas, Texas 75261-9911

4950 W Royal Ln
Irving, TX 75063-2524

972-550-0911
800-798-1822
www.acep.org

BOARD OF DIRECTORS
Vidor E. Friedman, MD, FACEP
President
William P. Jaquis, MD, FACEP
President-Elect
Stephen H. Anderson, MD, FACEP
Chair of the Board
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Vice President
Mark S. Rosenberg, DO, MBA, FACEP
Secretary-Treasurer
Paul D. Kivela, MD, MBA, FACEP
Immediate Past President
James J. Augustine, MD, FACEP
L. Anthony Cirillo, MD, FACEP
John T. Finnell II, MD, MSc, FACEP
Alison J. Haddock, MD, FACEP
Christopher S. Kang, MD, FACEP
Kevin M. Klauer, DO, EJD, FACEP
Aisha T. Liferidge, MD, MPH, FACEP
Debra G. Perina, MD, FACEP
Gillian R. Schmitz, MD, FACEP

COUNCIL OFFICERS
John G. McManus, Jr, MD, MBA, FACEP
Speaker
Gary R. Katz, MD, MBA, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Dean Wilkerson, JD, MBA, CAE

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Action on 2017 Council Resolutions

Resolution 1 Commendation for James M. Cusick, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends James M. Cusick, MD, FACEP, as a practicing emergency physician rendering excellent care to the patients we serve, for his leadership in the College as Council Vice Speaker and Council Speaker over the past four years, and for his lifetime of service and dedication to the specialty of Emergency Medicine.

Action: A framed resolution was presented to Dr. Cusick.

Resolution 2 Commendation for Robert E. O'Connor, MD, MPH, FACEP

RESOLVED, That the American College of Emergency Physicians commends Robert E. O'Connor, MD, MPH, FACEP, for his service as an emergency physician, clinical investigator, educator, and leader in a life-long quest dedicated to the advancement of the specialty of Emergency Medicine.

Action: A framed resolution was presented to Dr. O'Connor.

Resolution 3 Commendation for Gordon B. Wheeler

RESOLVED, That the American College of Emergency Physicians commends Gordon B. Wheeler for his service as Associate Executive Director of Public Affairs.

Action: A framed resolution was presented to Mr. Wheeler.

Resolution 4 In Memory of Charles of R. Bauer, MD, FACEP

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

RESOLVED, That the American College of Emergency Physicians extends to the family of Charles R. Bauer MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of Texas and the United States.

Action: A framed resolution was prepared for Dr. Bauer's family.

Resolution 5 In Memory of Diane Kay Bollman

RESOLVED, That ACEP and the Michigan College of Emergency Physicians hereby acknowledges the many contributions made by Diane Kay Bollman as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That ACEP and the Michigan College of Emergency Physicians extend to the family of Diane Kay Bollman, her friends, and her colleagues, our condolences along with our profound gratitude for her tremendous service to the specialty of emergency medicine, Michigan emergency physicians, and patients, who will never fully know her impact, across the United States and likely beyond.

Action: A framed resolution was prepared for Ms. Bollman's family.

Resolution 6 In Memory of Aaron T. Daggy, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Aaron T. Daggy, MD, FACEP, as one of the leaders in pre-hospital medicine, EMS and fire, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Aaron T. Daggy, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of New York and the United States.

Action: A framed resolution was prepared for Dr. Daggy's family.

Resolution 7 In Memory of Geoffrey E. Renk, MD, PhD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Geoffrey Edmund Renk, MD, PhD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife, Lisa Flaggman, his family, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of South Carolina and the United States.

Action: A framed resolution was prepared for Dr. Renk's family.

Resolution 8 In Memory of Salvatore Silvestri, MD

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the contributions made by Sal Silvestri, MD, as a leader in emergency medicine and EMS; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Sal Silvestri, MD, our deepest sympathy, our great sense of sadness and loss, and our gratitude for having been able to learn so much from a kind, gentle, caring leader in our emergency medicine world.

Action: A framed resolution was prepared for Dr. Silvestri's family.

Resolution 9 In Memory of Robert Wears, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Robert Wears, MD, FACEP, as one of the leaders in emergency medicine and a true pioneer of the specialty; and be it further

RESOLVED, That national ACEP and the Florida College of Emergency Physicians extends to his wife, Dianne Wears, his children and grandchildren, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine.

Action: A framed resolution was prepared for Dr. Wears' family.

Resolution 10 Chapter Bylaws Conformance Standards – Housekeeping Change – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 2 – Chapter Bylaws, paragraph 1, be amended to read:

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

Action: The Bylaws were updated.

Resolution 12 Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment

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

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

Action: The Bylaws were updated.

Resolution 13 Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment

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

"Councillors, members of the Board of Directors, past presidents, ~~and~~ past speakers**, and past chairs of the Board** wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each

person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, **past chair,** etc.), and whether they are speaking "for" or "against" the motion;" and be it further

RESOLVED, That the "Nominations" section, paragraph one, of the Council Standing Rules be amended to read:

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

RESOLVED, That the "Past Presidents and Past Speakers Seating" section of the Council Standing Rules be amended to read:

"Past Presidents**,** ~~and~~ Past Speakers**, and Past Chairs of the Board** Seating"

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

Action: The Council Standing Rules were updated.

Resolution 18 ACEP Wellness Center Services

RESOLVED, That ACEP explore alternative funding opportunities (e.g., use of personal insurance reimbursement and/or sponsorship by third parties) to restore the traditional (and possibly expanded) services available at the Annual Conference Wellness Center; and be it further

RESOLVED, That ACEP explore ways to better promote available resources for the wellness center at the Annual Conference and in general throughout the year.

Action: Assigned to the Well-Being Committee, Corporate Development staff, and Member Communications & Marketing staff. Several changes were made for the 2018 Wellness Center and publicized on the ACEP website and other ACEP communications:

- Reinstated blood draws for 2018 and increased the fee to cover the cost.
- Reviewed the burnout survey and added online capability or iPad on site.
- Moved the pet therapy booth next to the wellness pod.
- Individual tasked with a hand clicker, scanner, wall-based scanned (how to incentivize attendees to scan their own badge on a wall) have giveaways of wellness t-shirt etc. to incentivize people to scan in be counted as a visitor.
- Wellness Center backdrop with hashtag to encourage group photos.
- Increase the speaker volume and add TED talk signage.
- Allow freelance drawing instead of an artist's mural.
- Additional signage to promote the Story Booth.
- Additional seating, background music, and charging stations.
- Promoted the Wellness Center on social media.
- Provided fun photo opportunities.
- Distributed buttons, t-shirts, and a water bottle with the wellness logo or #Wellness.
- Asked Wellness Champions to announce speakers.

In April 2019, the Board reviewed the results of the lab services offered in the Wellness Center during *ACEP18*. Only 44 individuals took advantage of the lab services. The direct costs for offering lab services totaled $26,320 resulting in a loss of $17,520 to provide lab services. The Board approved discontinuing offering lab services in the wellness center at *ACEP19* and focus on other year-round wellness programs led by the Well-Being Committee and the Wellness Section.

Resolution 22 Funding of Emergency Medicine Training (as amended)

RESOLVED, That ACEP work with the appropriate organizations to optimize GME funding for all formats of emergency medicine training.

Action: Assigned to the ACEP-SAEM GME Work Group and to the Public Affairs staff for federal advocacy initiatives. ACEP's Legislative & Regulatory Priorities include: "Work with Members of Congress to increase the overall number of federally funded GME slots.

Resolution 23 Information Sharing, Regular ACEP/Chapter Contact, and Regional State/Chapter Relationships (as amended)

RESOLVED, That ACEP work with state chapters to identify, develop, and implement processes that enhance the relationship, optimizing appropriate and timely information sharing; and be it further

RESOLVED, That individual Board members and an appropriate staff member participate in regular contact with state chapters and report back to the Council in 2018.

Action: Assigned to the National/Chapter Relations Committee and Chapter & State Relations staff. The following strategies were implemented:

1. Basecamp as a collaboration tool for sharing information and resources between chapter executives.
2. Regular communication from national to the chapters with information about Board meetings, communications from the president, and ACEP Leadership Updates.
3. Regular communication about national activities, programs, partnerships, opportunities, etc. to chapter executives and chapter presidents with encouragement to include relevant notifications in communications to chapter members as appropriate.
4. Continue holding bi-annual all-chapter audio conferences.
5. Continue providing funding for the Chapter Leader Visit Rotation Program (national ACEP provides funding for national leaders to visit up to 20 chapters each year).
6. Sent "Welcome" letters to newly installed/elected chapter presidents (with copy to the chapter executive director). The letter highlights the resources and support provided by national ACEP to chapters.
7. Held Chapter Leadership sessions at *LAC18* and *LAC19* for current or aspiring chapter leaders and provides strategies for effectiveness in their role. Topics included state advocacy, chapter finances, how to be an effective chapter leader, how to create an effective and diverse Board, and succession planning. Session leaders included national ACEP Board members and staff as well as chapter leaders and staff.
8. Launched the chapter engagED online community. Additional community groups can be created for many topic areas or groups, such as Chapter Officers (to discuss issues, share resources, ask questions) and Chapter Membership Chairs (to share best practices, challenges on membership recruitment, retention, and engagement).

These communication efforts are ongoing. Additionally, a Chapter Executives Leadership Summit was held at ACEP in November 2018 and another summit will be held in November 2019.

Resolution 25 Resolution Co-Sponsorship Memo

RESOLVED, That the Council Steering Committee develop and promote a standardized format for a "co-sponsorship memo" that can be distributed through the Council listserve or other platform so that councillors may collaborate and further refine resolutions prior to submission.

Action: The Council Steering Committee discussed the resolution at their February 2018, meeting. The new engagED community platform was launched. This platform provides the means for collaboration and information sharing. Resolution topics and resolutions in development can be shared in this forum and cosponsors can be identified. A resolution preparation checklist" was also created. A Council Forum session was held at *LAC19* that focused on resolution development.

Resolution 26 Study of Locums Physicians Representation (as amended)

RESOLVED, That the ACEP Board study the impact and potential membership benefit of a new chapter or section representing locums physicians and report back to the Council at the 2018 meeting.

Action: The Board approved formation of the section in February 2018. The Steering Committee discussed the resolution at their February 2018 meeting and interpreted that formation of the section met the intent of the resolution. Authors of the original resolution clarified that the intent of the resolution was to conduct a study because the section may not meet be sufficient to meet the needs of locums physicians. The Membership Committee was assigned an objective for 2018-19 to conduct the study.

The section met the minimum requirements for membership and was allocated a councillor for the 2019 Council meeting. The Membership Committee has completed the study and plans to submit their recommendation to the Board in October 2019.

Resolution 27 9-1-1 Number Access and Prearrival Instructions

RESOLVED, That ACEP create a policy statement supporting 9-1-1 number access to a Public Safety Answering Points for 100% of the U.S. population at next generation 9-1-1 level; and be it further

RESOLVED, That ACEP create and advocate for broad recognition of a policy statement supporting every Public Safety Answering Point or EMS dispatch point be able to give appropriate medical prearrival instruction for bystander aid, including CPR and hemorrhage control, and include EMS physician involvement in their creation, implementation, and quality improvement activities; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to inventory and summarize models for 9-1-1 and Public Safety Answering Point funding as a resource for areas in need of increased service levels; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to engage in development of model legislation incorporating enduring funding streams for 9-1-1 call centers/Public Safety Answering Points incorporating key elements including: bringing systems to at least the next generation 9-1-1 level, providing medically appropriate prearrival instructions, and incorporating EMS physician involvement in quality oversight, response profiles, and prearrival instructions.

Action: Assigned to the EMS Committee with input from the State Legislative/Regulatory Committee and Chapter & State Relations staff.

In December 2017, ACEP was invited by the National Highway Traffic Safety Administration (NHTSA) to participate as a stakeholder in the Next Generation 911 (NG911) project. The primary author of this resolution was recommended to serve as ACEP's representative on the project.

The Board approved the policy statement "Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch & Public Emergency Aid Training" in June 2018.

Resolution 28 Coverage for Patient Home Medication While Under Observation Status (as amended)

RESOLVED, That ACEP support the coverage of all administered medications for patients under observation status without having to apply for reimbursement; and be it further

RESOLVED, That ACEP support a goal that patient out-of-pocket expenses for observation be no greater than the cost to the patient for inpatient services.

Action: This resolution is a policy statement. Assigned to the Reimbursement Committee to review and determine if additional language was needed in the policy statement. Assigned to Public Affairs staff for federal advocacy initiatives.

The Board approved the policy statement "Coverage for Patient Home Medication While Under Observation Status" in June 2018. ACEP's Legislative & Regulatory Priorities include "Monitor CMS/OIG reports and public-understanding on use of observation units that are protocol driven."

Resolution 29 CPR Training (as amended)

RESOLVED, That ACEP draft model state legislation and assist chapters in advocating for CPR training in schools; and be it further

RESOLVED, That ACEP work with other stakeholder organizations to advocate for legislation to support CPR training in schools; and be it further

RESOLVED, That ACEP work with other stakeholder organizations to advocate for increased CPR training for laypersons.

Action: Assigned to the State Legislative/Regulatory Committee and Chapter & State Relations staff with input from the EMS Committee. The committee collaborated with the EMS Committee and obtained material from outside resources to develop a toolkit of resources that are available on the ACEP website.

ACEP has taken an active role in supporting and sponsoring layperson CPR training through partnering with the Texas College of Emergency Physicians for the Texas Two-Step Hands-Only CPR training. In 2017, 6,500 were trained across the state. During EMS Week 2017, ACEP partnered with the International Association of Fire Chiefs (IAFC) and American Medical Response (AMR) to sponsor the World CPR Challenge where more than 68,000 bystanders were trained nationwide.

In June 2018, the Board approved ACEP pursuing development of a program for laypersons to stop bleeding and render CPR. A business plan was developed and in June 2019, the Board approved the "Until Help Arrives" program. This program is designed for ACEP members to offer resources to their home communities. The campaign has broad appeal and presents an opportunity to partner with a variety of other healthcare provider groups on its training delivery. ACEP is also reaching out to other medical partners, emergency medicine organizations, the EMS community, and other medical associations to create partnerships for course delivery.

EMS Week 2019 featured the Stop the Bleed/CPR Challenge. In January 2019, ACEP was invited by the National Academies of Sciences, Engineering, and Medicine participate as a stakeholder in their development of a Stop the Bleed Action Collaborative. They plan to organize the action collaborative under the existing National Academies'

Forum on Medical and Public Health Preparedness for Disasters and Emergencies of which ACEP has been a member for several years.

Resolution 30 Demonstrating the Value of Emergency Medicine to Policy Makers and the Public (as amended)

RESOLVED, That a repository of public relations materials demonstrating the value of emergency medicine, including printed, video, and other information including emergency medicine economic research be assembled on the ACEP web site and such materials would be accessible to all members of ACEP who wish to reach specific target markets; and be it further

RESOLVED, That specific public relations materials regarding the value of emergency medicine be developed for legislators, which would include printed material and materials in various electronic formats; and be it further

RESOLVED, That the ACEP Board of Directors provide a report to the 2018 Council on the development and distribution of public relations materials demonstrating the value of emergency medicine to policy makers and the public.

Action: Assigned to the Public Relations Committee and Public Relations staff. The Board of Directors approved funding of up to $100,000 in October 2017 to fund a study on the value and cost effectiveness of emergency care.

A repository of materials was developed demonstrating the value of emergency medicine and is available on the ACEP website. Additionally:

- Developed a new fact sheet about the value of emergency medicine.
- As part of promoting ACEP's 50th anniversary, filmed and posted dozens of one-minute videos of members telling their stories about the value of emergency medicine.
- Developed and promoted a public opinion poll about the value of emergency medicine. The poll results found high trust and high satisfaction for emergency care.
- Continued to promote the Saving Millions campaign to policymakers and the general public Campaign tools included web and print advertising in Washington, DC, policymaker publications and included a link to ACEP's website www.SavingMillions.org.
- As insurance company giant Anthem Blue Cross Blue Shield began implementing a policy that devalued emergency care and denied coverage for patients, ACEP conducted its Fair Coverage campaign. Three viral videos were released in 2018 pushing back and promoting messages about the need to protect emergency care and emergency patients. ACEP promoted the videos through the news media and through Facebook ads, generating more than 600,000 views.
- Conducted a marketing campaign in 2018 to the general public to promote the value of emergency medicine and to promote emergency physicians as experts and as leaders in finding solutions to the opioid crisis. The campaign tools included a press release, a flyer, website and web banner ads on Facebook, generating results that exceeded estimates with a click-through rate of 3.15%, which is four times Facebook's benchmark for health care campaigns. The ad campaign generated more than 20,000 click-throughs to ACEP's Faircoverage.org site.
- Promoted ACEP's consumer website, which promotes the value of emergency medicine to the general public. ACEP refreshes and promotes content on this site, and at least monthly develops and distributes a press release about a consumer health and safety topic, such as flu, hot cars and carbon monoxide poisoning. These statements promote emergency physicians as medical experts and help create a white-hat environment in which ACEP can advocate.
- ACEP's external Twitter feed, @EmergencyDocs, has grown to more than 15,000 followers and includes policymakers and national health policy reporters. Relevant news stories that promote the value of emergency medicine (such as life- saving stories) are tweeted every day.

The Value of Emergency Medicine study was completed in August 2019. The results of the study are pending publication.

Resolution 31 Development and Study of Supervised Injection Facilities (as amended)

RESOLVED, That ACEP join their partner organization, the American Medical Association, in supporting the development and study of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision and endorse Supervised Injection Facilities for their feasibility, effectiveness, and legal aspects as a potential public health intervention in areas and communities heavily impacted by IV drug use.

Action: Assigned to the Public Health & Injury Prevention Committee. The committee developed the information paper "After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use." It was reviewed by the Board in June 2019 and will soon be available on the ACEP website.

Resolution 32 Essential Medicines (as amended)

RESOLVED, That ACEP collaborate with other medical organizations to speak with a unified voice to government agencies and elected officials as to the urgent need for resolution of the on-going crisis of lack of access to emergency drugs; and be it further

RESOLVED, That the ACEP Board of Directors make developing and promoting federal legislation to ensure adequate drug supply of critical medications a priority for ACEP's legislative agenda;

Action: Assigned to the Federal Government Affairs Committee to include in ACEP's legislative priorities and to Public Affairs staff to include in federal advocacy initiatives. This issue was included in the Legislative and Regulatory Priorities for the Second Session of the 115th Congress and for the First Session of the 116th Congress.

ACEP staff developed and led a successful effort to urge the FDA to convene a Drug Shortages Task Force to identify the root causes of drug shortages. ACEP drafted a bipartisan congressional sign-on letter, and secured lead Congressional sponsors for it of Reps. Brett Guthrie (R-KY) and Mike Doyle (D-PA) in the House, and Sens. Bill Cassidy (R-LA) and Chris Murphy (D-CT), that garnered 107 and 31 signatories, respectively. ACEP arranged to have members advocate for the letter as part of the 2018 Legislative & Advocacy Conference and through the 911 Network. These efforts were supplemented by ACEP staff and several other physician specialties affected by drug shortages that ACEP contacted to strengthen its efforts. The letter was successful in that just several weeks later, FDA Commissioner Gottlieb announced the creation of a new Drug Shortages Task Force to identify and address the root causes of drug shortages. His statement used verbatim language from the ACEP-led Congressional letter in describing the task force and its charge. ACEP staff maintained direct contact with the FDA's lead staff of the task force to ensure ACEP was represented in this effort. Details about ACEP's efforts are available on ACEP's website.

On September 20, 2018, ACEP President Paul Kivela, MD, MBA, FACEP, participated in a drug shortage summit hosted by the American Society of Anesthesiologists, the American Hospital Association, and the American Society of Health-System Pharmacies. The summit focused on the national security aspect of drug shortages and ways to improve the resilience of the nation's health care infrastructure. Many of the speakers were federal employees representing HHS, ASPR, FDA, CDC, and the Defense Logistics Agency (DLA) who engaged the attendees in discussions on how their programs could work better to facilitate patient care, improve transparency and communications, and more effectively utilize the supply chain capacity.

ACEP's Legislative & Regulatory Priorities for the First Session of the 116th Congress include: "Work with Congress to enact recommendations of the FDA Drug Shortage Task Force" and "Work with the FDA to reduce drug shortages and opioid abuse." On January 10, 2019, ACEP submitted an official response to the Drug Shortages Task Force that was convened by the FDA. On September 16, 2019**,** Reps. Brett Guthrie (R-KY) and Eliot Engel (D-NY), along with 92 other bi-partisan lawmakers, sent a letter to Acting FDA Commissioner Dr. Ned Sharpless urging the agency to prioritize the release of the interagency Drug Shortages Task Force report. ACEP and other interested parties have participated in ongoing discussions with the FDA, but we have been awaiting the release of the report.

Resolution 34 Generic Injectable Drug Shortages (as amended)

RESOLVED, That ACEP work with other medical specialties and patient advocacy groups to achieve consensus on the root cause of the shortage of generic injectable drugs and educate our members, the general medical community, and the public on this critical issue and how to solve it; and be it further

RESOLVED, That ACEP work with other medical specialties and patient advocacy groups to seek Congressional legislative repeal of the Group Purchasing Organizations' safe-harbor protection.

Action: Assigned to Public Affairs staff to pursue this initiative through appropriate channels, such as continued involvement with the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor, and business groups. NCHC is currently engaged in drug shortages/pricing initiatives, including the Campaign for Sustainable Rx Pricing.

ACEP met and consulted with other medical specialties and discussed potential strategy. Additionally, ACEP broached the topic of the potential role of GPOs with some congressional staff, though congressional staff and members of Congress are reticent to make any specific assertions or take action without clear, compelling, and evidence-based research to support any legislative efforts. Early in 2018, ACEP became aware that a member of Congress was looking into possible legislation to repeal the safe harbor repeal but ultimately declined to do so. ACEP worked with congressional appropriators in an attempt to secure language in H.R. 6470, the FY2019 Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, to insert the following language into the committee's report:

> "Shortages of critical drugs continue to impact the delivery of health care in the U.S. The committee requests that GAO build upon its existing examinations of the causes of drug shortages and specifically examine the role of group purchasing organizations (GPO) and their related safe harbor in shortages."

This language was shared with House Appropriations Committee Chairman Tom Cole (R-OK), but unfortunately

it was not included in the committee report accompanying the legislative text.

ACEP staff developed and led a successful effort to urge the FDA to convene a Drug Shortages Task Force to identify the root causes of drug shortages. ACEP drafted a bipartisan congressional sign-on letter, and secured lead Congressional sponsors for it of Reps. Brett Guthrie (R-KY) and Mike Doyle (D-PA) in the House, and Sens. Bill Cassidy (R-LA) and Chris Murphy (D-CT), that garnered 107 and 31 signatories, respectively. ACEP then arranged to have members advocate for the letter as part of the 2018 Legislative & Advocacy Conference and through the 911 Network; these efforts were supplemented both by ACEP staff as well as several other physician specialties affected by drug shortages that ACEP contacted to strengthen its efforts. The letter was successful in that just several weeks later, FDA Commissioner Gottlieb announced the creation of a new Drug Shortages Task Force to identify and address the root causes of drug shortages. His statement used verbatim language from the ACEP-led Congressional letter in describing the task force and its charge. ACEP staff maintained direct contact with the FDA's lead staff of the task force to ensure ACEP was represented in this effort. Details about ACEP's efforts are available on ACEP's website.

On September 20, 2018, ACEP President Paul Kivela, MD, MBA, FACEP, participated in a drug shortage summit hosted by the American Society of Anesthesiologists, the American Hospital Association, and the American Society of Health-System Pharmacies. The summit focused on the national security aspect of drug shortages and ways to improve the resilience of the nation's health care infrastructure. Many of the speakers were federal employees representing HHS, ASPR, FDA, CDC, and the Defense Logistics Agency (DLA) who engaged the attendees in discussions on how their programs could work better to facilitate patient care, improve transparency and communications, and more effectively utilize the supply chain capacity.

ACEP's Legislative & Regulatory Priorities for the First Session of the 116th Congress include: "Work with Congress to enact recommendations of the FDA Drug Shortage Task Force" and "Work with the FDA to reduce drug shortages and opioid abuse." On January 10, 2019, ACEP submitted an official response to the Drug Shortages Task Force that was convened by the FDA. On September 16, 2019**,** Reps. Brett Guthrie (R-KY) and Eliot Engel (D-NY), along with 92 other bi-partisan lawmakers, sent a letter to Acting FDA Commissioner Dr. Ned Sharpless urging the agency to prioritize the release of the interagency Drug Shortages Task Force report. ACEP and other interested parties have participated in ongoing discussions with the FDA, but we have been awaiting the release of the report.

A similar resolution was submitted to the 2018 Council. Resolution 27(18) Generic Injectable Drug Shortages called for ACEP to prepare a press release calling for repeal of the group purchasing organization (GPO) safe harbor. It was referred to the Board of Directors. The Board will consider further action on this resolution at their October 24, 2019 meeting.

Resolution 36 Maternity and Paternity Leave (as amended)

RESOLVED, That ACEP advocate for paid parental leave for emergency physicians; and be it further

RESOLVED, That ACEP develop an information paper on best practices regarding paid parental leave for emergency physicians; and be it further

RESOLVED, That ACEP's Board of Directors report their findings at the 2018 ACEP Council.

Action: Assigned to the Well-Being Committee. The committee revised the "Family Leave of Absence" policy statement to include the tenets of the resolution and it was approved by the Board in June 2019. The committee will continue to work on developing an information paper or Policy Resource & Education Paper (PREP) as an adjunct to the policy statement.

Resolution 39 ACEP Involvement in State Legislative Activities (as amended)

RESOLVED, That ACEP develop policy that addresses ACEP involvement in state level regulatory and legislative agendas, including direct lobbying efforts, by in coordination with the state chapter and consistent with ACEP policy; and be it further

RESOLVED, That ACEP present a policy that addresses ACEP involvement in state level regulatory and legislative activities for consideration and comment at the 2018 Council meeting.

Action: Assigned to the State Legislative/Regulatory Committee. In May 2018, the Board approved the following policy: "If a conflict arises between a chapter and national ACEP regarding a state legislative issue, national ACEP leadership must consider whether the disagreement is a matter of strategy or a matter of policy. on issues of strategy, national should defer to the chapter, given the chapter's better understanding of local political dynamics. on issues of policy, national should intervene if the issue is material to the specialty or counter to existing ACEP policy. First, national ACEP should take action to find a position that is in the best interests of the specialty and the chapter by reaching out to the chapter leadership. if no compromise can be reached, then national ACEP may choose to take a position that differs from the chapter position and would become the official position of the specialty."

Additionally, the Board approved the following actions: 1) increase frequency and improve quality of

communication between chapters and the national ACEP Board and staff on important state legislative issues to help prevent disagreements from arising; 2) direct the State Legislative/Regulatory Committee and the National/Chapter Relations Committee to investigate alternate methods to convene representatives from a chapter or multiple chapters for consultation between Council meetings in the case of important state legislative issues requiring further urgent discussion.

Resolution 40 Reimbursement for Emergency Services (as amended)

RESOLVED, That the policy of many third party payers of denying payment for Emergency Medical Services is in opposition to the prudent layperson definition of an emergency and federal EMTALA laws; and be it further

RESOLVED, That ACEP work with third party payers to ensure access to and subsequent reimbursement for emergency medical care as defined by the prudent layperson definition of an emergency regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care; and be it further

RESOLVED, That ACEP, in order to promote public health and patient safety, continue to uphold federal EMTALA laws by providing a medical screening examination and appropriate medical care to all patients who request emergency services and ACEP will advocate for subsequent reimbursement for such services; and be it further

RESOLVED, That ACEP continue to advocate for our patients to prevent any negative clinical or financial impact caused by the lack of reimbursement for emergency medical services; and be it further

RESOLVED, That ACEP partner with affected states and the American Medical Association to oppose this harmful policy and the denial of payment for emergency services.

Action: This resolution has been addressed through the work of the Reimbursement Committee, the ACEP/EDPMA Joint Task Force on Reimbursement Issues, and federal advocacy initiatives by ACEP's Public Affairs staff.

The AMA adopted a resolution in June 2017 that addresses these issues and also sent a letter to Anthem on June 29, 2017, asking Anthem to rescind the policy citing federal patient protections under PLP, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage. ACEP sent a letter to the president and CEO of Anthem on August 1, 2017, regarding their announcement to deny coverage for ED care in several states. ACEP, and many individual members, have participated in media interviews (Associated Press, Modern Healthcare, The New York Times, Time Magazine, ABC News, The Washington Post, and others) to bring national attention to Anthem's assault on the prudent layperson standard in the denial of payment for emergency services. In December 2017, ACEP issued press releases about Anthem's denial of payments in Ohio and New Hampshire. In late December 2017, ACEP met with representatives of Anthem to discuss their announced policy that ACEP contends are in violation of federal and state law protecting patients according to the prudent layperson standard. ACEP continues to meet with members of Congress to educate them about denial of payment for emergency services by several payers.

The AMA developed model legislation, "Patient Protections from Unanticipated Out-of-Network Care Act," that includes recommended language provided by ACEP. Physicians for Fair Coverage (PFC) has formally adopted a "skinny version" of the original AMA model with the network adequacy and assignment of benefits provisions removed. The majority of the remaining PFC model mirrors the AMA bill, except that the AMA bill would set out of network payment at the lesser of the physician's actual charge or the 80th percentile of an independent charge database, and the PFC model simply sets payment at the 80th percentile of a charge database. Arguments can be made in support of either approach, but the two model bills are largely complementary and attempt to drive a positive legislative resolution to this issue that is being fought out in state legislatures across the country. The PFC model bill was introduced in Kentucky and Oklahoma. The Board of Directors discussed the model legislation (AMA and PFC) at their February 7, 2018, meeting.

On January 16, 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). On July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court in an effort to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients. To read the lawsuit, click here.

Following five years of meetings and attempts by ACEP staff to obtain an explanation from the United States Center for Consumer Information and Insurance Oversight (CCIIO) regarding the methodology used in the 2010 Interim Final Rule governing payments of out-of-network emergency services, ACEP filed suit on May 12, 2016, against the Departments of Health & Human Services, Labor, and Treasury ("the Departments") challenging the Greatest-of-Three ("GOT") regulation. On August 31, 2017, the U.S. District Court for the District of Columbia (the "Court") partially granted ACEP's Motion for Summary Judgment and denied the Government's Cross Motion for Summary Judgment, finding that the Departments failed to seriously respond to comments and proposed alternatives submitted by ACEP and others regarding perceived problems with the GOT regulation. On April 30, 2018, the Departments published in the *Federal Register* the "Clarification of Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient

Protections under the Affordable Care Act". In this final regulation, the Departments declined to revise or rescind the rule, instead reaffirming it and rejecting ACEP's proposal to use an independent database to set payment rates. On May 19, 2018, the Board of Directors approved dismissing the lawsuit based upon recommendation of legal counsel, noting that the suit was successful in providing the College with valuable information, such as the "NORC Report," and sent a strong message that ACEP will fight on behalf of the rights of its members; however, the likelihood of ultimately prevailing was low and ACEP's legal resources could be best utilized in other arenas. Based upon a Joint Stipulation of Dismissal filed with the Court on May 23, 2018, Judge Colleen Kollar-Kotelly signed the Order dismissing the case. In June 2018, the Board discussed legislative and regulatory strategies and next steps for pursuing the Greatest-of-Three methodology governing payments for out-of-network emergency services with CCIIO.

ACEP continues to work on this issue and assist chapters in their efforts. State public policy grants have been provided to several chapters to support efforts on out-of-network/balance billing legislation.

Resolution 43 Expanding ACEP Policy on Workforce Diversity in Health Care Settings (as amended)

RESOLVED, That ACEP expand its policy statement "Workforce Diversity in Health Care Settings" to help identify and promote inclusion of qualified individuals with additional diverse characteristics (including racial and ethnic diversity, as per existing policy) and amend it to read:

The American College of Emergency Physicians believes that:

- Hospitals and emergency physicians should work together to promote staffing of hospitals and their emergency departments with qualified individuals of diverse race, ethnicity, sex (including gender, gender identity, sexual orientation, pregnancy, marital status), nationality, religion, age, ability or disability, and other characteristics that do not otherwise preclude an individual emergency physician from providing equitable, competent patient care; and
- Attaining diversity with well-qualified physicians in emergency medicine that reflects our multicultural society is a desirable goal.

Action: The "Workforce Diversity in Health Care Settings" policy statement was revised in November 2017.

Resolution 44 Guidelines for Opioid Prescribing in the ED

RESOLVED, That ACEP encourage electronic medical record providers to incorporate easy-to-use Prescription Monitoring Programs functionality into their products; and be it further

RESOLVED, That ACEP strongly discourage mandates for screening all emergency department patients for opioid use; and be it further

RESOLVED, That ACEP promote development of national guidelines to assist emergency physicians in their practice of prescribing opioids for acute pain.

Action: Assigned to the Emergency Medicine Practice Committee to review ACEP's current policy statements to determine if revisions are needed and review the current resources available to determine if additional resources are needed. ACEP's clinical policy "Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department" is currently under review by the Clinical Policies Committee.

The Emergency Medicine Practice Committee reviewed the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment." The policy statement supports ACEP chapter autonomy to establish and coordinate evidence-based pain management guidelines that promote access to appropriate pain control with physician clinical judgement. The EQUAL Network has also developed guidelines in association with the EQUAL Opioid Management focus area.

On June 12, 2018, two bills were passed in the House of Representatives that were championed by ACEP:

- The Alternatives to Opioids (ALTO) in the Emergency Department Act (H.R. 5197 – Pascrell/McKinley; S. 2516 – Booker/Capito)
  - Provides grants to help emergency departments and hospitals implement non-opioid, evidence-based pain management protocols, based on the successful and proven ALTO program developed at St. Joseph's in Paterson, New Jersey.
  - In New Jersey, the ALTO program at St. Joseph's Hospital saw opioid prescriptions drop by 82 percent over two years. These results were recently replicated at 10 hospitals in Colorado, where hospital systems noted a 36 percent drop in opioid prescriptions in the first six months of the program.
- The Preventing Overdoses While in Emergency Rooms (POWER) Act (H.R. 5176 – McKinley/Doyle; S. 2610 – Capito/Murphy)
  - Provides grants to establish policies and procedures for initiating Medication-Assisted Treatment (MAT) in the emergency department, and to develop best practices to provide a "warm handoff" to appropriate

community resources and providers to keep patients engaged in treatment. MAT is a proven medical treatment that can relieve withdrawal symptoms and psychological cravings of opioid use disorder.

- Studies show success for this model – after one month, 78 percent of patients remained in addiction treatment programs with ED-initiated MAT, compared to 37 percent when given only a simple referral in the ED to treatment in the community.

On June 13, 2019, the House of Representatives approved a bipartisan amendment to provide $10 million for the Alternatives to Opioids (ALTO) in the Emergency Department program that was authorized in the 2018 opioids bill, the *SUPPORT for Patients and Communities Act* (P.L. 115-271). The amendment was offered to the Fiscal Year 2020 Labor/Health and Human Services (L/HHS) appropriations bill. ACEP DC staff worked with Rep. Pascrell's office to ensure the amendment was made in order and passed successfully. ACEP submitted a letter of support from and Rep. Pascrell's office informed submitted ACEP's letter of support for the amendment into the Congressional Record.

The Pain Management & Addiction Medicine Section continues to develop resources on pain management and addiction medicine. ACEP has developed the E-QUAL Network Opioid Initiative, which includes toolkits, webinar series, podcasts, and other resources. The Emergency Medicine Practice Committee and the Public Health & Injury Prevention Committees have developed opioid resources that are available on the ACEP website.

Resolution 49 Participation in ED Information Exchange and Prescription Drug Monitoring Systems

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures to encourage and facilitate their participation in state prescription drug monitoring programs; and be it further

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures, to encourage and facilitate their participation, to the extent consistent with federal law, a system for real-time electronic exchange of patient information, including recent emergency department visits and hospital care plans for frequent users of emergency departments.

Action: Assigned to Public Affairs staff to work with the cited agencies and to Chapter & State Relations staff to support chapter advocacy efforts for adoption of EDIE programs and implementation of effective state prescription drug monitoring programs. ACEP's Legislative and Regulatory Priorities for the Second Session of the 115th Congress included "support funding for voluntary, interstate prescription drug monitoring programs" and "promote DoD, VA, and HIS prescription data sharing with state PDMPs."

An ACEP-developed provision that requires the Department of Defense to share controlled substance prescribing information of TRICARE beneficiaries with State Prescription Drug Monitoring Programs was successfully passed into law as part of H.R.5515, the John S. McCain National Defense Authorization Act for Fiscal Year 2019. ACEP staff worked closely with Representative Mike Turner (D-OH) to develop this legislative effort and ensure its inclusion in the defense authorization bill. A month later, Rep. Turner and Rep. Seth Moulton (MA) sent a letter to the Secretary of Defense advancing this initiative. The "Sharing Health Information to Ensure Lifesaving Drug Safety" (SHIELDS) Act (2018 H.R. 5591) was introduced in April 2018 and passed into law in August 2018. In January 2019, Virginia became the first state to systematically integrate its PDMP with those of the DoD Medical Treatment Facilities.

ACEP's Legislative & Regulatory Priorities for the First Session of the 116th Congress include:"support funding for voluntary, interstate prescription drug monitoring programs" and "seek Indian Health Service submission of prescription records to state PDMPs." Unfortunately, there is no central authority that can mandate HIS action. Each tribe/nation makes their own determination and most tribes have very little resources.

In May 2019, ACEP met with IHS to discuss ways to work together to improve care for Native Americans. A two-year non-financial memorandum of understanding (MOU) was developed in September 2019 between ACEP and IHS to explore opportunities for collaboration in the following areas: emergency physician recruitment and retention; emergency physician resident training at IHS sites; provider training/knowledge transfer in key topic areas to be identified; clinical guidelines and best practices in key topic areas to be identified; technical assistance in key topic areas to be identified; collaboration with ACEP on IHS-related or American Indians/Alaska Natives-related topics as well as fellowship projects or rotations; practice-based research to improve quality; and achieving health equity for the American Indian/Alaska Native population.

Resolution 51 Retirement or Interruption of Clinical Emergency Medicine Practice

RESOLVED, ACEP study and evaluate mechanisms to support practicing emergency physicians to help recognize potential physical and emotional limitations to clinical practice, to educate members about alternatives and opportunities for temporary interruption of active clinical practice to include mechanisms for reintegration back into clinical practice, and to support members considering career transitions including retirement; and be it further

RESOLVED, That ACEP actively engage in developing resources and communication of career transition

opportunities to members, including support for members who believe they are being restricted from practice for discriminatory reasons as outlined and regulated by established federal equal employment opportunity discrimination laws.

Action: Assigned to the Well-Being Committee to review ACEP's current resources, including the report developed by the ACEP/ABEM Aging Physician Task Force, and develop additional resources as needed, specifically to address interruption of clinical emergency medicine practice. Work is in progress and the committee will continue to work on this resolution in 2019-20.

Resolution 52 Support for Harm Reduction and Syringe Services Programs

RESOLVED, That ACEP endorse Syringe Services Programs for those who use injection drugs; and be it further

RESOLVED, That ACEP promote the access of Syringe Services Programs to people who inject drugs; and be it further

RESOLVED, That ACEP invest in educating its members on harm reduction techniques and the importance of Emergency Departments to partner with local Syringe Services Programs to advance the care of people who inject drugs.

Action: Assigned to the Public Health & Injury Prevention Committee. The committee developed the information paper "After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use." It was reviewed by the Board in June 2019 and will soon be available on the ACEP website.

Resolution 55 Workplace Violence (as amended)

RESOLVED, That ACEP move past policy creation and simple awareness campaigns with state and national regulatory agencies to develop actionable guidelines and measures (e.g., percent of events with legal outcome, paid post-trauma leave, use of de-escalation techniques, counseling provided), to ensure safety in the Emergency Department for patients and staff; and be it further

RESOLVED, That ACEP work with local, state, and federal bodies to provide for appropriate protections and enforcement of violations of Emergency Department patient and staff protections from violence in the workplace to provide safe and efficacious emergency care; and be it further

RESOLVED, That ACEP create model legislative and regulatory language that can be shared with state chapters and hospitals addressing workplace violence

Action: Assigned to the State Legislative/Regulatory Committee and to Public Affairs staff for federal advocacy initiatives. This issue was included in the Legislative and Regulatory Priorities for the Second Session of the 115th Congress and the First Session of the 116th Congress. The State Legislative/Regulatory Committee compiled information and resources to develop a toolkit for chapters.

In March 2019, ACEP sent a letter of support for H.R. 1309: The Workplace Violence Prevention for Health Care and Social Service Workers Act, asking Congress to consider how EDs are staffed to ensure the important provisions of this legislation are implemented appropriately. ACEP's letter requested additional clarity of the legislation's wording to ensure any new federal requirements do not create any unintentional burdens for entities that do not control the health care workplace.

Resources on workplace violence are available on the ACEP website.

ACEP has partnered with ENA to launch a joint campaign, "No Silence on ED Violence," to combat violence in the emergency department. The campaign will launch at ENA's annual conference in September 2019 and at *ACEP19*. Elements of the campaign will include a standalone website with resources to help members address the problem in their hospitals and advocate for change at the hospital, state, and federal level. Advocacy resources will include materials to support state legislative efforts for chapters and a social media campaign that will seek to engage our joint membership in sharing their stories to help highlight the extent of the problem. A public relations campaign will launch in November 2019 to increase public and media awareness of the issue.

Resolution 56 In Memory of Robert E. Blake, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Robert Eugene Blake, MD, FACEP, as one of the leaders in the medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Robert Eugene Blake, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of West Virginia and the United States.

Action: A framed resolution was prepared for Dr. Blake's family.

Resolution 57 In Memory of James H. Creel, Jr., MD, FACEP

RESOLVED, That the American College of Emergency Physicians fondly remembers and honors the many contributions of James H. Creel, Jr., MD, FACEP, one of the truest pioneers and leaders in emergency medicine and emergency medical services; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of James H. Creel, Jr., MD, FACEP, his colleagues, friends, residents, staff, and students our heartfelt condolences and gratitude for his tremendous accomplishments, devotion, and service to the specialty of emergency medicine, the State of Tennessee, and the United States of America.

Action: A framed resolution was prepared for Dr. Creel's family.

Resolution 58 In Memory of Paul Berger, Jr., MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions by Paul Berger, Jr, MD, FACEP, as one of the leaders in emergency medicine, EMS, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife Lanie Berger, his son Paul Berger, III, DO, his friends, and his colleagues our deepest sympathy and our gratitude for having been able to learn so much from a kind, gentle, caring leader in emergency medicine and gratitude for his tremendous service to the specialty of emergency medicine and the State of Iowa.

Action: A framed resolution was prepared for Dr. Berger's family.

Resolution 59 In Memory of William Wilkerson, Jr., MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by William Wilkerson, Jr, 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 William Wilkerson, Jr, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of Michigan and the United States.

Action: A framed resolution was prepared for Dr. Wilkerson's family.

Resolution 60 Commendation for First Responders to 2017 Hurricanes

RESOLVED, That ACEP recognizes all ACEP members, staff, and their families that were involved in the response to Hurricanes Harvey, Irma, and Maria and commends the significant commitment they have made to the ideals of emergency medicine and the service provided to the people in the States of Texas, Louisiana, and Florida and the territories of Puerto Rico and the United States Virgin Islands.

Action: The resolution was read aloud at the Council Awards Luncheon and all first responders were thanked for their service.

Resolution 61 In Memory of Michael G. Guttenberg, DO, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Michael G. Guttenberg, DO, FACEP, FACOEP, FAEMS, 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 Michael G. Guttenberg, DO, FACEP, FACOEP, FAEMS, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of New York State and the United States.

Action: A framed resolution was prepared for Dr. Guttenberg's family.

Referred Resolutions

Resolution 20 Campaign Financial Reform – to the Steering Committee (as amended)

RESOLVED, That the Council Steering Committee create expenditure limitations to ~~allow~~ ~~younger~~ **encourage**

additional members to consider candidacy for leadership positions without the concern for financial means.~~; and be it further~~

~~RESOLVED, That the Candidate Campaign Rules be amended by adding: "Candidates will not attend annual chapter meetings unless officially invited, on the meeting's agenda for a planned educational endeavor, and accept reimbursement of travel expenses in accordance with the chapter's policies.;" and be it further~~

~~RESOLVED, That the Council Steering Committee consider changes in the election process such as:~~

- ~~requiring candidates to disclose financial expenditures on their candidacy;~~
- ~~capping the monetary amount that can be used on all candidate-related expenditures, including travel, "coaches," videos, etc.;~~
- ~~prohibit ACEP residency and ACEP chapter visits for each candidate during the period of declared candidacy;~~
- ~~restricting publication of non-scholarly work in non-peer reviewed journals such as *ACEP Now* and other Emergency Medicine open subscription media; and~~
- ~~restricting social media "public service announcements."~~

Action: Assigned to the Council Steering Committee for discussion at the February 2018, meeting. The Steering Committee approved adding the following information to the Candidate Campaign Rules #13:

a. Once the Nominating Committee announces the slate of candidates for the upcoming Council meeting, except for their home chapter, President-Elect, Board of Directors, Speaker, and Vice Speaker candidates should not travel to ACEP state chapter meetings until the conclusion of the elections. This includes, but is not limited to, educational meetings, chapter Board of Directors meetings, or chapter fund-raisers other than for the candidate's home chapter. A written request for an exception may be made to the Council Speaker for candidates needing to visit state chapters for purposes other than campaigning such as legislative assistance, official ACEP business, or prior faculty commitments to education programs. In such instances, active campaigning is not permitted.
b. After nominations are announced by the Nominating Committee, President-Elect, Board of Directors, Speaker, and Vice Speaker candidates may utilize video or audio conferencing methods to communicate with ACEP state chapters. The use of this technology will be monitored by the Council Steering Committee to ensure fair use.

Resolution 21 Creation of an Electronic Council Forum – to the Steering Committee

RESOLVED, That the Board of Directors task the appropriate committees to create a year round forum for councillors to introduce, debate, and vote on resolutions; and be it further

RESOLVED, That the results of the votes in the electronic Council forum be nonbinding resolutions to offer ACEP leadership expeditious guidance on emergent issues; and be it further

RESOLVED, That the electronic Council forum product feature include a user experience that can be used during the annual Council meeting to receive and display proposed amendments in real time during discussion and voting.

Action: Assigned to the Council Steering Committee for discussion at the February 2018, meeting. There was consensus that the current process for conducting the annual Council meeting meets the Council's needs, but additional communication is needed to the Council about the features of the current Council meeting website that is used to distribute all Council meeting materials. The website has a "chat" feature to discuss resolutions in advance of the Council meeting, in addition to using the Council e-list (c-mail) for discussion purposes. The new engagED community platform was launched for the Council. This platform replaced the Council e-list and allows collaboration and information sharing.

Resolution 24 Maintenance of Competence for Practicing Emergency Physicians (as amended)

RESOLVED, That ACEP study the needs, and cost-effective evidence-based requirements that would support practicing board-certified emergency physicians to legitimately demonstrate their ongoing competence and skills necessary for their own practice settings and develop appropriate minimum guidelines for appropriate "maintenance of competence" with minimum and legitimate barriers to continued practice, and present a report for consideration at the 2018 Council meeting.

Action: The Board of Directors continued to dialogue and collaborate with ABEM and ABMS and monitor their activities on this issue. ABEM held a Summit on October 2-3, 2017, to discuss modifications and alternatives to the ConCert exam. Representatives from ACEP attended the Summit.

An article appeared in the July 2018 issue of *ACEP Now* highlighting ABEMS's efforts to create a new process for continuing certification by offering an alternative to the ConCert Examination. ABEM pursued several critical activities including redefining the purpose of continuing certification for ABEM and developing success metrics. All

diplomates were invited to complete a survey to confirm and further explore the information ABEM received during the calls with 25 state chapters in 2017. Additional surveys were used to refine the design. The ACEP Board of Directors continued to dialogue and collaborate with ABEM and ABMS and monitor their activities on this issue. ABEM updated the Council on their efforts at the 2017 and 2018 annual meetings. In December 2018, ABEM released the draft report *"Continuing Board Certification: Vision for the Future"* (developed by an independent commission) for comments by January 15, 2019. ACEP's comments were provided to ABEM. "MyEMCert" is now in development and physicians with certification ending in 2022 or later can maintain certification using MyEMCert.

Resolution 33 Immigrant and Non-Citizen Access to Care

RESOLVED, That ACEP develop model hospital policy language similar to the "Delivery of Care to Undocumented Persons" policy that physicians can access and present to their hospital systems for implementation; and be it further

RESOLVED, That ACEP make available online for public use, in multiple languages, a "Safe Zone" statement that notifies patients of an implemented hospital policy regarding immigrant and non-citizen access to care so that physicians can ensure the policy is communicated in the languages most relevant to their patient populations.

Action: Assigned to the Emergency Medicine Practice Committee to review and provide a recommendation to the Board regarding further action on the resolution.

The committee reviewed the current policy statement "Delivery of Care to Undocumented Persons." Revisions were recommended to include reference to safe zones. The revised policy statement was approved by the Board in June 2018.

Resolution 35 Legislation Requiring Hyperbaric Medicine Facility Accreditation for Federal Payment

RESOLVED, That ACEP work with the Undersea & Hyperbaric Medical Society and the ACEP Undersea & Hyperbaric Medicine Section to petition and advocate for CMS to require that hyperbaric facilities be accredited to receive federal payment.

Action: The Undersea & Hyperbaric Medicine Society drafted a letter to CMS outlining the rationale for requiring facility accreditation and requested ACEP to sign on to the letter. Leaders of ACEP's Undersea and Hyperbaric Medicine Section reviewed and revised the letter and recommended ACEP's endorsement. In February 2018, the Board of Directors approved sending the letter to CMS.

Resolution 38 Prescription Drug Pricing

RESOLVED, That ACEP create a policy statement that:

- recognizes the threat that unaffordable prices of medications used to treat acute and chronic diseases poses to our patients and the challenges this imposes upon the emergency medical system;
- supports the negotiation of drug prices under Medicare Part D;
- supports the importation of prescription drugs; and
- supports value-based pharmaceutical pricing; and be it further

RESOLVED, That ACEP work with the American Medical Association and other stakeholders to support regulatory and legislative efforts to address these issues.

Action: Assigned to the Emergency Medicine Practice Committee to review and provide a recommendation to the Board regarding further action on the resolution.

ACEP is a member of the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor, and business groups. NCHC is currently engaged in drug shortages/pricing initiatives, including the Campaign for Sustainable Rx Pricing.

ACEP's Legislative and Regulatory Priorities for the Second Session of the 115th Congress and the First Session of the 116th Congress included "promote access to affordable medications for emergency patients and monitor legislative activities regarding excessive drug pricing" and "monitor efforts by the Administration to reduce prescription drug prices.

The Emergency Medicine Practice Committee developed the policy statement "Prescription Drug Pricing" that was approved by the Board in June 2018.

Resolution 41 Reimbursement for Hepatitis C Virus Testing in the ED

RESOLVED, That ACEP encourage the adoption of state laws that allow for reimbursement for HCV testing in settings beyond the primary care setting including the Emergency Department.

Action: Assigned to the Reimbursement Committee to review and provide a recommendation to the Board regarding further action on the resolution.

A Reimbursement Committee member, who is a former regional medical director for CMS, investigated the options ACEP could use to encourage reimbursement by payers for Hepatitis C testing in the ED. In June 2019, based on the analysis, the committee recommended to the Board that ACEP petition the Office of Coverage and Analysis Group at CMS to reconsider the addition of the ED as the place of service for Hepatitis C testing as a next step since state Medicaid plans largely follow precedence set by CMS. CMS defines coverage for Hepatitis C testing for Medicare beneficiaries in Decision Memo CAG-00436N as taking place in primary care settings. State Medicaid programs have largely followed suit with similar criteria for reimbursement. Furthermore, testing would need to be billed to the facility, not the professional or physician. Emergency physicians would also be required to follow up with results and provide counseling, which exceeds their scope of practice. Thus, it is imperative to seek CMS clarification of the addition of POS 23 (Hospital ED) for Hepatitis C testing before seeking individual state Medicaid program approval. The Board approved the committee's recommendation and a letter was sent on August 13, 2019, to the Office of Coverage and Analysis Group at CMS.

Resolution 45 Group Contract Negotiation to End-of-Term Timeframes

RESOLVED, That ACEP establish a recommendation for appropriate timeframes for initiation of contract renewal discussions and contract negotiation deadlines to end of coverage; and be it further

RESOLVED, That ACEP ~~oppose~~ **not support** sudden, abrupt changes in contract groups without time for adequate transition and training.

Action: Assigned to the Contracts Transitions Task Force. The task force developed the information paper "Emergency Department Physician Group Staffing Contract Transition." It is available on ACEP website in addition to other contract resources.

Resolution 46 Impact of Climate Change on Patient Health and Implications for Emergency Physicians

RESOLVED, That ACEP research and develop a policy that addresses the impact of climate change on the health and well-being of our patients and utilize the policy statement to guide future research, training, advocacy preparedness, mitigation practices, and patient care.

Action: Assigned to the Public Health & Injury Prevention Committee to review and provide a recommendation to the Board regarding further action on the resolution. The Committee developed the policy statement " Impact of Climate Change on Public Health and Implications for Emergency Medicine" that was approved by the Board of Directors in June 2018.

Resolution 47 Improving Patient Safety Through Transparency in Medical Malpractice Settlements

RESOLVED, That ACEP develop a policy to reduce medical error and improve patient safety by assuring that pre-trial settlements of medical malpractice lawsuits against an emergency physician are anonymized and the learnings distributed to all members of the College and others as appropriate; actively support the elimination of non-disclosure clauses in pre-trial settlements of medical malpractice lawsuits; and report progress on this objective at the ACEP annual meeting in 2018.

Action: Assigned to the Medical-Legal Committee to review and provide a recommendation to the Board regarding further action on the resolution. In June 2018, the Board of Directors approved the committee's recommendation to not pursue the recommendations contained in the resolution at this time. An objective was assigned to the committee for 2018-19 to explore opportunities to use information from the National Practitioner Data Bank (NPDB) or related closed claims materials that might provide teachable information that may help reduce medical errors and improve patient safety.

In June 2019, the Board approved the committee's recommendation to not seek to access malpractice data from the NPDB directly but review any relevant aggregate data that may be made available. The committee believes that trying to access and review some portion of the 1.4 million records in the NPDB is a high-effort, low-yield exercise. As a membership association, the amount of access ACEP would have to the data would be limited by the NPDB and there would be no ability to drill into specifics of individual cases that would be needed to yield information that could be most helpful in identifying concerning trends. Much of the data that would be critical for this type of review and analysis, such as charts, are not included in the NPDB. It was also noted that much easier access to useful information on high-risk practices is already available through a plethora of published sources.

Resolution 48 Non-Fatal Strangulation

RESOLVED, That ACEP work with the Emergency Nurses Association, International Association of Forensic

Nurses, Training Institute on Strangulation Prevention, and other related organizations and stakeholders, to provide educational and clinical resources as well as in person and enduring educational programs for emergency providers on the evaluation, radiographic investigation, and management of non-fatal strangulation; and be it further

RESOLVED, That ACEP create a policy statement on the seriousness of non-fatal strangulation and develop a clinical practice guideline for the emergency department evaluation, treatment, and management of non-fatal strangulation.

Action: Assigned to the Clinical Policies Committee to review and provide a recommendation to the Board regarding further action on this resolution. The committee conducted an initial literature review and concluded there is not enough evidence to develop a clinical policy on the topic. In September 2018, the Board approved the committee's recommendation to take no further action to develop a clinical policy or policy statement and to disseminate existing educational materials on this topic.

Resolution 50 Promoting Clinical Effectiveness in Emergency Medicine

RESOLVED, That ACEP create a Clinical Effectiveness Committee that is responsible for identifying, assessing, and promoting evidence-based, cost-effective emergency medicine practices.

Action: This resolution is addressed through ACEP's clinical policies process and E-QUAL Network.

Clinical policies are created by an expert panel that reviews and grades the literature and answer specific question regarding preferred practice guidelines. These reviews may cover effectiveness, but rarely consider cost as a variable.

Though not a formal cost effectiveness program, the Emergency Quality Network (E-QUAL) offers analysis and recommendations for cost effective treatment. E-QUAL offers learning collaboratives in four main areas: sepsis, avoidable imaging (low back pain, minor head injury, pulmonary embolism, and renal colic), low risk chest pain, and opioid management. The network offers a toolkit with best practices and sample guidelines, as well as access to benchmarking data. It provides free CME and meets the CMS Improvement Activity requirements of the CMS Quality Payment Program (MIPS). Any ACEP member may join the network at no cost.

Resolution 62 Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States (as amended)

RESOLVED, That ACEP ~~lobby Congress to give~~ **advocate giving** CMS the authority to recognize independent Freestanding Emergency Centers as Medicare Certifiable locations of acute unscheduled healthcare in the United States in Federally Declared Disaster areas.

~~RESOLVED, That ACEP lobby Congress to give CMS the authority to create Critical Access Emergency Center Designation where Critical Access Hospitals no longer exist due to catastrophic destruction from natural disasters or where Critical Access Hospitals cannot be feasibly maintained leaving areas of the Country without access to Emergency Medical care.~~

Action: Assigned to the Federal Government Affairs Committee to review and provide a recommendation regarding further action on this resolution.

The Board of Directors discussed this resolution at their December 2017 retreat. On December 14, 2017, ACEP sent a letter to the Chairman of the Commerce, Justice, and Science Subcommittee of the House Committee on Appropriations requesting support for the disaster supplemental appropriations bill to ensure freestanding emergency care facilities and their emergency physicians are eligible for any federal assistance appropriated to offset the ongoing losses associated with uncompensated care provided to Medicare beneficiaries affected by Hurricane Harvey. The letter provided specific language that could be inserted in the bill.

ACEP's Legislative & Regulatory Priorities for the Second Session of the 115th Congress and the First Session of the 116th Congress included:

- monitor legislative actions regarding oversight, licensing, and reimbursement for independent freestanding emergency centers;
- acknowledge the role of freestanding emergency centers and other health care delivery models as crucial to encourage coverage innovation;
- enact legislation allowing critical access hospitals to convert to rural emergency hospitals by eliminating inpatient services.

In August 2018, ACEP supported the Emergency Care Improvement Act that allows for independent freestanding EDs that meet criteria to bill Medicare for a certain amount of facility-side reimbursement, depending on geography and acuity. The legislation contained specific language to protect professional-side reimbursement by Medicare at full physician fee schedule amounts at all acuity levels and to bring the facilities under federal EMTALA requirements.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Memorandum

To: 2019 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 27, 2019

Subj: Action on 2016 Resolutions

The 2016 Council considered 31 resolutions: 24 were adopted, 2 were not adopted, and 5 were referred to the Board of Directors.

The attached report summarizes the actions taken on the 2016 resolutions adopted by the Council and those that were referred to the Board.

HEADQUARTERS
Post Office Box 619911
Dallas, Texas 75261-9911

4950 W Royal Ln
Irving, TX 75063-2524

972-550-0911
800-798-1822
www.acep.org

BOARD OF DIRECTORS
Vidor E. Friedman, MD, FACEP
President
William P. Jaquis, MD, FACEP
President-Elect
Stephen H. Anderson, MD, FACEP
Chair of the Board
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Vice President
Mark S. Rosenberg, DO, MBA, FACEP
Secretary-Treasurer
Paul D. Kivela, MD, MBA, FACEP
Immediate Past President
James J. Augustine, MD, FACEP
L. Anthony Cirillo, MD, FACEP
John T. Finnell II, MD, MSc, FACEP
Alison J. Haddock, MD, FACEP
Christopher S. Kang, MD, FACEP
Kevin M. Klauer, DO, EJD, FACEP
Aisha T. Liferidge, MD, MPH, FACEP
Debra G. Perina, MD, FACEP
Gillian R. Schmitz, MD, FACEP

COUNCIL OFFICERS
John G. McManus, Jr, MD, MBA, FACEP
Speaker
Gary R. Katz, MD, MBA, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Dean Wilkerson, JD, MBA, CAE

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Action on 2016 Council Resolutions

Resolution 1 Commendation for Michael J. Gerardi, MD, FACEP

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

Action: A framed resolution was presented to Dr. Gerardi.

Resolution 2 In Memory of Kenneth L. DeHart, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Kenneth L. DeHart, MD, FACEP, as one of the leaders in Emergency Medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Kenneth L. DeHart, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of South Carolina and the United States.

Action: A framed resolution was prepared for Dr. DeHart's family.

Resolution 4 Legacy Fellows – Housekeeping Change – Bylaws Amendment

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

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

Action: The Bylaws were updated.

Resolution 6 Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians (as amended)

RESOLVED, That the ACEP Board of Directors create a task force to study issues specific to Senior/Late Career Emergency Physicians. The task force shall make recommendations regarding identified issues to the Board, which shall deliver an update on this matter to the 2017 ACEP Council.

Action: The American Board of Emergency Medicine conducted a substantial review of cognitive skill and physician age and used data from their ConCert exam. An ACEP/ABEM Task Force on the Aging Physician was appointed and their final report was accepted by the ACEP Board of Directors at their October 26, 2017 meeting.

Resolution 7 Diversity in Emergency Medicine Leadership (as amended)

RESOLVED, That the ACEP Board of Directors work in a coordinated effort with the component bodies of the Council to develop strategies to increase diversity within the Council and its leadership and report back to the Council on effective means of implementation.

Action: The resolution was addressed through the work of the Diversity & Inclusion Task Force, the Leadership Development Advisory Group (LDAG), the Leadership Diversity Task Force (LDTF), and the National/Chapter Relations Committee. The majority of ACEP's 26 committees were assigned objectives in the 2016-17 committee year to address diversity and inclusion. In January 2018, the Council Steering Committee approved changes to the Candidate Campaign Rules recommended by the LDTF and in May 2018 agreed to cosponsor two resolutions for the 2018 Council: 1) Codifying the LDAG in the Council Standing Rules, and 2) Nominating Committee Revision to Promote Diversity. The Board of Directors also agreed to cosponsor the resolutions. In May 2018, the Board of Directors approved two recommendations from the LDTF: 1) collecting demographic data, including the proportion

of underrepresented populations within ACEP's overall membership and leadership (including the Board of Directors, Council, sections, and committees) and including, but not limited to, domains such as gender, race, ethnicity, sexual orientation, and age; and 2) reviewing diversity data every three years and presenting the findings to the ACEP Council to determine whether efforts have been effective in promoting increased diversity within ACEP leadership and to inform future initiatives to increase diversity. The Board of Directors accepted the final report from the Diversity & Inclusion Task Force in September 2018 and the final report of the Leadership Diversity Task Force in January 2019. The Diversity, Inclusion, & Health Equity Section continues to work on the strategies developed by the Diversity & Inclusion Task Force.

Resolution 9 Accreditation Standards for Freestanding Emergency Centers

RESOLVED, That ACEP explore the possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers; and be it further

RESOLVED, That ACEP explore the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where they are allowed by state law.

Action: A task force was appointed with representation from the Freestanding Emergency Centers Section. A report with the following recommendations was provided to the Board in May 2018: 1) Develop an obtainable standard for FECs aspiring to achieve ACEP Accreditation. 2) Establish protocols for FECs obtaining ACEP Accreditation related to staffing, laboratory and imaging services, documentation, quality improvement (QI), billing practicing, EMS integration, public education, signage, and ethics. 3) Establish a national set of standards for FECs that could be referred to as a unified national resource for legislators, insurers, and physicians. 4) Create standards for ACEP Accreditation that will be beneficial to patients, emergency physicians, and ACEP. The Board accepted the task force report for information. The Board requested additional information about The Joint Commission's accreditation of FECs. At their September 28, 2018, meeting the Board directed the task force to explore models and develop a business plan. In April 2019, the Board approved partnering with the Center of Improvement in Healthcare Quality (CIHQ) to provide accreditation services for FECs. The contracts have been signed and the application process for FEC accreditation will begin soon.

Resolution 11 CMS Recognition of Independently Licensed Freestanding Emergency Centers

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

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

Action: Assigned the first resolved to Public Affairs staff to include in advocacy and regulatory initiatives. Assigned the second resolved to the AMA Section Council on Emergency Medicine.

ACEP staff discussed this issue with MedPAC's Executive Director and with the director of CMS' outpatient payment program. Both individuals reiterated the methods CMS uses to collect cost data as the basis for adjusting Medicare reimbursements. This same approach was used several years ago, which resulted in Type A and Type B emergency department designations based on 24/7 emergency department versus less than 24/7 availability for reductions in the "technical" (facility payments in the Outpatient Prospective Payment System) for Type B facilities.

In October 2017, the AMA Section Council on Emergency Medicine recommended to the Board of Directors that no further action be taken on the resolution at this time. The Board did not adopt the recommendation and discussed the resolution at their December 2017 retreat. On December 14, 2017, ACEP sent a letter to the Chairman of the Commerce, Justice, and Science Subcomittee of the House Committee on Appropriations requesting support for the disaster supplemental appropriations bill to ensure freestanding emergency care facilities and their emergency physicians are eligible for any federal assistance appropriated to offset the ongoing losses associated with uncompensated care provided to Medicare beneficiaries affected by Hurricane Harvey. The letter provided specific language that could be inserted in the bill.

ACEP's Legislative & Regulatory Priorities for the Second Session of the 115th Congress included:

- monitor legislative actions regarding oversight, licensing, and reimbursement for independent freestanding emergency centers;
- acknowledge the role of freestanding emergency centers and other health care delivery models as crucial to encourage coverage innovation;
- enact legislation allowing critical access hospitals to convert to rural emergency hospitals by eliminating inpatient services.

ACEP's Legislative & Regulatory Priorities for the First Session of the 116th Congress also included these initiatives.

Resolution 13 ED Boarding and Overcrowding is a Public Health Emergency (as amended)

RESOLVED, That ACEP request that the Secretary of the Department of Health and Human Services (HHS) under section 319 of the Public Health Service (PHS) Act determines that emergency department boarding and hallway care is an immediate threat to the public health and public safety; and be it further

RESOLVED, That ACEP work with the United States Department of Health and Human Services, the United States Public Health Service, The Joint Commission, and other appropriate stakeholders to determine the next action steps to be taken to reduce emergency department crowding and boarding with a report back to the ACEP Council at the Council's next scheduled meeting; and be it further

RESOLVED, That ACEP publicly promote the following as sustainable solutions to hospital crowding which have the highest impact on patient safety, hospital capacity, ICU availability, and costs:

1. Smoothing of elective admissions as a mechanism for sustained improvement in hospital capacity.
2. Early discharge strategies (e.g., 11:00 am discharges, scheduled discharges, staggered discharges) as a mechanism for sustained improvement in hospital capacity.
3. Enhanced weekend discharges as a mechanism for sustained improvement in hospital capacity.
4. The requirement for a genuine institutional solution to boarding when there is no hospital capacity, which must include both providing additional staff as needed AND redistributing the majority of ED boarders to other areas of the hospital.
5. The concept of a true 24/7 hospital.

Action: Assigned first resolved to Public Affairs staff to include in advocacy initiatives and the third resolved to the Public Relations Committee to develop messaging.

ACEP continues to work with HHS and the appropriate committees of jurisdiction to identify emergency department boarding solutions, which include a variety of options. This issue was addressed specifically in comment letters responding to the 2018 proposed Medicare Physician Fee Schedule and the 2018 proposed Outpatient Prospective Payment System rules. ACEP met again with The Joint Commission in June 2017 and with other stakeholders to address and eliminate boarding in the ED.

Regarding the second resolved, in June 2016, the Board reviewed the updated information paper, "Emergency Department Crowding High-Impact Solutions" The Emergency Medicine Practice Committee and representatives from the Emergency Nurses Association, the Society of Emergency Medicine Physician Assistants, and the American College of Osteopathic Emergency Physicians collaborated on the revisions. ACEP has continued to hold meetings with The Joint Commission and other organizations about boarding.

The Public Relations Committee updated ACEP's crowding and boarding messaging to include the solutions proposed in the resolution. Boarding solutions were promoted to news media organizations, including WLOS-TV in Ashville, NC, which received ACEP's journalism award, an Emmy, and an Edward R. Murrow award.

ACEP sponsored the first Hospital Flow Conference in Boston, MA in May 2017.The conference focused on improving hospital efficiency, capacity, and flow and provided participants with the knowledge and tools needed to eliminate ED boarding, improve hospital capacity, enhance patient safety, shorten length of stay, and improve patient and staff satisfaction. The processes discussed do not add cost or staff, are associated with significant and sometimes dramatic savings to the institution and focus on a small number of practically proven key processes that can dramatically improve overall hospital capacity. The conference provided an introduction to these processes, followed by workshops to discuss the practical details, both procedural and political, in implementing institutional change. The faculty included individuals who have had firsthand experience in implementing these processes at their own institutions. A second Hospital Flow Conference was held July 25, 2018 and was cosponsored by the American Hospital Association. Crowding and boarding resources are available on ACEP's web site.

Resolution 14 Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs (as amended)

RESOLVED, That the ACEP promote the development and application of throughput quality data measures and dashboard reporting for behavioral health patients in EDs; and be it further

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

Action: Assigned to the Quality & Patient Safety Committee. In June 2017, the Board approved the committee's recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in Emergency Departments. The Clinical Emergency Department Registry (CEDR) currently has dashboard functionality and the ED throughput measures are included in the registry and reportable to CMS for the Quality Payment Program (QPP). CMS currently collects data on CMS OP-18c measure for arrival to ED departure time for psychiatric and mental health patients and CMS ED-2c measure for admit decision to ED departure time for psychiatric and mental health patients. The Quality Improvement & Patient Safety (QIPS) Section worked on an ACEP-funded grant "Best Practices for Reducing Behavioral Health Patient Length of Stay in the Emergency Department White Paper." The paper addresses issues pertinent to the length of stay of behavioral health patients in the ED and describe best practices to reduce length of stay. The toolkit is still in development. A literature review has been conducted, references compiled, and the writing phase is underway.

Resolution 15 Enactment of Narrow Networks Requirements (as amended)

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

RESOLVED, That ACEP dedicate resources and support to ensure any proposed legislation regarding narrow networks protects fair payment for emergency medical care.

Action: Assigned to Public Affairs staff to discuss with ACEP's health policy consultants and to Chapter & State Relations staff for recommendations.

Two bills were introduced in Congress, the "End Surprise Billing Act" (H.R. 817/S. 284), which would limit how much an out-of-network hospital or provider could be reimbursed for their services to the in-network or participating provider rate and prohibit balance billing. ACEP opposed these bills.

The "Patient Freedom Act" (S. 191), was also introduced. It sought to limit reimbursement for emergency medical services for individuals with a Health Savings Account to the "cash price" for these services or 85% of the usual, customary, and reasonable (UCR) charge. ACEP worked to modify the language to the 85th percentile (not percent) of UCR.

In June 2017, the ACEP Board of Directors approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider. The model legislation was shared with chapters and is important for state legislatures that are considering out-of-network and balance billing legislation and look to emergency medicine for guidance.

The Public Relations Committee developed a "Fair Coverage" campaign about out-of-network issues, which counters health insurance industry statements about "surprise billing." The campaign focuses on coverage for emergency patients, not payment for physicians. Committee members participated in a "letters to the editor campaign" promoting ACEP's key fair coverage messages and participated as cast members of ACEP's parody Cigna video. The video served to promote ACEP's fair coverage campaign messages and generated more than 300,000 views on Facebook and YouTube and resulted in a meeting with Cigna. The messaging was tested with focus groups consisting of policymaker audiences.

Network adequacy and fair payment for out of network services was a constant emphasis of state advocacy in 2016-17. State legislation related to network adequacy was included in the legislative tracking reports provided to chapters. Staff also participated in meetings and communications with other hospital based specialties about proposals regarding network adequacy and the sufficiency of efforts by regulators to enforce existing laws.

The AMA adopted a resolution in June 2017 that addresses these issues and sent a letter to Anthem on June 29, 2017, asking Anthem to rescind the policy citing federal patient protections under PLP, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage. ACEP sent a letter to the president and CEO of Anthem on August 1, 2017, regarding their announcement to deny coverage for ED care in several states. ACEP, and many individual members, have participated in media interviews (Associated Press, Modern Healthcare, The New York Times, Time Magazine, ABC News, The Washington Post, and others) to bring national attention to Anthem's assault on the prudent layperson standard in the denial of payment for emergency services. In December 2017, ACEP issued press releases about Anthem's denial of payments in Ohio and New Hampshire. In late December 2017, ACEP met with representatives of Anthem to discuss their announced policy that ACEP contends are in violation of federal and state law protecting patients according to the prudent layperson standard. ACEP continues to meet with members of Congress to educate them about denial of payment for emergency services by several payers.

The AMA developed model legislation, "Patient Protections from Unanticipated Out-of-Network Care Act," that includes recommended language provided by ACEP. Physicians for Fair Coverage (PFC) formally adopted a "skinny version" of the original AMA model with the network adequacy and assignment of benefits provisions

removed. The majority of the remaining PFC model mirrors the AMA bill, except that the AMA bill would set out of network payment at the lesser of the physician's actual charge or the 80th percentile of an independent charge database, and the PFC model simply sets payment at the 80th percentile of a charge database. Arguments can be made in support of either approach, but the two model bills are largely complementary and attempt to drive a positive legislative resolution to this issue that is being fought out in state legislatures across the country. The PFC model bill was introduced in Kentucky and Oklahoma. The Board of Directors will discuss the model legislation (AMA and PFC) at their February 7, 2018, meeting.

On January 16, 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). On July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court in an effort to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients. To read the lawsuit, click here. The lawsuit is still pending.

Following five years of meetings and attempts by ACEP staff to obtain an explanation from the United States Center for Consumer Information and Insurance Oversight (CCIIO) regarding the methodology used in the 2010 Interim Final Rule governing payments of out-of-network emergency services, ACEP filed suit on May 12, 2016, against the Departments of Health & Human Services, Labor, and Treasury ("the Departments") challenging the Greatest-of-Three ("GOT") regulation. On August 31, 2017, the U.S. District Court for the District of Columbia (the "Court") partially granted ACEP's Motion for Summary Judgment and denied the Government's Cross Motion for Summary Judgment, finding that the Departments failed to seriously respond to comments and proposed alternatives submitted by ACEP and others regarding perceived problems with the GOT regulation. On April 30, 2018, the Departments published in the *Federal Register* the "Clarification of Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act". In this final regulation, the Departments declined to revise or rescind the rule, instead reaffirming it and rejecting ACEP's proposal to use an independent database to set payment rates. On May 19, 2018, the Board of Directors approved dismissing the lawsuit based upon recommendation of legal counsel, noting that the suit was successful in providing the College with valuable information, such as the "NORC Report," and sent a strong message that ACEP will fight on behalf of the rights of its members; however, the likelihood of ultimately prevailing was low and ACEP's legal resources could be best utilized in other arenas. Based upon a Joint Stipulation of Dismissal filed with the Court on May 23, 2018, Judge Colleen Kollar-Kotelly signed the Order dismissing the case. In June 2018, the Board discussed legislative and regulatory strategies and next steps for pursuing the Greatest-of-Three methodology governing payments for out-of-network emergency services with CCIIO.

ACEP continues to work on this issue and assist chapters in their efforts. State public policy grants have been provided to several chapters to support efforts on out-of-network/balance billing legislation.

Resolution 16 Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. (as amended)

RESOLVED, That ACEP develop a report or information paper analyzing the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where Emergency Departments in Critical Access and Rural Hospitals that have closed or are in-the process of closing.

Action: In 2015, Sen. Chuck Grassley's (R-IA) office developed a paper outlining the unique challenges rural hospitals face and the need to protect emergency medical services in these rural communities. Based on the findings of the white paper, ACEP worked with Sens. Grassley, Amy Klobuchar (D-MN), and Cory Gardner (R-CO) to develop legislation (REACH Act) that would allow a Critical Access Hospital (CAH) to voluntarily convert to a new category of hospital, the Rural Emergency Hospital (REH), if it eliminated all inpatient services and maintained 24-hour emergency medical care, among other things. ACEP met with Senator Grassley's health legislative assistant and health policy fellow on January 10, 2017, to discuss ACEP's positions heading into ACA reform and the REACH Act. Senator Grassley re-introduced the bill, S. 1130, in the first session of the 115th Congress.

On December 14, 2017, ACEP sent a letter to the Chairman of the Commerce, Justice, and Science Subcomittee of the House Committee on Appropriations requesting support for the disaster supplemental appropriations bill to ensure freestanding emergency care facilities and their emergency physicians are eligible for any federal assistance appropriated to offset the ongoing losses associated with uncompensated care provided to Medicare beneficiaries affected by Hurricane Harvey. The letter provided specific language that could be inserted in the bill.

ACEP's Legislative & Regulatory Priorities for the Second Session of the 115th Congress included:

- monitor legislative actions regarding oversight, licensing, and reimbursement for independent freestanding emergency centers;

- acknowledge the role of freestanding emergency centers and other health care delivery models as crucial to encourage coverage innovation;
- enact legislation allowing critical access hospitals to convert to rural emergency hospitals by eliminating inpatient services.

ACEP's Legislative & Regulatory Priorities for the First Session of the 116th Congress also included these initiatives.

In August 2018, ACEP supported the Emergency Care Improvement Act that allows for independent freestanding EDs that meet criteria to bill Medicare for a certain amount of facility-side reimbursement, depending on geography and acuity. The legislation contains specific language to protect professional-side reimbursement by Medicare at full physician fee schedule amounts at all acuity levels and will also bring the facilities under federal EMTALA requirements.

Resolution 18 Opposition to CMS Mandating Treatment Expectations (as amended)

RESOLVED, That ACEP work with CMS regarding mandated reporting standards that may result in harm to patients without the recognition of evidence based care of individual patients; and be it further

RESOLVED, That ACEP actively communicate to members and hospitals the dangers that quality indicators could present harm to potential patients, and the importance of physician autonomy in treatment.

Action: Assigned first resolved to Public Affairs staff to include in federal advocacy initiatives. Assigned second resolved to the Public Relations Committee to develop messaging.

A similar resolution was submitted to the AMA from ACEP members. It was referred to the Board of Trustees and adopted as policy.

<u>Development of Quality Measures with Appropriate Exclusions and Review</u> Processes H-450.927

1. Our AMA will advocate for quality measures, including those in the Hospital Inpatient Quality Reporting Program, to have appropriate exclusions to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making, and for denominators of quality measures to be appropriately defined to ensure patients for whom the treatment may not be appropriate are adjusted for or excluded.
2. Our AMA will advocate for CMS to allow for any proposed quality measures to be reviewed by the appropriate medical specialty societies prior to adoption.

Resolution 19 Health Care Financing Task Force (as amended)

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

Action: A task force was appointed in June 2017. The name was changed to "Single-Payer Task Force" to differentiate it from the previously appointed Health Care Financing Task Force that has focused on alternate payment models. The task force examined the essential elements of a health care system that should be funded by the US citizens through the federal government and potential supplemental health insurance plans to cover other benefits. The Board of Directors accepted the final report from the task force at their September 28, 2018, meeting and it was distributed to the Council. The 2018 Council Town Hall Meeting topic was "Single-Payer: Has the Time Finally Arrived?" The task force report served as a foundation for the discussion.

Resolution 20 Support & Advocacy for 24/7 Hyperbaric Medicine Availability

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

Action: Assigned to Public Affairs staff to include in advocacy initiatives, in collaboration with UHMS and DAN.

ACEP supported a legislative effort to authorize the Department of Defense to provide hyperbaric oxygen therapy (HBOT) to service members with post-traumatic stress disorder (PTSD) or traumatic brain injuries (TBIs) as part of the FY 18 National Defense Authorization Act. The language was included in the House-approved version of the bill (H.R. 2810), but not its Senate counterpart. Based on projections by the Congressional Budget Office (CBO) of what it would cost to implement this treatment option at the roughly 50 military facilities that could house such equipment, the Department of Defense did not offer this service.

Resolution 21 Best Practices for Harm Reduction Strategies

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

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

Action: Assigned to the Emergency Medicine Practice Committee and the Public Health Committee.

Both committees developed alcohol screening and brief intervention in the ED resources and opioid resources that are available on the ACEP Website. Other resources include the Sobering Centers and "Alcohol Screening in the ED" information papers. ACEP has multiple policy statements that address alcohol and substance abuse that are available on the ACEP Website..

The Pain Management & Addiction Medicine Section continues to develop resources on pain management and addiction medicine. ACEP has developed the E-QUAL Network Opioid Initiative, which includes toolkits, webinar series, podcasts, and other resources.

Resolution 22 Court Ordered Forensic Evidence Collection in the ED

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

Action: Assigned to the Ethics Committee and the Medical-Legal Committee. The committees collaborated to revise the policy statement "Law Enforcement Information Gathering in the ED."

Resolution 23 Medication Assisted Therapy for Patients with Substance Use Disorders in the ED (as amended)

RESOLVED, That ACEP review the evidence on ED-initiated treatment of patients with substance use disorders to provide emergency physician education; and be it further

RESOLVED, That ACEP support, through reimbursement and practice regulation advocacy, the availability and access of novel induction programs from the Emergency Department.

Action: Assigned to the Emergency Medicine Practice Committee and the Public Health & Injury Prevention Committee. The Public Health & Injury Prevention Committee prepared an information paper on Medication Assisted Therapy.

The Emergency Medicine Practice Committee compiled resources on opioid counseling and reversal agents. The committee also compiled information on nine alternatives to opioids for use in the ED and developed a web-based application point-of-care tool.

Comprehensive list of work ACEP has done regarding opioids and Medication Assisted Therapy:

- MAT Waiver training at *ACEP18, LAC19, and ACEP19.*
- The ACEP Emergency Quality (E-QUAL) Network is a CMS funded Support and Alignment Network of the Transforming Clinical Practice Initiative that recently launched the **E-QUAL Network Opioid Initiative**. The aim for this initiative includes helping EDs to implement treatment options to opioids for pain, improve opioid prescribing and adopt harm reduction strategies such as naloxone prescribing and MAT. More information can be found on the ACEP E-QUAL Opioid Initiative Website. Many education resources are available at no cost including presentations and webinars on topics such as:
    - Alternatives to Opioids
    - Safe Opioid Prescribing
    - Treating Patients with Opioid-Use Disorder (OUD) in the ED
    - Treating OUD in the ED: Cutting-Edge Care
    - Setting Up a Buprenorphine Program in the ED
- ACEP has developed a point of care, beside tool to support clinicians as they utilize alternate pain treatments, called the **MAP tool.**
- **Podcasts** on ACEP Frontline, hosted by Dr. Ryan Stanton, including:
    - Eric Ketcham, MD and Kathryn Hawk, MD – MAT 3-day Rule

- Dr. Ryan Stanton discusses the MAT 3-Rule for prescribing buprenorphine for the opioid use disorder patient. Recorded live at *LAC18*, ACEP experts Dr. Eric Ketcham and Dr. Kathryn Hawk talk about how helping the patient with opioid withdrawal symptoms, they are more likely to continue on a path to help and recovery.
- https://soundcloud.com/acep-frontline/eric-ketcham-md-and-kathryn-hawk-md-mat-3-rule
  - Medication Assisted Treatment EMPRN Survey Results
- Dr. Ryan Stanton discusses Medication Assisted Treatment as a for patients with opioid use disorder. ACEP experts Dr. Eric Ketcham and Dr. Kathryn Hawk share the results of a survey from the Emergency Medicine Practice Research Network (EMPRN) about current practices for patients with an addiction disorder.
- https://soundcloud.com/acep-frontline/eric-ketcham-md-and-kathryn-hawk-md-emprn-medication-assisted-treatment-survey-results
  - ALTO Update, LAC18
    - Dr. Ryan Stanton talks to Dr. Alexis LaPietra, DO, FACEP, and Dr. Mark Rosenberg, DO, FACEP, about being better stewards of opioids and the emergency departments role in the opioid crisis. They discuss innovations in pain management and how to safely and more effectively treat the patient without opioids. At St Joseph Regional Medical Center in NJ, they have seen an 82% reduction in the prescriptions of opioids using ALTO (Alternatives to Opioids). "Its real simple, if you're not part of the solution, you're part of the problem."
    - https://soundcloud.com/acep-frontline/alexis-lapietra-do-facep-and-mark-rosenberg-do-facep-alto-update-lac18

- ACEP also has multiple **publications** in *Annals of Emergency Medicine* (which has more than 38,000 subscribers) and *ACEP Now* (which have 40,000 BPA audited subscribes) including:
  - Opportunities for Prevention and Intervention of Opioid Overdose in the Emergency Department.
  - Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department.
  - Sometimes Opioids Are Necessary
  - Buprenorphine Explained, And Opioid Addiction Treatment Tips
- ACEP has also developed and launched numerous **educational products**, including those providing free opportunities for Continuing Medical Education (CME), such as:
  - Opioid Wave I – Free CME
    - Introduction
    - Harm Reduction
    - Treating Opioid Use Disorder in the ED
  - Solving the Pharmacological Mystery of Buprenorphine - June 2018 (CME Now Article - FREE - 1.0 CME)
  - CME Now: Why Addiction is Not Just a "Tox" Problem (Article - FREE - 1.0 CME)

Resolution 24 Mental Health Boarding Solutions (as amended)

RESOLVED, That ACEP partner with stakeholders including the American Psychiatric Association, the Substance Abuse and Mental Health Services Administration, the National Alliance of Mental Illness, and other interested parties, to develop model practices focused on building bed capacity, enhancing alternatives, and reducing the length of stay for mental health patients in EDs; and be it further

RESOLVED, That ACEP develop and share these ED mental health best practices designed to reduce ED mental health visits, reduce ED mental health boarding, and improve the overall care of patients who board in our EDs; and be it further

RESOLVED, That ACEP work with the Agency for Healthcare Research and Quality and other appropriate stakeholders to develop community and hospital based benchmark performance metrics for ED mental health flow and psychiatric facilities acceptance of patients.

Action: This resolution is being addressed primarily through the work of the Coalition on Psychiatric Emergencies (managed by ACEP). The Coalition stemmed from a psychiatric emergency summit held in December 2014 comprised of multiple stakeholder groups from emergency medicine, emergency psychiatry, and patient advocacy to improve the treatment of psychiatric emergencies for patients and providers. The overarching goals of the Coalition are to bring awareness and recognition to the national challenges surrounding psychiatric emergencies and work collaboratively to address these problems and create change. There are four working groups (Education, Research,

Operations/Boarding, Advocacy) each with their own objectives and tasks. A repository of resources is available on the Emergency Medicine Foundation Website.

The Coalition sponsored a research consensus conference on December 7, 2016, with experts from around the country, on the evidence that rapid treatment of patients with acute mental health disorders leads to better patient outcomes. The goal of the conference was to address underlying questions related to time to treatment, and if early intervention can affect patient outcomes. Breakout sessions included: acute psychosis, depression and suicidality, substance use disorder and agitation in the elderly. Manuscripts are being developed and will be sent to peer reviewed publications for consideration.

The Coalition worked with ACEP's Emergency Medicine Practice Committee to develop the information paper, Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department, on best practices for boarding patients with mental health disorders. A podcast was developed and is available on the ACEP website.

The Clinical Policies Committee revised the Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department and it was approved by the Board in January 2017.

In June 2017, the Board approved the Quality & Patient Safety Committee's recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in Emergency Departments. The Clinical Emergency Department Registry (CEDR) currently has dashboard functionality and the ED throughput measures are included in the registry and reportable to CMS for the Quality Payment Program (QPP). CMS currently collects data on CMS OP-18c measure for arrival to ED departure time for psychiatric and mental health patients and CMS ED-2c measure for admit decision to ED departure time for psychiatric and mental health patients. The Quality Improvement & Patient Safety (QIPS) Section worked on an ACEP-funded grant titled "Best Practices for Reducing Behavioral Health Patient Length of Stay in the Emergency Department White Paper." The paper addresses issues pertinent to the length of stay of behavioral health patients in the ED and describe best practices to reduce length of stay. The section continues to work on developing the toolkit.

Resolution 25 Military Medics Integration into Civilian EMS (as amended)

RESOLVED, That the American College of Emergency Physicians, in order to promote high quality, safe, and efficient emergency medicine care, support current state and federal initiatives for accelerated training to allow transition of current military pre-hospital personnel to the civilian sector and which recognize the current level of training and experience of military medical specialist providers in our nation's service.

Action: Assigned to the EMS Committee to develop a policy statement and to Public Affairs and State Legislative staff to include in federal and state advocacy initiatives.

The EMS Committee worked with several members with past military experience as well as representatives from the Government Services Chapter to develop a draft policy statement. The committee also reviewed current projects underway that are supported by the National Association of State EMS Officials (NASEMSO), the National Association of EMS Educators (NAEMSE), the National Association of EMTs (NAEMT) and the National Registry of EMT's (NREMT) on military to civilian EMS transition to ensure ACEP's policy is consistent with these initiatives. The Board approved the policy statement "Support for Transition of Military Medics into Civilian EMS Careers" in June 2017. On September 28, 2018, The Board approved the policy statement "Military Considerations in Emergency Medical Services (EMS)" and rescinded two existing policy statements ("Military Emergency Medical Services" and "Support for Transition of Military Medics into Civilian EMS Careers") that were superseded by this new comprehensive policy statement.

Resolution 26 Opposition of Exclusive Imaging Contracts Limiting Clinical Ultrasound Use and Billing by Emergency Physicians (as amended)

RESOLVED, That ACEP supports users of emergency ultrasound with a statement declaring opposition to the use of exclusive imaging contracts to limit the use of emergency ultrasound by non-radiology specialists and the billing for such services; and be it further

RESOLVED, That ACEP continue to support emergency physicians working to develop and implement emergency ultrasound programs who face opposition in hospitals where radiologists or others hold exclusive imaging contracts.

Action: Assigned to the Emergency Medicine Practice Committee and the Emergency Ultrasound Section to develop a policy statement. The Board approved the policy statement " Advocacy for Emergency Department Ultrasound Privilege and Practice" in June 2017.

Resolution 27 Pediatric Surgery Centers

RESOLVED, That ACEP dispute the current Pediatric Surgery Center Guidelines and work with appropriate stakeholders to amend the guidelines; and be it further

RESOLVED, That ACEP reaffirm the Guidelines for the Care of Children in the Emergency Department as the standard for pediatric emergency care.

Action: Assigned to the Pediatric Emergency Medicine Committee. The committee was assigned objective in 2016-17 to work with the Pediatric Surgery Society to revise the guidelines.

ACEP discussed concerns with the leadership of the Pediatric Surgical Society and the American College of Surgeons (ACS) in March 2017. ACEP met with leaders of the American Academy of Pediatrics (AAP) during the 2017 ACEP Advanced Pediatric Emergency Medicine Assembly. AAP indicated they were not aware of the concerns prior to this meeting and agreed to review their processes on endorsement of documents and involve ACEP in future revisions of the Pediatric Surgery Center Guidelines. The ACEP Board had further discussions on this issue at their June 2017 meeting and a letter was sent to ACS on August 28, 2017. ACS responded on September 25, 2017, providing additional background about development of the Guidelines and agreed to include representation from ACEP in future revisions.

Resolution 28 Reimbursement for Opioid Counseling

RESOLVED, That ACEP develop a strategy to seek reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for our patients; and be it further

RESOLVED, ACEP develop a toolkit and education for implementing safe opioid use, reversal agent instruction, and drug abuse counseling in our Emergency Departments.

Action: Assigned first resolved to the Coding & Nomenclature Committee. Assigned second resolved to the Emergency Medicine Practice Committee.

The Emergency Medicine Practice Committee compiled resources on opioid counseling and reversal agents.. The resources were reviewed by the Board in October 2017 and are available on the ACEP Website. The Coding & Nomenclature Advisory Committee developed a CPT code change proposal developed describing opioid counseling, including a discussion of risk and symptoms of overdose and the appropriate steps to discuss should one of these occur. The proposal was submitted to the CPT Editorial Panel for review at the September 2017 meeting. Unfortunately, the proposal was not adopted.

Resolution 29 The Opioid Epidemic – A Leadership Role for ACEP (as amended)

RESOLVED, That ACEP advocates and supports the training and equipping of all first responders, including police, fire, and EMS personnel to use injectable and nasal spray Naloxone; and be it further

RESOLVED, That ACEP advocates and supports that appropriately trained pharmacists be able to dispense Naloxone without prescription; and be it further

RESOLVED, That ACEP develop a comprehensive policy on the prevention and treatment of the opioid use disorder epidemic including innovative treatments.

Action: Assigned to the Emergency Medicine Practice Committee (EMPC) to review current policies and resources and determine if revisions or additional resources were needed. The following resources and activities were identified:

- 2012 "Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department." The Clinical Policies Committee has started work on a revision to this policy that will be completed in 2020.
- "Naloxone Prescriptions by Emergency Physicians" policy statement approved October 2015.
- "Naloxone Access and Utilization for Suspected Opioid Overdoes" policy statement approved June 2016.
- "Optimizing the Treatment of Acute Pain in the Emergency Department" policy statement approved April 2017.
- ACEP Website Resources: see comments on Resolution 21 and 23.
- The Pain Management & Addiction Medicine Section continues to develop resources on pain management and addiction medicine.
- ACEP has developed the E-QUAL Network Opioid Initiative, which includes toolkits, webinar series, podcasts, and other resources.
- State Legislative/Regulatory Committee 2016-17 objective expanding and updating previous work to "research and report on successful approaches to opioid prescribing legislation impacting EDs, with a focus on state mandates related to PDMP's, the use of clinical guidelines, programs with state agencies (e.g., "warm hand off" programs and expansion of local treatment programs) and the availability of naloxone." A panel discussion was held at the 2017 Leadership & Advocacy Conference that featured

creative responses led by ACEP members to the opioid crisis in Paterson, NJ and northwestern NM. The committee is developing a tool kit of legislative resources that will be available on ACEP's website.

- State legislative staff tracks legislation related to opioid prescribing, PDMP's, and the availability of naloxone, and provides that information to state chapters.

In April 2017, the Board approved the committee's recommendation to take no further action and concurred that the intent of the resolution was addressed.

Resolution 31 Opposing the Development of Sublingual Sufentanil (as amended)

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

Action: Assigned to the EMS Committee to obtain more information and provide a recommendation to the Board. The resolution was initiated because the pharmaceutical company contacted EMS providers and indicated that EMS supported the development. A letter was sent to the FDA in February 2017 opposing the use of sublingual fentanyl by EMS and in civilian emergency departments. ACEP leaders had multiple discussions with the pharmaceutical company that developed the drug to inform them of ACEP's concerns.

Referred Resolutions

Resolution 8 Opposition to Required High Stakes Secured Examination for Maintenance of Certification

RESOLVED, That ACEP work with members, other interested organizations, and interested certifying bodies to develop reasonable, evidence based, cost-effective, and time sensitive methods to allow individual practitioners options to demonstrate or verify their content knowledge for continued practice in Emergency Medicine.

Action: The officers of ACEP and ABEM have met multiple times since the 2016 Council meeting to discuss these issues. ACEP relayed the growing discontent among some ACEP members with the Maintenance of Certification (MOC) process and particularly the high-stakes ConCert exam. ABEM explored alternative approaches to physician assessment. This exploration included detailed analyses of every pilot project in which other specialty boards are involved. ABEM informed ACEP that it participated in direct discussions and research consortia with other American Board of Medical Specialties (ABMS) specialty boards to understand the strengths and weaknesses of alternative forms of longitudinal assessment. Unfortunately, the pilots of other specialty boards are so new that outcomes or validity data are extremely limited. ABEM held a special Board meeting in September 2017 to explore modifications and options to the ConCert examination and held a national ConCert Summit October 2-3, 2017, that included representatives from every emergency medicine organization to explore modifications and options to the ConCert examination. ABEM wants to keep the ConCert examination as an option and decrease the anxiety, cost, and consequence of the ConCert examination as an assessment option for some diplomates. ACEP, along with dozens of other specialty societies and state medical societies met with ABMS and its certifying boards in early December 2017 to discuss concerns regarding both MOC and the high-stakes exams.

An article appeared in the July 2018 issue of *ACEP Now* highlighting ABEMS's efforts to create a new process for continuing certification by offering an alternative to the ConCert Examination. ABEM pursued several critical activities including redefining the purpose of continuing certification for ABEM and developing success metrics. All diplomates were invited to complete a survey to confirm and further explore the information ABEM received during the calls with 25 state chapters in 2017. Additional surveys were used to refine the design. The ACEP Board of Directors continued to dialogue and collaborate with ABEM and ABMS and monitor their activities on this issue. ABEM updated the Council on their efforts at the 2017 and 2018 annual meetings. In December 2018, ABEM released the draft report *"Continuing Board Certification: Vision for the Future"* (developed by an independent commission) for comments by January 15, 2019. ACEP's comments were provided to ABEM. "MyEMCert" is now in development and physicians with certification ending in 2022 or later can maintain certification using MyEMCert.

Resolution 10 Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use

RESOLVED, That ACEP adopt and support a national policy that the possession of small amounts of marijuana for personal use be decriminalized; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association for national action on decriminalization of possession of small amounts of marijuana for personal use.

Action: Originally assigned to the Ethics Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committee to review and provide a recommendation to the Board regarding further action on the

resolution. The resolution was subsequently assigned to the Emergency Medicine Practice Committee since they were also assigned Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED. After extensive discussion, there was not a consensus on a recommendation to the Board. A two-question survey was developed and shared with the four committees identified to review this resolution. The questions asked were: 1) Should ACEP adopt a policy supporting decriminalization of marijuana? and 2) Should ACEP submit a resolution to the AMA in support of decriminalization? While approximately 67% of the respondents were opposed to ACEP adopting a policy in favor of decriminalization of marijuana, all but one of the comments were in opposition. Others commented they were in favor of decriminalization of position of small amounts of marijuana but did not believe it was an issue for ACEP to address. After review of the survey results and consideration of the comments, the Emergency Medicine Practice Committee recommended that no further action be taken on the resolution. The Board approved the committee's recommendation in June 2017.

Resolution 12 Collaboration with Non-Medical Entities on Quality and Standards (as amended)

RESOLVED, That the American College of Emergency Physicians reach out and build coalitions with non-medical organizations involved in developing non-clinical quality standards that include an evaluation of the cost of providing the highest level quality of care.

Action: Assigned to the Quality & Patient Safety Committee. In June 2017, the Board approved the committee's recommendation to support new and existing partnerships with non-medical organizations involved in developing quality standards including: 1) renewing membership in the National Quality Forum; 2) continue participation in Technical Expert Panels (TEP) that developing quality measures for CMS; and 3) conduct outreach and communications with international associations for emergency physicians, such as the Canadian Association of Emergency Physicians (CAEP) and other organizations within the International Federation of Emergency Medicine (IFEM), for international visibility and collaboration for ACEP.

Resolution 17 Insurance Collection of Beneficiary Deductibles (as amended)

RESOLVED, That ACEP add to its legislative agenda as a priority to advocate for health care insurance companies to be required to collect patients' deductibles for EMTALA-related care after the insurance company pays the physician; and be it further

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

Action: Assigned to the Federal Government Affairs Committee to review and provide a recommendation to the Board regarding further action on the resolution. The committee did not support adding this issue to the legislative and regulatory priorities given the scope of work on initiatives related to the repeal and/or replacement of the Affordable Care Act. The Board approved the committee's recommendation at their October 26, 2017, meeting.

The AMA adopted a similar resolution in November 2016. The AMA Board of Trustees was directed to make a decision and provide a report at the June 2017 AMA Annual meeting. At their April 2017 meeting, the AMA Board of Trustees determined:

> Health Insurance Companies Should Collect Deductible From Patients After Full Payment to Physicians – The Board received a report in response to Resolution 805-I-16 which was referred for decision at the 2016 Interim Meeting of the House of Delegates. Resolution 805, sponsored by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont delegations, asks our AMA to "seek federal and state legislation that requires health insurers to reimburse physicians the full negotiated payment rate for services to enrollees in high deductible plans and that the health insurers collect any patient financial responsibility, including deductibles and co-insurance, directly from the patient."
>
> Those in support of Resolution 805-I-16 argued that such legislative action was necessary to address the potential increase in bad debt as a result of patient collections becoming more challenging due to the growth in high-deductible health plans. Conversely, others expressed concern over the unintended consequences to physician practices and the larger political challenges of successfully enacting such legislation.
>
> In lieu of Resolution 805-I-16, the Board voted to approve that the AMA: 1. Reaffirm Policies H-165.849, "Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans," and D-190.974, "Administrative Simplification in the Physician Practice;" 2. Engage in a dialogue with health plan representatives (e.g., America's Health Insurance Plans, Blue Cross and Blue Shield

Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans.

In June 2017, the ACEP Board of Directors approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider. The model legislation was shared with chapters and is important for state legislatures that are considering out-of-network and balance billing legislation and look to emergency medicine for guidance.

Resolution 30 Treatment of Marijuana Intoxication in the ED

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

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

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

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

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

Action: Assigned to the Emergency Medicine Practice Committee, the Public Health Committee, and the State Legislative/Regulatory Committee to review and provide a recommendation to the Board regarding further action on the resolution.

A thorough analysis was conducted and in June 2017, the Board approved the committee's recommendation to take no further action on the first, second, and fourth resolveds; assign the third resolved to the Toxicology Section or other body for additional work; and for the fifth resolved, educate ED providers to document diagnosis of marijuana intoxication and make subsequent efforts to correlate the diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. When data is available, ACEP can then focus on determining the resources needed to coordinate treatment of marijuana intoxication.

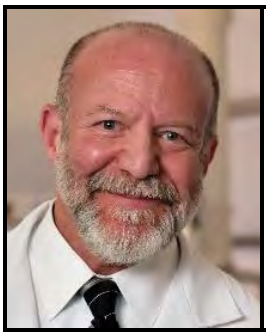
President-Elect Candidates

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 President-Elect Candidates

Jon Mark Hirshon, MD, PhD, MPH, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer



Mark S. Rosenberg, DO, MBA, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Jon Mark Hirshon, MD, PhD, MPH, FACEP

***Question #1:* Describe a past failure as a leader and what you learned from that experience.**

In 2009, I was nominated to run for the American College of Emergency Physicians' Board of Directors, a true honor and something that I had worked towards for many years. I tightened my belt and prepared for the contest, excited and nervous to be able to participate and contend. To be elected, I needed 155 votes. I carefully prepared for the election, including crafting and practicing my two-minute speech. At the appointed time, I stood in front of the hundreds of members of the ACEP Council and gave my speech. Afterwards, I campaigned, meeting individually with Councillors, going room to room as part of the important Candidate Forum, and talking with many friends and colleagues. When the vote was done and the dust had cleared, I had received 125 votes. "Not bad," I said to myself, "The Council rewards perseverance and I will run again next year and get elected."

Well, 2010 came and I ran again. This time, I got… 125 votes. Again. A disappointing result. As Albert Einstein is credited with saying, "The definition of insanity is doing the same thing over and over again, but expecting different results." So, I had to take a step back and evaluate what I was doing in order to change the outcome. But first, I needed to answer an important question: Is serving on the ACEP Board of Directors really what I want? After thoughtful introspection and discussions with friends and colleagues, my answer was a resounding yes! I wanted to make a difference for my colleagues and my patients. My next question was then: What do I need to do differently to have a different result?

I stepped away from the fray and started handicapping the election process. After a year or two, I became quite good at picking the winners. I realized the skill that I needed to improve was my public speaking; I needed to become a more persuasive spokesperson and better convey my ideas and passion. So, I found a speech coach, someone with whom I had worked with previously when I chaired the ACEP National Report Card Task Force. He drilled me and grilled me to improve my speaking skills and style. When I was nominated again in 2014, I crafted and practiced my two-minute speech, met with many ACEP Councillors and did all the other important steps for the election. This time, the outcome was different; I was successfully elected to the Board of Directors!

Becoming a better public speaker was a key step in my growth as a leader. What did I learn from this experience? Perseverance is key to success, but so is thoughtful analysis and appropriate support. I learned that a leader needs to know his or her strengths and weaknesses and to ask for help when needed. As a leader and a lifelong learner, I continue to work on my speaking and other important leadership skills in order to better serve our colleagues, our patients and our profession.

***Question #2:* Your CEO proposes replacing an emergency physician with two mid-level providers (PA, NP, etc.). What is your response?**

The first thing I would ask the CEO is, "Why are you proposing this change?" I'd want to know if there is a good clinical rationale, such as splitting the patient flow to allow for lesser acute patients to be seen in a new fast track area while the emergency physicians are preferentially seeing high acuity patients, or is this strictly a money saving maneuver? It would be a good chance to use the Six Sigma "5 Whys" technique to understand the underlying rationale and motivation for this proposed change. If there is not a good clinical reason for the staffing change, then I would argue against it. Replacing an emergency physician with two mid-level providers is not an equivalent exchange. The quality of the care by emergency physicians is different based upon our more extensive and thorough training. Providing the highest quality emergency care is what we are trained to do. Additionally, I firmly believe the ACEP policy that NPs and PAs should not provide unsupervised ED care. This is a position that is supported by the professional societies of our mid-level provider colleagues who work with us in EDs.

Additionally, I conducted research looking at the financial impact of mid-level providers in the ED, which we recently published in the Western Journal of Emergency Medicine. If you look at community EDs that use PAs and NPs versus EDs with just physicians, there is a clear increase in resource utilization as measured by the number of imaging studies ordered and the number of patients admitted. The projected increase in costs for the hospital was approximately $415,000 per year from increased admissions alone. Our study highlighted that the use of mid-level providers within the health system is a complex issue that requires careful thought and further study. I should note that this was preliminary work as it looked at practice patterns at the ED

level and not at the individual patient or the ordering physician or mid-level provider. We are currently exploring this issue with a new data set.

Rather than simply replacing a physician with mid-level providers, as my CEO proposed, the more important question is to find the right balance of staffing to be able to most efficiently and effectively provide the highest quality of emergency care to our patients. We need to understand the direct and indirect costs and effects of the proposed change. In the end, the hospital's (and the CEO's) success will be based upon good community relations by working collaboratively to best serve our stakeholders and patients.

***Question #3:* What are the biggest internal and external threats to emergency medicine and how will you address them?**

As emergency physicians, we are caring, thoughtful, hardworking health professionals. Individually, we have our own personal reasons for choosing emergency medicine, but we knew going into this career that we would be working days, nights, weekends. We can be found in our EDs on holidays, in the middle of snow storms, and after a mass shooting taking care of the critically ill and injured. Patients come to us in need, and we take care of them regardless of their ability to pay. However, we live in divisive and conflictual times and the future looks threatening with many storm clouds on the horizon.

The health care financing environment is turbulent and changing. ACEP, and emergency medicine, plays a critical and ever-increasing role within the U.S. health care system. Externally, we face a number of significant challenges, most importantly assuring appropriate financial and societal support for our important work. Patients cannot choose where or when they will have a medical emergency, and they should not be punished financially for seeking emergency care. ACEP must, and I will, continue to fight for fair compensation for our important work. In Congress, the issue is called "surprise billing." Out of pocket medical expenses are mounting astronomically for patients while insurance companies are making record profits. We want to assure access to high quality emergency care while taking the patients out of the middle of the billing issues. It is said that "if you're not at the table, you're on the menu." On a near daily basis, ACEP leaders and staff meet with legislators, their staff and other stakeholders in the federal government. We use a multi-pronged approach, including legal, educational and lobbying activities on both federal and state levels to assure that our voice is heard. The need is for a steady hand at the helm in order to assure consistent messaging. I would continue our successful efforts to develop relationships on all levels so we can enjoy the meal and not be part of it. Maintaining and growing financial and societal support for emergency care remains the most critical external issue for emergency medicine. We must succeed at this.

Internally, as I said last year, we are faced with the challenge of unifying the multiple voices in emergency medicine into a strong and effective chorus. We are a diverse group and bring many different perspectives together in order to care for our varied patients. From a business perspective, companies with greater diversity have been shown to be more successful. ACEP, and emergency medicine as a specialty, will be more successful through embracing diversity, and not just gender and race diversity, but the many aspects of our practices- gender, race, ethnicity, large groups, small groups, academics, rural providers, young physicians, individuals near retirement, etc. Together, we can agree on specific topics and issues and work together collaboratively on these. This will strengthen our voice. On other topics, we can continue to disagree respectfully and professionally without personal attacks. Speaking with one voice will allow us to be heard above the discordant clamor found in Washington, D.C. and in many state capitols.

Personally, I feel very fortunate to have a profession that gives me both personal satisfaction through helping individual patients as well as the ability to make a difference on a larger stage. I will work for you in conjunction with our many partners to forcefully advocate for emergency medicine and to sustain and to grow the support for our important work. Working together we can, and we will, make a difference.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Jon Mark Hirshon, MD, PhD, MPH, FACEP

Contact Information

Department of Emergency Medicine
University of Maryland School of Medicine
110 S. Paca Street, 6th Floor, Suite 200
Baltimore, Maryland 21201
Phone: 667-214-2208
Cell: 410-271-4825
E-Mail: jhirshon@acep.org

Current and Past Professional Position(s)

My current position is as Professor in both the Department of Emergency Medicine and the Department of Epidemiology and Public Health in the University of Maryland School of Medicine. I work clinically in inner city Baltimore at the University of Maryland Medical Center where I treat patients and teach medical students and residents. I am also Senior Vice-Chair of the University of Maryland, Baltimore Institutional Review Board, a position that I have held for over a decade. Prior positions include assistant professor at University of Maryland School of Medicine and Johns Hopkins School of Medicine, as well as prior clinical employment in multiple community emergency departments in Baltimore, Maryland. Additionally, I am a former director of the Charles McC. Mathias, Jr. National Study Center for Trauma and EMS. Within ACEP, I currently serve as Vice-President.

Education (include internships and residency information)

1984	Bachelor of Arts, Biology and French Literature, University of California, Santa Cruz
1990	Doctor of Medicine, University of Southern California, School of Medicine
1990–1993	Emergency Medicine Residency, Johns Hopkins Hospital, Johns Hopkins University
1994–1995	Preventive Medicine Residency, Johns Hopkins Bloomberg School of Public Health,
1994	Master's in Public Health, Johns Hopkins Bloomberg School of Public Health, Special Emphasis on International Health
2011	Doctor of Philosophy in Epidemiology, Department of Epidemiology and Public Health, University of Maryland School of Medicine

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

1994, 2004, 2014	Diplomate, American Board of Emergency Medicine
2002, 2012	Diplomate, American Board of Preventive Medicine

Professional Societies

1990–current	Alpha Omega Alpha Medical Honor Society
1998–current	American Academy of Emergency Medicine (fellow)
1997–current	American College of Emergency Physicians (fellow)
2002–current	American College of Preventive Medicine (fellow)
1994–current	Delta Omega Public Health Honor Society
1993-current	Society for Academic Emergency Medicine
2011-current	African Federation of Emergency Medicine
2016-current	American Medical Association

National ACEP Activities – List your most significant accomplishments

1996-2006	Member, then Chair, Public Health Committee
2001–2010	Liaison, ACEP to the American Public Health Association
2002–2003	Member, Terrorism Response Task Force
2003	Representative, ACEP to the Institute of Medicine's Meeting on Committee on Smallpox Vaccination Program Implementation
2004–2008	Tellers, Credentials and Elections Committee
2004–2008	Scientific Review Committee
2006–2008	Council Steering Committee
2006–2007	Finance Committee
2006–current	ACEP International Ambassador to Egypt (starting 2006) and Sudan (starting 2016)
2006–2009	National Report Card Task Force, Chair, Data Subcommittee
2008	Hero of Emergency Medicine, American College of Emergency Physicians
2008–2009	Liaison, ACEP to the Healthy People Consortium
2011-current	Member, International Ambassador Program Committee
2011-2013	Chair, National Report Card Task Force
March 16th, 2014	Testified before the Subcommittee on Oversight and Investigations of the House of Representatives' Energy and Commerce Committee concerning access to emergency care related to mental health and the shortage of psychiatric services.
2014-current	***National Board of Directors***, multiple tasks and roles over the past 5 years, including: *Liaison/member to the following committees and task forces*: Annals of Emergency Medicine, Bylaws, Clinical Resources Review Committee, Clinical Policies Committee, Coding & Nomenclature Committee, ED Health Information Technology Safety Task Force, Epidemic Expert Panel, Finance Committee, Freestanding Emergency Centers Task Force, National/Chapter Relations Committee, Nominations Committee, Reimbursement Committee, ACEP/SAEM Research Work Group, State Legislative/Regulatory Committee, *Liaison to the following sections:* Air Medical Transport, Emergency Medicine Informatics, Emergency Medicine Practice Management and Health Policy, Wilderness Medicine, Young Physicians *Liaison to* Emergency Medicine Residents Association Chair, Emergency Department Sickle Cell Care Collaborative (EDSC^3), a private/public partnership, which provides a national forum dedicated to the improvement of the emergency care of patients with SCD in the United States.
2018-2019	***Vice President***

ACEP Chapter Activities – List your most significant accomplishments

2000–2001	Member, Board of Directors
2000–current	Education Committee
2001–2002	Treasurer
2001–2014	Representative or Alternate Representative from Maryland ACEP to the National ACEP Governing Council
2001–current	Public Policy Committee
2002–2004	Vice-President
2004–2007	President
2007	Award in Appreciation for Outstanding Leadership, Dedication and Support of Emergency Medicine as President, Maryland Chapter, ACEP
2007–2009	Immediate Past President
2015	Physician of the Year, 2015. Maryland Chapter, ACEP

Practice Profile

Total hours devoted to emergency medicine practice per year: **2080** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **40** % Research **15** % Teaching **20** % Administration **25** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

My primary clinical site is a busy, academic emergency department with an approximate annual volume of 65,000 adults. In this location, I work closely with residents, students and advance practice providers. Teaching is an important aspect of the work I do, but I also see patients by myself. In addition to the inner-city, adult population that we serve, we are a tertiary referral center that receives many patients from around the state. Of note, the State of Maryland is a unique practice environment because of our Global Budget Revenue hospital funding model, which is a population-based payment model that caps total hospital revenue growth. This model, which is starting to be replicated in other states, is driving substantial practice changes including increased pressure to decrease hospital admissions and to coordinate patient care.

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**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Jon Mark Hirshon, MD, PhD, MPH, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: University of Maryland

Address: 110 S. Paca Street, 6th Floor, Suite 200

Baltimore, Maryland 21201

Position Held: Professor, Senior Vice-Chair of the Institutional Review Board

Type of Organization: University

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Maryland Chapter, ACEP

Address: 1211 Cathedral Street

Baltimore, Maryland 21201

Type of Organization: Professional Society

Duration on the Board: 2000-2009

Organization: The Hilltop Institute, Advisory Board

Address: University of Maryland, Baltimore County,

Sondheim Hall, 3rd Floor, 1000 Hilltop Circle, Baltimore, MD 21250

Type of Organization: University

Duration on the Board: 2018-2019

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE

☒ If YES, Please Describe:

I am a consultant and advisory board member to Pfizer, Inc. concerning the medical care and treatment of patients with sickle cell disease.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

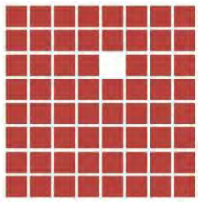
☒ NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Jon Mark Hirshon Date May 31, 2019

1211 Cathedral Street
Baltimore, MD 21201-5585
410-727-2237
e-mail: info@mdacep.org
www.mdacep.org



Maryland Chapter
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

August 15, 2019

Dear Colleagues,

On behalf of Maryland ACEP, it is with great pride that we enthusiastically support Dr. Jon Mark Hirshon's candidacy for ACEP President-Elect. Our Chapter wholeheartedly endorses his candidacy because we know that his leadership will benefit both the College and specialty during these trying times in the U.S. health care system. He is uniquely qualified in a number of critical ways, including that he is a dedicated and respected practicing clinician and educator, an enthusiastic leader, a keen organizer, and a master of data concerning the emergency care environment. He is a man with the wisdom, knowledge and vision to help improve access to high quality emergency care in the U.S. and globally. He is the type of leader we need to continue moving ACEP forward.

It is important to list some of his accomplishments to demonstrate Dr. Hirshon's solid and deep experiences in emergency medicine, including his current important leadership role as ACEP's Vice-President. For many years, he has been an integral and vital member of Maryland ACEP. He is a Past President of Maryland ACEP, having completed the executive offices of Secretary, Vice President and President. His passion for our patients, our colleagues and our organization is evidenced by his dedication to ACEP's legislative efforts, both within Maryland and nationally. He was a national ACEP Councillor or Alternate Councillor for approximately 15 years prior to his election to the Board of Directors. Additional roles included service on ACEP's Steering Committee as well as serving as the Task Force Chair for the 2014 ACEP Report Card. This second position not only demonstrated his keen intellect and knowledge of the multitude of forces impacting emergency care today, but also highlighted his skill and ability to promote ACEP and emergency medicine to television, radio and print media.

Dr. Jon Mark Hirshon is a well-respected national and international leader in public health and emergency medicine. He is the Senior Vice Chair of the University of Maryland's Institutional Review Board and is a former director of the Charles McC. Mathias, Jr. National Study Center for Trauma and EMS. He has been the principal investigator on over $8 million in federal research and training grants and has taught emergency physicians, residents and medical students both domestically and in the Middle East. Dr. Hirshon serves as a role model and mentor by practicing high quality clinical emergency medicine while broadening the frontiers of scientific knowledge through collaborative research efforts.

His vision, leadership and contributions of time as a volunteer while working to enhance the profession of emergency medicine, improve patient care and his extraordinary efforts toward optimal emergency medicine practices are inspiring. His career has been dedicated to delivery of the very finest quality of emergency care which has included not only his personal commitment to his patients, but a greater calling to the education of others and himself, advocacy for our specialty, and support of organizations and causes beyond himself, all of which have benefited by his national and international efforts to further emergency medicine.

Maryland ACEP was also honored to select Dr. Hirshon as the "Physician of the Year 2015." His career constantly and consistently demonstrates his passion for emergency medicine, his belief in lifelong education, his commitment to public health and, most importantly, his dedication to the delivery of the highest possible quality of emergency care to those in need.

Clearly, Dr. Hirshon has worked tirelessly to improve access to emergency care and to promote emergency medicine, both in the U.S. and globally. He is an exceptional candidate and Maryland ACEP is honored to support his candidacy for ACEP President-Elect.

Respectfully,

Orlee Panitch

Orlee Panitch, MD, FACEP
Maryland ACEP President

Jon Mark Hirshon, MD, PhD, MPH, FACEP

Dear Friends and Colleagues,

Over 25 years ago, as a resident in emergency medicine, I made an exceptional decision. I joined the American College of Emergency Physician. In becoming a member of ACEP, I joined my wonderful professional family. Through the years I have learned from the best and have grown in many ways. Today I am honored to be a nominee for ACEP President-Elect.

So, what will I do for you as ACEP President? Let me share with you three key challenges that we are facing:

- First, we must, and I will, work to improve our lives in the emergency department
- Second, we must, and I will, work to assure we can deliver the highest quality emergency care possible
- Third, we must, and I will, work to make sure that we receive fair compensation for the care we deliver.

Every day that we take care of patients, we face the same challenges and problems, including:

- Boarded patients
- Prolonged psychiatric stays
- Work place violence
- Too much time in front of computers instead of being with patients.

For every 5 minutes I spend with a patient, I seem to spend 20 minutes in front of the computer. And let's be clear, none of us went to medical school for this. We need to improve our lives in our emergency departments.

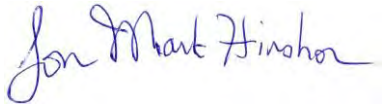
In addition to the daily challenges we face in our clinical work are the divisions and conflicts within the house of emergency medicine. We are a diverse group and bring together many different perspectives in order to care for our patients. I will work to build on the strength of our diversity by unifying our voices and highlighting our shared common values without compromising the uniqueness of ACEP.

Why am I running for ACEP president-elect? *I am running because I know I can make a difference.*

What will I do for us as ACEP President? *I will fight to improve our lives in the emergency department and to assure the highest quality of emergency care for our patients*.

We are caring, thoughtful, hardworking, and dedicated professionals. We care about our patients and for our colleagues. ACEP and emergency medicine play a critical and ever- increasing role within the health care system. Together we *will* go far and make a difference.

I ask for your support and your vote as ACEP President-Elect. Thank you.



Jon Mark Hirshon, MD, PhD, FACEP
Cell: 410-271-4825
Email: jhirshon@acep.org

JON MARK HIRSHON

MD, PHD, MPH, FACEP

Leadership

Integrity

Passion

Dedication

Candidate for President-Elect

SELECTED LIST OF ACEP SERVICE

- **ACEP Vice-President, 2018-2019**
- **ACEP Board of Directors, 2014-2019**
- **Past President of Maryland ACEP**
- **Chair, National Report Card Task Force 2014**
- **Past Chair of the Public Health Committee**
- **Board Liaison to multiple National Committees and Sections, including:**
  - **Clinical Policies**
  - **State Legislative**
  - **Reimbursement**
  - **National/Chapter Relations**
- **Testified before Congress on the national psychiatric boarding crisis**
- **Member of multiple Task Forces, including:**
  - **Epidemic Expert Panel**
  - **Freestanding Emergency Center Accreditation TF**
  - **ED Health Information Systems Safety TF**
- **ACEP International Ambassador to Egypt and Sudan**

Personal Statement:
It feels like yesterday that I was a young impressionable intern walking into the halls of my emergency medicine residency. Three years later, I transitioned out of academia to the finishing school of community emergency practice in Baltimore for five years. Fast-forward 25 years, and I am now a grey-haired survivor of tens of thousands of clinical hours, manned both with and without residents. I've championed our specialty, as well as our colleagues and patients, in the halls of Congress and my state capital, Annapolis. I've striven to provide the best quality emergency care while at the bedside, through teaching and as a researcher and writer. As a life-long learner, these experiences have formed me into a leader and advocate. Whether at the bedside, in the board room, meeting with my Senator or standing in front of policy makers and the public, I continue to passionately, thoughtfully and tirelessly advocate for you, our profession, and our patients.

There is an old African proverb- *If you want to go fast, go alone. If you want to go far, go together.* This proverb has been a guiding principle of my career; I consistently work to build bridges and break down barriers. As Emergency Physicians, we are caring, thoughtful professionals. We work hard, and we play hard. We care about our patients and for our colleagues. ACEP and emergency medicine play a critical and ever-increasing role within the health care system. I will work together with our many partners to forcefully advocate for emergency medicine and to sustain and to grow the support for our important work. Working together we can, and we will, make a difference.

ACEP's mission is to promote the highest quality of emergency care and be the leading advocate for emergency physicians, our patients, and the public. This has been our mission during my time on the ACEP Board of Directors and for me personally in my other professional activities. Thank you for the honor and privilege to serve as your representative and voice on the ACEP Board of Directors for the past five years.

I ask for your vote for President-Elect in order to continue to serve as your advocate.

Background: Jon Mark Hirshon, MD, MPH, PhD, FACEP

- ***Professor,*** Department of Emergency Medicine and the Department of Epidemiology and Public Health at the University of Maryland School of Medicine.
- ***Mentor and Teacher,*** both domestically and internationally
- ***Senior Vice-Chairman,*** Institutional Review Board, U. of Maryland, Baltimore
- ***Federally funded researcher and teacher*** with specific interest in improving access to acute care and in developing emergency departments as sites for surveillance and hypothesis driven research in public health and emergency department operations
- ***Prolific Author*** of over 100 articles and chapters on emergency care topics, including placing emergency care on the global health agenda.
- Honored by his peers and the American College of Emergency Physicians as a "***Hero of Emergency Medicine***".

CONTACT INFORMATION:
Department of Emergency Medicine, University of Maryland School of Medicine
110 South Paca Street, 6th Floor, Suite 200, Baltimore, Maryland 21201
Cell: 410-271-4825
Email: jhirshon@acep.org

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Mark S. Rosenberg, DO, MBA, FACEP

***Question #1:* Describe a past failure as a leader and what you learned from that experience.**

My father was a no-nonsense man who joined the army at 17 years of age, fought in WWII and landed on Normandy beach. Failure was not even a consideration for him. I don't think he knew the meaning of the word. So, my initial response was something my father instilled in me: that I've made mistakes but never failed. Which started a conversation in my own head as I started down memory lane. Yes, there were failures. More importantly I recognized how I contributed to my own failed outcomes, learned from them and moved on to the next challenge.

One failure that stands out is the opioid crisis. Due to many contributing factors, we as physicians were failing our patients. In a well-intentioned effort to aggressively treat pain, we were creating unintentional addiction. I remember a scenario in early 2015 when I was administering naloxone in one treatment bed and prescribing opioids for acute pain in the next. I felt I could not win. I was stuck perpetuating the problem, reflexively ordering opioids for my patients as the addiction rate and death tolls continued to rise. I did not want to fail my patients; I wanted to help them.

From that desire came ALTO, the Alternatives to Opioids, Program. Physicians can still aggressively treat pain, but we had to change the way we thought about pain. We had to know how to layer on modalities, not just order one pill. ALTO proved extremely effective and ultimately grew to become a nationally recognized model in the management of pain. The ALTO Bill was signed into legislation by President Trump in October 2018, allocating funds to start ALTO Program in EDs across the country. From this failure came motivation, empowerment and change. I wanted to first do no harm and continue to remain accountable to my patients. In the words of Colin Powell "Success is the result of perfection, hard work, learning from failure, loyalty, and persistence." I was certainly part of creating the opioid epidemic as many of us were, but I am proud to have learned from that failure and to be part of a successful movement to address it and find solutions for our patients.

***Question #2:* Your CEO proposes replacing an emergency physician with two mid-level providers (PA, NP, etc.). What is your response?**

As the leader of the ED, it is important first and foremost to have adequate quality care for your patients. I believe your CEO would understand and support that. Depending on your CEO, the approach might be as simple as saying, "Emergency physicians and mid-level providers are not equal. Mid-levels can be an excellent adjunct to the ED team but they do not replace emergency physicians."

For those CEO's who require a more substantive response, there are three major factors to consider when utilizing mid-level or advanced practice providers:

- The training and experience of the mid-level provider.
  - The training curriculums for mid-level providers vary considerably in the number of hours of specific emergency medicine (EM) training requirements. Physician Assistants may have as little as 200 clinical hours in EM and some NPs complete their training without any EM clinical rotations as compared with Emergency physicians, which have approximately 6000 clinical hours with a completed residency. Nationwide less than 10% of advanced practice providers (APP) have any advanced training in EM.
- The American College of Emergency Physicians (ACEP) policy statement:
  - PAs/NPs should not perform independent unsupervised care in the ED without active EP involvement or oversight. This holds true regardless of state and local practice laws.
- Individual state guidelines regarding independent mid-level provider practice.

Specific to this question, I would explain to my CEO that as chairman of the ED, I have to advocate for the highest quality care available and therefore just simply replacing an EP with APPs may put our patient population at risk. This is best illustrated by a story of an ED patient presenting with leg pain after hitting the turf with his fore foot while playing soccer. An experienced ED physician assistant saw the patient. The patient was complaining of severe pain but x-rays were negative. The PA was discharging the patient with a dx of sprain. He documented that the patient was complaining of pain out of

proportion to the injury and therefore was drug seeking. A residency trained board certified EP reviewed the case prior to discharge and determined that the patient was at risk for compartment syndrome. The patient did have a compartment syndrome and appropriate measures were taken. This unlikely diagnosis would have been missed by the PA, the patient discharged to home, with a potentially bad outcome. Best practice and ACEP policy have all APP cases seen or reviewed by the ED Physician, which in this case provided the highest quality care for the patient.

***Question #3*: What are the biggest internal and external threats to emergency medicine and how will you address them?**

There are several internal and external threats to EM. The biggest external threat has been well stated by our President, Vidor Friedman. Out of network billing and surprise bills have taken front stage this year for our president. If negotiations in Washington go our way, EM will exist as it has in the past as a thriving specialty and a great business model that allows us to take care of patients 24/7/365. The threat exists mainly because our ability to negotiate fair payment may be removed from our business model leaving us at the mercy of the insurance companies to decide how much are services are worth. The insurance companies care about profits not fair payment. We must, as emergency physicians be able to negotiate fair payment for the services we provide. As much as we love our specialty and take care of patients regardless of ability to pay, we must realize that EM is a business. As a business, we need to make a fair living for the services we provide. We have all invested much to become emergency physicians. Years of training and significant cost to ourselves and our families. Many are starting their career in significant financial debt. What is a fair wage? What is a fair price to resuscitate a dying patient? How we get paid and what we get paid and our ability to negotiate is at the core of the out-of-network debate. We all agree the patient should be out of the middle but our ability to negotiate fair payment with the insurance companies is at the center of the argument. Part of the solution is to allow emergency physicians to negotiate either directly or through an appropriate arbitration process with insurance companies. This allows us to negotiate for you, our members, and the future of our specialty. Over the years, I have developed tremendous relationships with members of Congress and will utilize my resources and those of NEMPAC to negotiate on your behalf, on our behalf.

The biggest internal challenge for the college is to evolve our membership model into one that works for all emergency physicians regardless of where you are in your career. Our college provides much value but when talking to my colleagues who are not members they tell me the cost is too great. What they are really saying is that there is not enough value for the cost. Therefore, membership value is our biggest internal challenge. Annals of Emergency Medicine, State Advocacy, NEMPAC, PEER, EMF, and CME programs including the well-attended Scientific Assembly are a partial list of highly valued aspects of membership. Although these aspects are valued, membership needs to be more. To be of value, ACEP needs to provide different value to members who are in different parts of their career. ACEP has to change how it provides the value. For instance, CME needs to be different than it was 20 years ago. Lectures and symposiums are being replaced with PodCast and other asynchronous learning.

My philosophy has always been join ACEP for life. Every decade of our careers we have different needs that the college can meet. A new attending may be challenged by debt when someone in their third decade of practice will have different needs. Maintaining CME and board certification may be top on their list. But the evolution of the college as we know it is essential to keep up with the changing needs of all our members regardless of where they are in their career the college needs to provide value. This is our biggest internal challenge to evolve as a college to meet the needs and provide value to all its members and all potential members.

As president elect and President I will fight every day to defend and protect the practice of emergency medicine. As president I will take a sabbatical year from my current chairmanship position (with my CEO's agreement and support) so that I can be a full-time working president of this college. Defending our rights, as emergency physicians, for fair payment for our services and -defending the practice of emergency medicine will be first and foremost my job and responsibility. Analyzing membership value and creating and developing ACEP for life initiative will be one of the cornerstones of my presidency.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Mark S. Rosenberg, DO, MBA, FACEP

Contact Information

38 North Ridge Road Denville, NJ 07834
Phone: 9732240570
E-Mail: mrosenberg@acep.org

Current and Past Professional Position(s)

CURRENT POSITIONS

Chairman, Emergency Medicine
Chief Innovation Officer (CINO)
Associate Professor Emergency Medicine
St Joseph's Health, Paterson NJ

Secretary-Treasurer, Board of Directors, - American College of Emergency Physicians (**ACEP**)
Secretary-Treasurer, Board of Directors - Emergency Medicine Foundation (**EMF**)

Pain Management Best Practice Task Force - U.S Department of Health & Human Services (**HHS**)
Pain Task Force - Institute of Healthcare Improvement (**IHI**)
Opioid Use Best Practice Task Force – Center of Disease Control (**CDC**)

PAST POSITIONS, 10 Years

Chief Population Health - – St Joseph's Health Paterson NJ

Chief, Geriatric Emergency Medicine 2009 to 2015 – St Joseph's Health Paterson NJ

Chief, Palliative Medicine 2010 to 2015 – St Joseph's Health Paterson NJ

President and CEO, Evergreen Emergency Solutions, Contract Management Group, FL and NJ
2004 - 2008

President PhyAmerica Physician Services, Contract Management Group, Ft Lauderdale, FL
1997 - 2004

Vice President of Medical Affairs, Coastal Physician Services
1995 – 1997

Chief, Emergency Services, The Germantown Hospital and Medical Center, Philadelphia, PA
1993 - 1997

Director of Emergency Services, Roxborough Memorial Hospital, Philadelphia, PA
1987 - 1993

Director of Emergency Services, Metropolitan Hospital - Parkview Division, Philadelphia PA
1982 – 1986

Education (include internships and residency information)

Masters, Business Administration in Medical Management
St. Joseph's University
Philadelphia, Pennsylvania 19131
1990 to 1995

Internship and Residency, Emergency Medicine
Metropolitan Hospital
201 8th Street
Philadelphia, PA
1978-1980

Doctor of Osteopathic Medicine
Philadelphia College of Osteopathic Medicine
Philadelphia, PA 19131
1974 to 1978

Certifications

Board Certified Emergency Medicine (AOBEM-AOA)
Certificate No. 161, Feb. 29, 1988

Board Certified Emergency Medicine (ABEM-ABMS)
December 6, 1995; September 2004, October 2013

Board Certified Hospice and Palliative Medicine (ABIM)
December 31, 2010

Professional Societies

American Academy of Hospice and Palliative Medicine
American College Emergency Physicians
American Geriatric Society
American Osteopathic Association
American Medical Association
American College Osteopathic Emergency Physicians
New Jersey Chapter of the American College Emergency Physicians
Society of Academic Emergency Medicine

National ACEP Activities – List your most significant accomplishments

ACEP Board of Directors- Current
Multiple activities as BOD Member
Emergency Medicine Foundation Board of Directors – Current
HHS Pain Management Task Force – Representing ACEP - Current
IHI Opioid Task Force – Representing ACEP
Past Chairman, ACEP Section of Geriatric Emergency Medicine 10/2011-2013
Past Chairman and Founder, ACEP Section of Palliative Medicine 10/2012-10/2014
ACEP Councilor 2011-2017
ACEP Disaster Committee 2013-2015
ACEP Ethics Committee 2014-2016
ACEP NOW – Editorial and Advisory Board 2014-Present
ACEP Practice Management Committee 2014-2016
ACEP Steering Committee 2013-2015

ACEP Chapter Activities – List your most significant accomplishments

NJ-ACEP President 7/2015-6/2016

Practice Profile

Total hours devoted to emergency medicine practice per year: **>2080** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **5** % Research **5** % Teaching **20** % Administration **70** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am Chairman of Emergency Medicine as a hospital employee and manage two emergency departments. The larger is a busy inner city teaching hospital that sees 170,000 visits per year. The second is a community hospital Emergency Department seeing 36,000 visits/year

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**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Mark S. Rosenberg, DO, MBA, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: St Joseph's Health

Address: 703 Main Street

Paterson NJ 07503

Position Held: Chairman, Emergency Medicine and Chief Innovations Officer

Type of Organization: Healthcare

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: ACEP

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Emergency Medicine Membership Organization

Duration on the Board: 4 Years

Organization: D2i formally EMBI

Address: 110 Cornelia Street

Boonton, NJ 07005

Type of Organization: Data Analytics

Duration on the Board: 5 Years

Organization: Patient Code Software

Address: 150 Allen Road

Basking Ridge, NJ

Type of Organization: Software

Duration on the Board: < 1 Year

Organization: EMF, Emergency Medicine Foundation

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Research Foundation

Duration on the Board: 2 year

Organization: New Jersey Hospital Association Health Research Educational Trust

Address: 760 Alexander Road

Princeton NJ

Type of Organization: Education and Research Funding

Duration on the Board: 9/2014- 12/2018

Organization: American College of Osteopathic Emergency Medicine

Address: 142 E Ontario Street Suite 1500

Chicago IL 60611

Type of Organization: Professional Membership Organization

Duration on the Board: 2 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Mark Rosenberg Date / 5/25/19

NEW JERSEY CHAPTER
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

August 13, 2019

Dear Councillors:

The New Jersey Chapter of the American College of Emergency Physicians (NJ-ACEP) would like to provide our enthusiastic support to Dr. Mark Rosenberg, DO, MBA, FACEP, FACOEP-D for ACEP President-Elect. Our Chapter wholeheartedly endorses Mark's candidacy because we are confident that his leadership will serve our College and our specialty particularly well during the current challenges in the U.S. health care system. He has created a significant impact in emergency medicine with his vision in the areas of pain management, geriatrics, palliative medicine, and most importantly the role of the emergency department as a major hub in future healthcare systems.

Mark's career spans 40+ years ranging from bedside ED physician to business owner to emergency department administrator. His intuition has served him well in terms of understanding the need to constantly evaluate and test new processes in the delivery of emergency care. Mark's vast experience has allowed him to forge ahead with pilot programs, innovations and creative solutions utilizing existing resources as well as identifying new solutions and strategies.

He is the Chairman of Emergency Medicine at a St. Joseph's Regional Medical Center in Paterson, NJ. This large teaching hospital is home to one of the busiest emergency departments in the country with over 170,000 visits. At St. Joe's, Mark started one of the nation's first comprehensive Geriatric Emergency Departments and also developed an ED based Palliative Medicine program called 'Life Sustaining Management and Alternatives'. He serves as faculty for their EM residency and was instrumental in their two new fellowship offerings: Acute Pain Fellowship and the newest, Mental Health and Addiction Fellowship. Mark chairs many committees and is recognized as one of the hospital clinical leaders. He is a nationally recognized leader and has authored many articles and textbook chapters. Mark has lectured internationally on Geriatric Emergency Medicine and Palliative Medicine. In 2016, he helped develop The Alternatives to Opioids (ALTO) program at St. Joe's, to address the issue of variation and over-prescribing. He has a sophisticated, broad based and profound understanding of the complex nature of our specialty and its relationship to all of medicine.

Mark has been an ACEP member since 1978 and has embraced service to ACEP with much enthusiasm and determination. He is one of the founding members and Past-President of both Sections on Geriatrics and Palliative Medicine. Through those sections,

he has helped guide not only ACEP's positions on these important matters but also unified many members with similar interests.

He is also active in our state chapter. He served as President from 2015-2016. He continues to provide guidance by attending quarterly Board meetings as a Past President in a non-voting capacity. He is an effective communicator at both the state and national levels. He testified before the New Jersey state legislature on Out-of-Network legislation in 2016 and testified before Congress in March 2018 regarding the need to combat the nation's opioid crisis.

His strongest qualities are his innovative management style, a desire and willingness to work collaboratively with others to improve patient care, and a passion for our specialty. The New Jersey councillors and the members we represent welcome an opportunity to talk with you at any time in Denver to discuss Mark's qualifications and share our unequivocal endorsement of him for election as ACEP President-Elect. We hope you will support his candidacy so that he may advance the advocacy of emergency medicine through our vital organization.

Sincerely,

Thomas Brabson

Thomas Brabson, DO, MBA, FACOEP, FACEP
President, New Jersey Chapter

Mark S. Rosenberg, DO, MBA, FACEP

Dear Councillors,

It's almost time for the October 2019 Council meeting. When you are ready to cast your vote, I would ask you to remember a few things...you deserve a president who is a proven leader. You deserve a president who is an innovative problem-solver. And you deserve a president who will protect not only our specialty but emergency physicians as well. I am that president.

I have 35 years emergency medicine medical director and chairman leadership experience. I am an innovator with several emergency medicine innovation successes that have improved the quality of care for our patients. I work every day to protect and defend the practice of emergency medicine at local, state, and national levels.

During my term as president, I will focus on three main areas of concern: global issues that affect the practice of emergency medicine and the rights of emergency physicians; domestic issues that affect society such as opioids, gun violence, mental health, and addiction; and third, increasing membership value.

- **Global issue initiative**: I will work and advocate every day to protect and defend the rights of emergency physicians and the practice of emergency medicine. There are many issues confronting our practice. Currently the issue is surprise billing. Next year it may be hospital consolidation or workforce issues. As a leader in healthcare and patient advocacy, I will be front and center in the discussion.

- **Domestic/Social initiative:** I will create an innovation center and strategy where we can take the brilliance of our members, ACEP staff, and College leaders and use that synergy to address the many challenges we face. Our initial focus will be on mental health, addiction, and the rise in gun violence.

- **Membership value initiative:** I will focus on increasing membership value by creating an ACEP for life initiative where ACEP gives value regardless of where you are in your career.

I'm committed to ACEP 100%. Being president-elect and president of ACEP requires a tremendous commitment. My hospital CEO, my clinical partners, my friends, and my family are committed to supporting me during my term as your president because they know that the work of the College is so very important**.** I am hereby making a full-time commitment to the College and its members.

Thank you for the opportunity to share a few brief insights about why I am the best candidate for ACEP president-elect and president, and I sincerely ask for your vote. I hope to see you all this October in Denver – safe travels!

Sincerely,

Mark Rosenberg, DO, MBA, FACEP

Moving ACEP Forward Together

Candidate
for President-Elect

Mark Rosenberg,
DO, MBA, FACEP, FAAHPM

Chairman, Emergency Medicine
Associate Professor, Emergency Medicine
St. Joseph's Health
Secretary/Treasurer - ACEP

Emergency Medicine
ADVOCACY

Innovative Care
SOLUTIONS

Enhancing Membership
VALUE

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Council Officer Candidates

acep Scientific Assembly DENVER 19

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Council Officer Candidates

Speaker

Gary R. Katz, MD, MBA, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Vice-Speaker

Kelly Gray-Eurom, MD, MMM, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Andrea L. Green, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Howard K. Mell, MD, MPH, CPE, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Gary R. Katz, MD, MBA, FACEP

***Question #1:* Consider that there is a proposal to eliminate voting rights of sections in the Council. What is your stance?**

The consideration here should not be tied to whether or not sections should have voting rights or not, but in determining the mechanism through which our members gain a voice and representation in our ACEP Council. Under the current model each member has a voice through his or her primary body (e.g. state, EMRA, GSACEP). However, additional representation can be purchased by and through section memberships. There is no limit to how many sections someone can join, nor should there be. However, since section representation is reliant on a threshold number of paying members, then an individual can singly, though expensively, increase their voice in a manner incongruent with a representative republic such as ACEP Council.

Therefore, the real question must be, "if building a representative body from scratch, how would you assure that the voice of emergency medicine covers both the breadth and depth of our specialty?"

To answer this, I would submit that we must create an organization that represents both geographic as well as subject matter expertise. For geographic representation, the current state model fits as well as any other. For subject matter, then a model that incorporates sections should be retained. There are many benefits to this and the reasons extend well beyond the following: from a geographic model, the members are enabled to contribute based on specific work environments unique to their geography (e.g. state laws, regional cultures) as well as have convenience of local opportunities to build leadership. Similarly, while from a subject matter area, there are increased opportunities upon which to build a national consensus, innovate new models in the practice of emergency medicine, and engage with peers on a national stage.

I believe that having a representative body that incorporates both geographic and subject matter expertise is the one that is most beneficial. Unless an appropriate alternate model, that maintains the outlined principles, is developed, I would not endorse blanket removal of Section voting rights.

***Question #2:* What is the role of the Council in debating divisive social issues?.**

The ACEP Council process is well designed to tackle any validly submitted resolutions as topics for consideration. And, it is important that we maintain this parliamentary ideal. While some may express concern that debating a divisive social issue is a distraction for ACEP, I would opine that key and critical actions have been accomplished from such debates once described as divisive or outside medicine's scope.

Take for example the last time you sat in a domestic airline flight where smoking was allowed onboard. I recall those days where one had to select seats as "smoking" or "not-smoking." The truth is there was no true difference between them. The advocacy to halt this practice was first introduced in the 1970's by medical students participating in debate. These students were admonished for submitting resolutions that, "had nothing to do with medicine," yet they persisted. I am glad they did as I travel very frequently these days and do not miss the smoking section (other than the ashtrays in which to dispose of my chewing gum).

The bigger question is how we deal with those resolutions that may appear beyond the pale or push the envelope of what guides ACEP's direction. Fortunately, our ACEP Council employs a reference committee hearing process to scrutinize resolutions and coalesce this debate into a clear consensus. We can strengthen this by having our reference committees make clearer and firmer recommendations based

on testimony heard both before the meeting and on-site. College standing rules currently discourage the wide application of consent agendas, which I find problematic. Finding consensus in the reference room translates to fewer attempts for people to take a second bite at the apple through debate on the council floor and allows our members to explore a variety of solutions while respecting the intensive commitment councilors make.

***Question #3*: Give an example of an issue where you had to sideline your personal viewpoints to represent the opinion of a group.**

One of my guiding principles is that when I represent an organization, I do so in a manner that speaks for that collective opinion without distancing myself from or otherwise undermining the decision authority of that organization. For this reason, I will focus on my process for when I assert my personal opinion and when I would set that aside in the duty of the organization to which I serve.

The first step is making sure I've asserted my personal opinion at the appropriate time. To do this, I must assure I have actively participated in the deliberative process to the extent allowable. During discussion if I find that a recommended action is errant or shows poor judgment, then it is appropriate to raise those concerns to the appropriate body, be that subcommittee, Chair, Council floor, or other administrative component of the organization.

However, if the organization has been thorough, fair, and fulfilled its duty as a deliberative body, once the final decision is made, my duty is to then represent that point of view. This must be completed without acting defiantly or undermining the decision. This goes so far as to avoid distancing myself through statements such as, "while I don't agree, the organization has decided to take [specified] action." In a similar vein, I view it as inappropriate to recruit others to object to the decision on my personal behalf via backroom conversations, which is just another way to skirt one's duty to properly represent a body's position.

While a specific position may be at odds with my personal stance, it is important to remember that our organization has redundant processes to properly consider positions and share where we might individually disagree or agree. Through proper channels, it is always possible to reconsider, modify or resolve decisions, but to do so, one must use the formal deliberative process to make amend or rescind prior action. A highly functioning organization can employ these tasks for greater agility than blindly implementing past decisions under a changed or new construct.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Gary R. Katz, MD, MBA, FACEP

Contact Information

7195 Wilton Chase
Dublin, OH 43017
Phone: 614-207-6882
E-Mail: katz.123@me.com

Current and Past Professional Position(s)

Community EM Partners, CMO, EM Physician, 2018 - present
The Ohio State University, Assistant Professor, Clinical, EM Residency Program, 2016 – present, 2003-2010
Family Care Partners, CMO, 2017
Schumacher Clinical Partners, Section Medical Officer, 2015-2017
Premier Physician Services 2009 – 2015
EVMS/EPT 2001-2002

Education (include internships and residency information)

Summa Health System, Akron, OH, 1998-2001
Medical College of Ohio, 1994-1998, MD 1998

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

ABEM, 2002, 2012

Professional Societies

ACEP, AMA, OSMA, EMRA, OH-ACEP

National ACEP Activities – List your most significant accomplishments

Vice Speaker ACEP Council

ACEP Chapter Activities – List your most significant accomplishments

President, Ohio ACEP

Practice Profile

Total hours devoted to emergency medicine practice per year: **2100** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **70** % Research **0** % Teaching **10** % Administration **20** %
Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Employee owner, private democratic group

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Gary R. Katz, MD, MBA, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Community EM Partners

Address: 525 Whip Rd

Dayton, OH 45459

Position Held: Chief Medical Officer

Type of Organization: Private employee-owner group

Employer: Ohio State University

Address: 410 w 10 Ave

Columbus, OH 43210

Position Held: Assistant Professor, Clinical

Type of Organization: Academic

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: ACEP

Address: 4950 W Royal Lane

Irving, TX 75063

Type of Organization: Medical Society

Duration on the Board: 2 years, Council Officer

Organization: OH ACEP

Address: Snoufer Road

Columbus, OH

Type of Organization: Medical Society

Duration on the Board: About 8 years

Organization: Ohio State Medical Association

Address: 5115 Parkcenter Avenue

Dublin, OH 43017

Type of Organization: Medical Society

Duration on the Board: 4

Organization: Family Care Partners Holdings

Address: No longer in business

Type of Organization: Multi-specialty medical group

Duration on the Board: 6 months

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: I am a founder, but minority shareholder, of Community EM Partners.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Gary Katz Date May 26, 2019

Ohio ACEP
American College of Emergency Physicians
Advocacy | Education | Leadership

Members of the ACEP Council:

It is with great pride and enthusiasm that Ohio Chapter ACEP nominates and endorses our colleague **Gary Katz, MD, MBA, FACEP**, to be the next Speaker of ACEP council.

Over the preceding two years, Dr. Katz has honorably served as Council Vice Speaker. In his capacity, he oversaw the rewrite of election guidelines to even the campaign playing field. He has brought innovation to our council by designing and moderating the new President-Elect debates. Under his leadership, candidates reached out via live town halls, online polling, and other interactive methods to hear to voice of the practicing Emergency Medicine Physician. This past spring he led the effort to revise the resolution writing guidelines. He also created a forum where members could meet with like-minded individuals and seed the construction of new and well-written policy, worthy of consideration.

Dr. Katz demonstrated similar leadership while president of Ohio Chapter ACEP. His history and recent performance shows the consistency we need to advance the Council and the profession. He is an **established leader** who has compiled an impressive record of **service** and **accomplishment** and we believe he will continue to **effectively advocate for emergency physicians**, our specialty, and the care of our patients.

Please join us in supporting Gary Katz to be the next ACEP Council Speaker.

Brad Raetzke

Bradley D. Raetzke, MD, FACEP
President
Ohio Chapter ACEP

President
Bradley D. Raetzke, MD, FACEP

President-Elect
Ryan Squier, MD, FACEP

Treasurer
Dan C. Breece, DO, FACEP

Secretary
Nicole A. Veitinger, DO, FACEP

Immediate Past President
John R. Queen, MD, FACEP

Executive Director
Laura L. Tiberi, MA, CAE

3510 Snouffer Road, Suite 100, Columbus, Ohio 43235
Phone: (614) 792-6506 | TollFree: 1 (888) 642-2374 | Fax: (614) 792-6508

Gary R. Katz, MD, MBA, FACEP

My name is Gary Katz. I am asking for your vote to become our next ACEP Council Speaker.

In my campaign for election to Vice Speaker two years ago, I proposed ideas to help create more robust business for Council. I also proposed new ways of engagement so we could arrive to Council ready to act.

Over the last two years I have created or facilitated movements to achieve these very goals. We have encouraged use of the Engaged communities and several delegations used this to garner national support for their resolutions. We also created a forum at LAC to serve as a think-tank and seed the ideas for business we will see at this upcoming meeting. Further, I advocated for a stronger voice of the council officers at ACEP Board meetings. In this fashion I have spoken on behalf of our Council and helped report on lessons learned when communicating in times of turmoil.

Even with these achievements, I believe there is more to accomplish. We must assure Council growth conforms to our ideals of member representation, so your voice is heard. We need to both safeguard cutting edge discussions and yet remain equally focused, as your contributions at Council are invaluable. We cannot stop our progress at pushing the Board to be Emergency Medicine's greatest advocates.

I believe I have the experience to move our Council from where it is to where you want it to be.

Thank you for the opportunity to serve as Vice Speaker and for your vote in Denver for Speaker.

Very respectfully,

Gary

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Kelly Gray-Eurom, MD, MMM, FACEP

Question #1: **Consider that there is a proposal to eliminate voting rights of sections in the Council. What is your stance?**

A top priority for ACEP right now is membership engagement. How can the College attract and retain more Emergency Medicine Physicians? How can we provide better value to our current members so they renew their ACEP membership? How can the College better hear the voice of their members? A proposal to eliminate the voting rights of sections at Council runs completely counter to that mission.

Sections were created to fill a perceived gap in the offerings of the College. Active, engaged, and paying members formed sections as a way for their voices to be heard on specific topics and areas of expertise. Sections represent different objectives compared to the state chapters and they bring diversity to the deliberative body of Council.

There is a discussion thread that maintaining section voting rights is duplicative membership representation. I would disagree with that premise based on simple math. No matter how many members pay section dues, each section has only one Council vote. The pros of supporting and encouraging members who wish to represent emergency medicine with their time and talents far outweighs the small nominal effect of duplicative membership.

Council is growing. We are outgrowing some conference centers. This is reason to celebrate, not to place limits on members who want to be involved. The solution to Council growth lies with event planning for different venues. It may lie with more innovative use of technology such as integrating Zoom or engagED into Council. It may lie in changes to the traditional Council meeting agenda. It will ultimately lie in a combination of ideas created by staff, leadership and members. I do not believe the solution lies in restricting Council voting representation.

I feel strongly about this topic and I am happy to give my personal opinion, but mine is not the only opinion that matters. A proposal like this would need to be a Council discussion with all councillors voicing their thoughts and talking about the pros and cons of membership engagement and Council growth.

As a Council Officer, my responsibility would be to ensure those discussions are facilitated so the views of Council can be heard and articulated in meaningful ways. My voice would be used to ensure the voice of Council is always represented to the Board.

Question #2: **What is the role of the Council in debating divisive social issues?**

I am running for Vice-Speaker because I ardently believe in the importance and purpose of Council. Council is the deliberative body that represents the ACEP membership. It provides the check and balance to the business of the College. Council is the embodiment of a democratic republic. The amazing power of a democratic republic is that the majority does not get to silence the minority. Council rules ensure minority voices are heard equally as strong on the Council floor. The debate is not limited to those who speak the loudest nor to those who return to the repeat-speaker's microphone the most often. Debate remains open on the council floor until comments have been heard on both sides of the issue. It is a powerful discussion forum that provides significant input into the work of the College.

Council is an exceedingly important forum, but it is not the only ACEP forum. Resolutions are powerful tools, but they aren't the only tools to move ACEP issues and discussions forward. Complex social issues don't always lend themselves well to the format and purpose of a resolution. We run the risk of short shrifting important conversations by trying to squeeze very complex topics into resolutions just so they can be heard on Council floor.

So don't start with the goal of a yea or nay resolution vote. We get lost in the task of getting to yes or no. The real goal for some complex social issues should be the discussion itself. Use the deliberative voice of Council as an information gathering tool. Use Council time to deliberate the topic and don't force the issue of a resolution vote. Those deliberations would be the

starting point for work groups to flush out the nuances of complex social issues in ways that are not possible on the Council floor. This is different than referral to the Board because Council is acknowledging *at the onset* of the discussion that the issue or topic is too large for a single setting or single round of discussions. It is the candid assessment that more than Council is needed for certain decisions.

Discussing and debating relevant issues is a key function of Council. Finding new ways for the voice of Council to be heard *effectively and efficiently* is a key charge for the Council Officers and one of the reasons I hope to be your Council Vice-Speaker.

***Question #3*: Give an example of an issue where you had to sideline your personal viewpoints to represent the opinion of a group.**

Emergency Physicians sideline their personal views all the time. We are 24/7/365. Anyone. Anything. Anytime. At any given moment, we are called upon to provide care and compassion to people we don't agree with and sometimes don't like very much. We deal with administrators and consultants that have vastly different viewpoints. Yet usually, we find a way to put aside our personal views and simply do our jobs to the best of our ability. I am no different. I take deep breaths. I walk away. I face-palm at my desk. I try to ignore the unimportant differences that cause needless turmoil during the shift. Most of the time in the ED, I can just keep moving.

Outside of the ED, it is harder. Social media and political advocacy in 2019 create entirely new levels of difficulty in the challenge of collaboratively finding common ground. Rapidly typing the first thing that pops into my inflamed brain when I see one of *those posts* is so tempting. The power is right there – a thumb click away. My view will be online for all to see. It is hard to step back from that adrenaline rush. When I start thinking, "Well, I will just tell them", delete and scroll down has become my favorite self-centering trick. Wait, pause and think it through. It doesn't have the same immediate gratification, but it also doesn't have the inevitable, "Ugh! What did I just do?"

Advocacy has a very different challenge because unlike social media, the people in the room can see me. Working across differences is critical to achieving our goals for ACEP and our EM physicians. I don't agree with some of the people that are important to our advocacy efforts. I don't always like their actions or their voting records. Mastering the poker face and reading the room have become key skill-sets. A sense of humor doesn't hurt either.

One of my DC representatives would take perverse delight in badmouthing my emergency department and my partners every time we entered their office. "You didn't treat my constituent's diabetes correctly. He had a blood sugar of 117 and you did nothing!" It was always a 15-minute brow beating from Dr. Google. They had no wish to be educated; they just wanted to start our conversations feeling their authority. I had to learn to hold my medical teaching moments for the ACEP issues. If I deviated too far from Dr. Google, I became the enemy and the conversation was over. I wouldn't let them get too far down the path of bad-bad doctor. Some things are just too important and our clinical reputation is one of them. But allowing a small personal annoyance to slide for the good of the group was necessary in that particular office, at that particular time, to achieve advocacy success.

Finding humor, having patience, picking the right moments and learning to set aside personal agendas are tools that will help me serve and facilitate discussions as Council Vice-Speaker.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Kelly Gray-Eurom, MD, MMM, FACEP

Contact Information

4228 Fairway Drive
Jacksonville, FL 32210
Phone: 904.389.9692 (h)
904.352.6379 (c)
E-Mail: Kelly.grayeurom@jax.ufl.edu

Current and Past Professional Position(s)

University of Florida / UF Health Science Center - Jacksonville

- Chief Quality Officer / Assistant Dean of Quality and Safety
- Associate Chair, Director of Business Operations, Director of PA Services Department of EM
- Administrative Director of Emergency Services at Winter Haven Hospital
- Chairman & Medical Director Division of EM at Orange Park Medical Center
- Assistant Medical Director & Vice-Chairman Division of EM at Orange Park Medical Center
- Assistant Medical Director, Clay County Fire and Rescue
- Professor, Associate Professor, Assistant Professor, Clinical Instructor

Education (include internships and residency information)

Masters of Medical Management (MMM) – Tulane School of Public Health (2008-2010)

Residency – University of Florida Health Science Center

- Chief Resident, Department of Emergency Medicine (1995-1996)
- Residency, Department of Emergency Medicine (1993-1995)
- Internship, Department of Internal Medicine (1992-1993)

University of Vermont College of Medicine – MD (1988-1992)
Iowa State University – BS (1985-1988)

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

American Board of Emergency Medicine (1997, 2007, 2017)
Just Culture Champion Certification (2015)

Professional Societies

American College of Emergency Physicians
Florida College of Emergency Physicians
American College of Physician Executives
Emergency Department Practice Management Association
Society of Academic Emergency Medicine
American Medical Association
Florida Medical Association

National ACEP Activities – List your most significant accomplishments

- ACEP Council Meritorious Service Award — 2017
- Council Tellers, Credentials & Elections Committee
  - Chair — 2011 – 2013
  - Member — 2010 – 2018
- ACEP Nominating Committee — 2010-2013; 2017
- Council Reference Committee
  - Chair — 2016, 2009
  - Member — 2008
- ACEP 50th Jubilee Task Force — 2015 – 2018
- ACEP Steering Committee — 2008 – 2010
- Councilor
  - Florida College of Emergency Medicine — 2008 – 2019
  - AAWEP — 2006 – 2007
  - AAWEP (alternate) — 2005 – 2006
  - Young Physicians Section — 2003 – 2004

- Membership Committee
  - Chair — 2013 – 2016
  - Member — 2008 - present
- Section Affairs Task Force / Grant Reviews
  - Chair — 2007-2013
  - Member — 2005-2007
- Outstanding Service to Section Award
  - Chair, Young Physicians Section — 2006
- Outstanding Section Newsletter Award
  - Editor, Young Physicians Section — 2006

- Fellow, American College of Emergency Physicians — 1997

ACEP Chapter Activities – List your most significant accomplishments

Florida College of Emergency Physicians

William T. Haeck, Member of the Year Award	2014
Immediate Past-President	2013 – 2014
President	2012 – 2013
Delegate to the FMA	2012 - 2013
President Elect	2011 – 2012
Vice-President	2010 – 2011
Member, Executive Committee	2009 - 2014
Secretary / Treasurer	2009 – 2010
Councilor	2008 - 2019
Chair, Bylaws Review	2008 - 2009
Member, Board of Directors	2006 – 2014
Member, Government Affairs Committee	2004 - 2015
Member, Professional Development Committee	2004 - 2015
Chair, Academic Affairs Committee	2004 – 2008
Member, Medical Economics Committee	1999 – 2015
Member	1992 - present

Practice Profile

Total hours devoted to emergency medicine practice per year: **2020** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **10** % Research **0** % Teaching **10** % Administration **80** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am a full-time Professor of Emergency Medicine for the University of Florida COM-Jacksonville. The Emergency Department (ED) at UFHealth-Jacksonville is an urban safety-net providing care to nearly 90,000 adult and pediatric patients presenting for acute medical, surgical, obstetrical and critical care. It is made-up of 6 different care units including a Critical Care Area, a separate ED Observation Area, level-1Trauma Center and dedicated Pediatric ED. We train emergency medicine residents, pediatric emergency medicine fellows, ultra-sound fellows, toxicology fellows and patient safety fellows.

I have served as the medical director of the academic ED, the administrative director of emergency services at a 60,000-volume community ED and the medical director of a 45,000-volume community ED. I have been the Director of Business Operations since 2001 overseeing EM billing, coding and compliance. In 2015, I became Chief Quality Officer and Assistant Dean of Quality & Safety for the organization. I coordinate a division of quality, safety, risk, accreditation, infection prevention & control and performance improvement. I remain an active part of the Department of EM and work clinically each week in the ED.

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**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Kelly Gray-Eurom, MD, MMM, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: University of Florida COM

Address: 655 W. 8th St.

Jacksonville, FL 32209

Position Held: Professor of EM / Chief Quality Officer / Assistant Dean of Quality & Safety

Type of Organization: Academic, Urban, Safety-Net Hospital / Multi-disciplinary physician practice

Employer: University of Florida COM

Address: 655 W. 8th St.

Jacksonville, FL 32209

Position Held: Please see attached sheet

Type of Organization: Academic, Urban, Safety-Net Hospital / Multi-disciplinary physician practice

(If additional space is needed, attach an additional sheet – see page 3.)

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Shands Jacksonville BOD

Address: 655 W 8th St.

Jacksonville, FL 322209

Type of Organization: Academic, Urban, Safety-Net Hospital; not-for-profit

Duration on the Board: 2013-2014

Organization: Winter Haven Hospital

Address: 200 Ave F NE

Winter Haven, FL 33881

Type of Organization: Community Hospital – non affiliated; not-for-profit

Duration on the Board: 2006-2012

Organization: Florida College of Emergency Physicians

Address: 3717 S Conway Rd

Orlando, FL 32812

Type of Organization: Not-for-profit

Duration on the Board: 2006-2014

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Kelly Gray-Eurom, MD,MMM, FACEP 6/12/19

Continued from page 1 – current employer.

Additional Positions Held

Employer: University of Florida COM

Address: 655 W. 8th St.

Jacksonville, FL 32209

Positions Held

Associate Chair, Director of Business Operations, Director of PA Services
Administrative Director of Emergency Services at Winter Haven Hospital
Chairman & Medical Director Division of EM at Orange Park Medical Center
Assistant Medical Director & Vice-Chairman Division of EM at Orange Park Medical Center
Assistant Medical Director, Clay County Fire and Rescue
Professor, Associate Professor, Assistant Professor, Clinical Instructor

Type of Organization: Academic, Urban, Safety-Net Hospital / Multi-disciplinary physician practice

Florida College of Emergency Physicians

A CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
3717 South Conway Road • Orlando, FL 32812
(407) 281-7396 • FAX (407) 281-4407
(800) 766-6335 • www.fcep.org

Officers:

Kristin McCabe-Kline, MD, FACEP
President

Sanjay Pattani, MD, MHSA, FACEP
President-Elect

Damian Caraballo, MD, FACEP
Vice-President

Aaron Wohl, MD, FACEP
Secretary-Treasurer

Adrian Tyndall, MD, FACEP, MPH
Immediate Past President

Beth P. Brunner, CAE, MBA
Executive Director

Board of Directors:

Rajiv Bahl, MD, MBA, MS
Matthew Beattie, MD EMRAF Rep.
Daniel Brennan, MD, FACEP
Jordan Celeste, MD, FACEP
Vidor Friedman, MD, FACEP
Jesse Glueck, MD
Shayne Gue, MD
Erich Heine, DO
Saundra Jackson, MD, FACEP
William Jaquis, MD, MSHQS, FACEP
Shiva Kalidindi, MD, MPH,MD(Ed.)
Gary Lai, DO, FACOEP
Russell Radtke, MD
Todd Slesinger, MD, FACEP,FCCM, FCCP
Jill Ward, MD, FACEP

August 14, 2019

Dear Councillors:

The Florida College of Emergency Physicians (FCEP) is proud to endorse our colleague Kelly Gray-Eurom MD, MMM, FACEP for Council Vice Speaker.Dr. Gray-Eurom has been active with FCEP and the American College of Emergency Physicians (ACEP) since her residency days over 20 years ago. She has dedicated countless years toward the advancement of emergency medicine in the state of Florida, in Washington DC, in service on ACEP Committees and during her 15-year tenure as an ACEP Councillor. The time has come for her to continue her service as the next Council Vice Speaker.

ACEP has benefited greatly from Dr. Gray-Eurom's talents. She has been a member and chaired many different committees including Membership, Section Affairs, Bylaws, Quality and CEDR. Council has also benefited from her time as a Councillor for AAWEP, YPS and for the last decade, as a member of the Florida Delegation. She has served on the Council Steering Committee, Nominating Committee and Awards Committee. Her leadership skills have been put to work as a Reference Committee Chair and for many years – including 3 years as Chair - serving on the Council Tellers, Credentials & Elections Committee. In 2017, in recognition for her outstanding service to Council, Dr. Gray-Eurom was awarded the Council Meritorious Service Award.

Dr. Gray-Eurom has spent her career with the University of Florida, Shands Jacksonville, but her career spans much more than traditional academics. Her areas of expertise include ED management, ED flow, billing, coding, compliance and quality. Her collaborative leadership style and attention to detail has led her to enhance system development with a focus on quality improvement. In her career, she has been a medical and business director of a 45,000 volume community ED, the Administrative Director of a 60,000 volume community ED in central Florida and became the Medical Director of the 90,000 volume academic ED in Jacksonville. She has continued her successful career as the Business Director for the Department of Emergency Medicine, UF Health Jacksonville. She is currently a Professor of Emergency Medicine and Chief Quality Officer for UF Health Jacksonville. She continues the clinical practice of emergency medicine and enjoys working with the emergency medicine residents. Her passion remains teaching young physicians how to transition from residency into a successful EM career.

Dr. Gray-Eurom has developed strong leadership skills over the years. She has spent her time as an ED Director, ACEP committee chair and as a Chief Quality Officer guiding diverse teams through difficult scenarios to reach meaningful and successful outcomes. She is now at the point of her career where it is time for her to use her exceptional leadership skills working to enhance emergency medicine through ACEP's Council. Her main goal as Council Vice Speaker will be to ensure your voice is always heard.

FCEP is pleased to support Kelly Gray-Eurom, MD, MMM, FACEP as Vice Speaker. If you would like to learn more about her outstanding abilities or why we unanimously support her election, please contact me, our Chapter Executive, or any of the Florida Councillors.

Sincerely,

KMcCabe MD

Kristin McCabe Kline, MD, FACEP
President

Kelly Gray-Eurom, MD, MMM, FACEP

To My Fellow Councillors

Thank you for your work in advancing emergency medicine, and thank you for the opportunity you have given me to continue my service to EM by running for Council Vice Speaker.

Each of us has an important voice used to promote the specialty of emergency medicine. We have an obligation to use those voices to the best of our abilities. The elected leadership has an increased obligation to use their voices wisely, but there is an important distinction between the voices of the Board of Directors and the voices of the Council Officers. The BOD members use media platforms to promote the public messages and mission for the College. They are the external voices. The Council Officers are the internal voices. They use their voice to advance the objectives of the Council clearly to the BOD throughout the year. As your Vice Speaker, I will use my voice to ensure YOUR voice is heard before, during and after Council.

BEFORE – Newer communication platforms allow pre-Council discussion at a level not previously experienced. Council Officers can link councilors and resolution authors; facilitating members to more fully integrate their concepts to streamline resolutions prior to arriving at Council. Merging siloed ideas before Council will make the resolution process stronger.

Council Officers can assist the Nominating Committee to increase representation by addressing the hesitation of well-qualified prospective candidates. A priority should be leveraging the tools and wisdom of prior BOD and Council Officers to educate prospective candidates in the "how to" strategies required to balance professional and personal obligations alongside College service. Asking someone to run is not enough. Guidance to make competing time demands workable is critical to getting the "Yes" we all need. The most qualified person is rarely the most available.

DURING – Council time is valuable. An efficient meeting has an agenda, starts on time, and ends on time. At a minimum, all agenda items are covered. To fully value Council time, the meeting has to be effective. An effective Vice Speaker listens to the room to hear what is not being said and engages the unrepresented voice. An effective Vice Speaker reads the room to anticipate issues. An effective Vice Speaker guides discussion to actionable items to bring a good ROI for your time.

As a CQO, I spend my days guiding diverse teams through challenging discussions to reach meaningful solutions. I would be honored to put those skills to work for you at Council.

AFTER – The talents of Council do not cease when the gavel falls on the 2nd day. Historically we have functioned in that way. Basecamp and ACEP engagED give the Council Officers the ability to solicit thoughts and opinions throughout the year.
I feel strongly about the need to increase communication. Council voice is more effective when heard more frequently.

Each candidate for Vice Speaker has exceptional qualities. Each brings different skill sets to the podium. I believe the time is right for my ideas and my skill sets to effectively and efficiently serve Council. I respectfully ask for your vote. I look forward to seeing, talking, and listening to each of you in Denver and earning your vote.

Kelly Gray-Eurom, MD, MMM, FACEP
Past President, Florida College of Emergency Physicians

Kelly Gray-Eurom MD MMM FACEP

FOR ACEP COUNCIL VICE SPEAKER

YOUR VOICE BEFORE, DURING & AFTER COUNCIL

- Empower Members
- Effective Forum Leader
- Mentor, Teacher, Team Player

SMALL TOWN ROOTS • URBAN TRAINING • ACADEMIC & COMMUNITY PRACTICE

Professional Experience

Professor of Emergency Medicine

Chief Quality Officer

Assistant Dean for Quality and Safety

Director of EM Billing, Coding & Compliance

Director of Business & Clinical Operations
- **90K academic ED**

Director of PA Services
- **90K academic ED**

Administrative Director of Emergency Services
- **60K community ED**

ED Medical Director
- **45k community ED**

Masters in Medical Management

Advisory Workgroup for CMS Hospital Star Rankings

Sr Lead for Strategic Planning University of Florida

Professional Activities / Committees

COUNCIL

15 year Council Veteran, YPS, AAWEP, FCEP
Tellers Credentials & Elections Committee Chair & Member (3ys/8yrs)
Reference Committee Chair & Member
Steering Committee
Bylaws Restructuring Committee
Nominating Committee
Awards Committee
ACEP Council Meritorious Service Award 2017

COLLEGE

Membership Committee, Chair & Member
ACEP 50th Jubilee Task Force
CEDR
Quality & Safety Committee
National Chapters & Relations Committee
Section Affairs, Chair & Member
Chair, YPS

FCEP

Past President (Sec't / VP / Pres-Elect /Pres)
Chair, Membership and Professional Development
Chair, Academic Affairs
Mentor, Young Physicians Fellowship
William T Haeck Member of the Year 2014

Proudly Endorsed By The Florida College Of Emergency Physicians

@KGrayEurom @KGrayEurom Kgrayeuorm.KGE

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Andrea L. Green, MD, FACEP

***Question #1:* Consider that there is a proposal to eliminate voting rights of sections in the Council. What is your stance?**

Sections provide leadership and a concentration of expertise that is a valuable and important resource for the College and the Council. Sections are essential in providing awareness, a voice, and full representation of the issues of the specialty groups they represent. The research and education produced by our sections is invaluable. Their expertise often drive policy, position statements, and critical decisions within ACEP. The right to vote gives them standing in the Council. To eliminate this right is to lose the unique perspectives sections bring to the Council and remove a minority voice that need to be heard by the Council and the College. Eliminating voting rights of sections would also remove representation of the interest of key members, decrease the influence of sections, and remove a valuable source of education from specialist available during the Council meetings.

Recently, I listened to a discussion about the growth of the Council and concerns about managing its size. The discussion did involve limiting section participation. It is becoming incumbent upon us to consider a long-term plan to address Council growth. However, the sections serve a critical mission for ACEP and the Council, and I do not feel that limiting their voting rights is the route to take. Additionally, when comparing the overall number of seats for sections to the total seats of the Council, the percentages are low. Therefore, removing the sections would not provide substantial impact on the size of the Council. Instead, I believe it would create the unintended consequence of providing minimal impact in reducing Council size while simultaneously decreasing available resources, decreasing available expertise, suppressing minority voices, and eliminating full representation of our membership. This is not a viable option to the long-term solution of limiting the overall growth and size of the Council. I would recommend appointing a Council sub-committee to study this and develop a plan for the Council to consider. Ultimately, the decision rests with the Council.

***Question #2:* What is the role of the Council in debating divisive social issues?.**

I believe that it is the role of the Council to consider and debate divisive social issues that may impact ACEP, our members, and our patients. The outcome of such debates should generate responsible recommendations for actions by the ACEP Board of Directors.

When debating divisive social issues however, the Council must keep in mind the mission and values of ACEP as well the best interest of the Council, the members, and the patients we serve.
The Council should consider information available from our highly respected sections, topic experts, and government affairs experts that can provide a wealth of knowledge on a multitude of issues. This expert input can be useful in making early determinations as to the wisdom of continuing the debate on these issues. This provides a benefit to our councilors' generous time and commitment which is valuable, and I will always seek to use effectively.

Should Council decide to proceed with debating a particular divisive issue, the debate should remained focused allowing determination as to what may or may not be a good fit for ACEP and our membership to be made as quickly as possible. Every effort should be made to identify common threads and work toward recommending non-polarizing solutions.

We face many challenges from our governments, hospitals, insurers, lawyers, and patients. Staying focused and using our resources wisely will allow us to continue with our mission and to continue to be American's "healthcare safety net".

***Question #3*: Give an example of an issue where you had to sideline your personal viewpoints to represent the opinion of a group.**

In the state of Texas, we breed big ideas and big points of view. When President of the Texas College of Emergency Physicians, of course, I had to tackle big issues. I fought against the repeal of Texas tort reform statutes, I shut down an effort by a teaching hospital that was trying to create an alternative board Emergency Medicine Fellowship, was involved with efforts to address the issue of Medicaid expansion in our state, and started our chapter residency visit program. I do not shy away from jumping into issues with both feet. I am skilled at recognizing when and how to intervene, putting things in proper

perspective, and the importance of creating win-win situations in a variety of settings. I have integrity and selflessness, and I unquestionably understand suspending your personal viewpoints on behalf of others.

A personal example was a situation that occurred when I was a member of a single hospital, independent, democratic emergency physician group. Our group was requested to provide staffing for a new facility being developed by our hospital. The group initially indicated to the CEO a willingness to accept the additional contract. However, as time grew closer to opening the new facility the group begin to reconsider the financial risk and the work. Our group hired a consultant who did an extensive financial and risk assessment and provided data indicating that the risk was not as substantial as the group predicted. I was comfortable with the data presented and the assessment of the consultant. I felt that our group could be successful and was concerned about the potential negative impact on our group of changing our position so late in the process. I encouraged our group to move forward with the project. After multiple meetings with the consultant, the group took a vote deciding not to move forward and requested that I present their decision to the CEO. This decision was made about 90 days prior to the opening of the new facility. I met with the hospital CEO concerning the decision of our group. I discussed with him the financial, staffing, and risk concerns of our group. He was extremely displeased with being advised of this decision at 90 days prior to his grand opening. To prevent our group from losing their contract, I knew I had to problem solve. I agreed to help him with an alternative plan to keep his opening on track, ultimately creating a win for our group who continued enjoying their single contract for over 20 years.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Andrea L. Green, MD, FACEP

Contact Information

5 Twin Springs Dr
Dalworthington Gardens, TX 76016
Phone: 817.233.2896
E-Mail: eli.chason.green@prodigy.net

Current and Past Professional Position(s)

Emergency Physician, American Physician Partners - current
Emergency Physician, Marshfield Clinic Eau Claire - current
Emergency Physician, Emergency Physicians Partners/USACS
Director, TeamHealth West Travel Team
TeamHealth West Traveling Medical Director
TeamHealth Medical Advisory Board
CEO 1st Care Healthgroup
CEO 1st Care Hospitalist Group
Medical Director, Swedish Medical Center, Denver, CO
Chairperson, Texas Health Resources Family Violence Prevention Initiative
Medical Director, Arlington Memorial South Medical Center, Arlington, TX
Chairperson, Arlington Memorial Hospital Emergency Department, Arlington, TX
Medical Director, Tarrant County Junior College EMS Program
Chairperson, Sinai Samaritan Medical Center, Milwaukee, WI
Medical Director, Worcester Hahnemann Hospital, Worcester, MA

Education (include internships and residency information)

Prairie View A & M University
University of Iowa College of Medicine
Michigan State Affiliated Emergency Medicine Residency
Howard University Emergency Medicine Residency

Medical Doctor, 1979

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

American Board of Emergency Medicine

Professional Societies

American College of Emergency Physicians
Texas College of Emergency Physicians
Texas Medical Association
American Medical Association
National Medical Association

National ACEP Activities – List your most significant accomplishments

Chair, Diversity, Inclusion, Health Equity Section
Speaker at ACEP Corporate Council
ACEP Council Steering Committee
ACEP Council Tellers and Credentialing Committee
ACEP Council Nominations Committee
ACEP Council Reference Committee
ACEP Awards Committee
ACEP Council Forum Subcommittee
ACEP Council Strategic Issues Forum Facilitator

ACEP Chapter Activities – List your most significant accomplishments

President, Texas College of Emergency Physicians
Board of Directors, TCEP
Texas College of Emergency Physicians Secretary
Texas College of Emergency Physicians Treasurer
TCEP Councilor
TCEP Reimbursement Committee, Chair
TCEP Government Affairs Committee

Practice Profile

Total hours devoted to emergency medicine practice per year: **1,584** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **95** % Research **0** % Teaching **5** % Administration **0** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I work as a traveling emergency physician for American Physician Partners, who manage multiple hospital contracts in a variety of settings and hospital facilities. Over 65% of my work is in rural emergency departments and the remainder of my work is in urban and suburban emergency departments. These facilities are part of multi-hospital systems. In addition, I work at Marshfield Clinic emergency department located in a small urban area.

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**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Andrea L. Green, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: American Physician Partners
Address: 5121 Maryland Way, Suite 300
Brentwood, TN 37027
Position Held: Attending Physician Travel Team
Type of Organization: Emergency Medicine Management Services

Employer: Burlington Healthcare Providers
Address: W329 N4476 Lakeland Dr
Nashotah, WI 53058
Position Held: Attending Physician
Type of Organization: Emergency Medicine Staffing Services

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Texas College of Emergency Physicians
Address: 401 W. 15th St, Suite 695
Austin, TX 78701
Type of Organization: 501C Chapter of ACEP
Duration on the Board: 1998 - 2007

Organization: Holt Bowser Charity Scholarship Foundation
Address: 904 Dover Heights Trail
Mansfield, TX 76063
Type of Organization: 501C3 Christian Scholarship Foundation
Duration on the Board: 2013 - current

Organization: Prairie View A & M University HKINE Advisory Board

Address: P.O. Box 519 Mail Stop 2415

Prairie View, TX 77446

Type of Organization: University

Duration on the Board: October 2018 - current

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: I am president and sole owner of Andrea Green, MD, PA. This is my professional association through which I provide independent contractor services to emergency medicine management companies.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Andrea L Green, MD, FACEP Date **June 11, 2019**

2019-2020
Board of Directors

Hemant Vankawala, MD, FACEP
President

Robert Hancock, DO, FACEP
President-Elect

Craig Meek, MD, FACEP
Treasurer

Sterling Overstreet, MD, FACEP
Secretary

Gerad Troutman, MD, FACEP
Immediate Past President

Justin Fairless, DO, FACEP

Justin Hensley, MD, FACEP

Doug Jeffrey, MD, FACEP

Alexander Kirk, MD, FACEP

Lorelle Knight, MS-III

Marcus Sims, MD

Theresa Tran, MD, MBA

Sandra Williams, DO, FACEP

Lee Wood, DO

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.

TCEP
TEXAS COLLEGE of EMERGENCY PHYSICIANS

Dear Councillors:

It is with great pleasure that the Texas College of Emergency Physicians (TCEP)and the Diversity, Inclusion, and Health Equity Section (DIHE) endorse Andrea Green, MD, FACEP as a candidate for the ACEP Council Vice Speaker position. Andrea has served with distinction as an emergency medicine leader on the local, state, and national levels.

Andrea is committed to the ACEP Council, having served on the Council for over 20 years. She knows the work of the Council Committees from her service on many including Steering committee, Reference Committee, Tellers, Credentials and Elections Committee, Nominations Committee and Awards Committee. Andrea dedicated over 10 years to attending ACEP board of Director meetings observing and learning the work of the Council Officers and their relations with the board and with ACEP staff.

Andrea served as President of TCEP from 2005 – 2006 and served on the TCEP board of Directors for nine years. In addition, her expertise is valued as she served many years on the Reimbursement Committee and as its chair, served many years on the Government Affairs Committee and on the EMS Committee. She continues to be involved with TCEP, particularly with legislative activities. Her experience working through difficult situations helps her stand apart when it comes to working cooperatively and effectively. She has demonstrated the ability to bring disparate people together and to gain control of difficult situations.

In addition to the work she has done on the state level, she has been a tremendous asset to national ACEP. On the national level, Andrea is a major donor to EMF and NEMPAC and is a member of the Wiegenstein Legacy Society. Her list of appointments to various ACEP committees is long and diverse.

Most recently, Dr. Green was the founding Chair of the Diversity, Inclusion, and Health Equity Section which began in 2018. Focused on promoting and highlighting how diversity improves health care outcomes, the Section's important work wouldn't exist if not for leaders like Dr. Green. Her leadership styles invites others to the table in a way that gets buy in. We have seen this over the last year in the DIHE section and for years in Texas. We feel strongly that she is the type of leader who can help ACEP face its challenges.

Her clinical work takes her to many states and to many hospitals and community environments as a travel team physician. This has provided her with an awareness that facilitates her ability to understand the perspectives of many members of the council.

She brings to the Council Vice Speaker position energy, initiative, leadership, and the willingness and ability to take control. These qualities, her vast accomplishments, and her long- standing commitment to the Council makes her the ideal candidate Vice Speaker. The Texas College of Emergency Physicians and the Diversity, Inclusion and Health Equity Section jointly endorse the candidacy of Andrea Green for ACEP Council Vice Speaker.

Sincerely,

Nicholas Vasquez, MD

DIHE Vice Chair

Hemant Vankawala, MD, FACEP

President, TCEP

Andrea L. Green, MD, FACEP

Hi, I am **Andrea Green,** and I am asking for your vote **for Vice Speaker** of the ACEP Council.

The history and leadership of emergency medicine over the past 50 years is impressive. The founding fathers created the blueprints for a road that has since been paved by many talented emergency medicine professionals. These emergency specialists continue the progression of emergency medicine in education, research, and patient care. Most of these leaders are integral members of the ACEP Council, composed of women and men, working conscientiously, developing policies, defining measures, and providing directions, which makes a profound impact on the practice of emergency medicine and the quality of care for our patients. Many of our Council members create access and opportunities with legislators and regulators generating powerful influences on the advancement of emergency healthcare. It was the ACEP Council that crafted the universally accepted definition of what defines an emergency medical condition. Now, it is the ACEP Council that is establishing the fact that whatever impacts emergency healthcare, "***is in our lane."***

Emergency physicians are the only group of physicians always on the "front lines." We experience the joys of providing lifesaving care on the one hand and simultaneously the destructions of violence and the devastation of healthcare disparities on the other hand. Our Council engages at the forefront of complicated issues that affect emergency healthcare and has left its footprint on many. Most recently, the federal governments' adaptations of solutions to the opioid crisis bear massive imprints from members of our Council. Make no mistake about it, the ACEP Council has been and will continue to be the voice of emergency medicine, defining our specialty and practices.

For over 20 years, it has been these strong, defining, characteristics of the ACEP Council that drives my passions and commitment to the Council. I am proud to be on this journey with you. This journey is driven by our joint desires of protecting our patient's rights, providing high-quality healthcare, supporting the practices of our colleagues, and creating safe environments. I have enjoyed the historical experiences of helping to pave these roads with you and am excited about the opportunities to serve as your Vice Speaker as we move ahead.

As your Vice Speaker, I will bring a unique grounding developed from my background of years of experience in the Council, working as a traveling emergency physician in a variety of hospital settings, and working in a variety of states. These experiences have provided me a unique preparation that allows familiarity and understanding of the issues on a broader scale. I will bring an eagerness to use my abilities to create energy when harmonizing the diverse voices of the Council into inclusive environments. These inclusive environments will keep us thinking forward and moving forward innovatively as we effectively address the challenges of our future. I will bring training that allows me to facilitate your journeys in organized and meaningful ways. I will create atmospheres that motivate others to engage in the Council and will support mentoring opportunities that continue to develop leadership.

My grandfather always said, "if you don't know where you are going, any road will take you there." I am here to tell you Councillors that I am so glad that I stepped into my first Council meeting and found the road with you. I have loved this journey and want to travel on with you as your Council Officer. My name is **Andrea Green**, and I am asking for your vote for **Vice Speaker**. **#VOTEGREEN**

Andrea L. Green, MD, FACEP

Chair, ACEP DIHE Section

Past President, Texas Chapter

Vice Speaker Candidate

- Mentoring Tomorrows' Leaders
- Proven Leadership
- Effective Energized Meetings
- Value Inclusivity
- Forward Thinking
- Parliamentary Procedure Training

Greand52@gmail.com

Andrea Green

Andrea Green, MD

#votegreen

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Howard K. Mell, MD, MPH, CPE, FACEP

***Question #1:* Consider that there is a proposal to eliminate voting rights of sections in the Council. What is your stance?**

First and foremost, I would like to hear the rationale for such a proposal. Some of the best discussions in Council have changed my opinion completely from my initial reaction. That said, my initial reaction here would be no way. As of the 2019 Council I will have spent 9 of my 11 years of council service as a section councilor or alternate. I am a product of that leadership track, I would be loath to abandon those who would follow me.

The fallout of such a decision would be to greatly increase the influence of large states, and to limit leadership opportunities for many members. The effect of magnification of the influence of large states is simply a numbers game, it requires no further explanation here. The effect on leadership opportunities would be much more insidious. As Aaron Burr laments in *Hamilton*, to lead one must be in the room where it happens. Eliminating the sections' right to vote would effectively block the door to that room for many members.

In some state chapters, Councilors are appointed, and the positions are often given to those who show up, can reliably represent the state, and can attend the meeting. In others, the Councilors are appointed, but with an eye toward a history of service to the state chapter. In these states, one must climb the state leadership ladder before becoming a Councilor. In a third group of states Councilors are elected, and those elections run the gamut from uncontested slates to competitive ballots. In short, for some ACEP members, the only path to the Council Floor comes from years of state chapter service. That may be tough for those who are geographically remote to their chapter offices, it may be difficult for those who fail to find local mentors to lift them up, and it may be impossible for those who move early in their career or frequently throughout their career. Should we limit the presence of these members who often find their way up the national leadership ranks through section and then committee service?

In short, absent a decent argument in favor of such a proposal, I would stand against it.

***Question #2:* What is the role of the Council in debating divisive social issues?**

For me there should be a two-pronged test to determine if the Council should debate a given divisive social issue. First, do emergency physicians, as a group, have a specific role in the issue? For example, world hunger and global warming are issues that can affect us all as humans, but emergency medicine has no specific stake in them. Homelessness and the mental health treatment afforded to veterans of the U.S. Military are two issues where emergency medicine has a decided role, and our collective voice should be heard. The second question that should be looked at is: are there other groups, more suited to the issue than ACEP, already speaking to our position? A good example of such an instance would be drunk driving. There is no question that driving while impaired leads to many crashes whose victims land in our EDs and we are left to pick up the pieces. We doubtless have a stake in seeing these crashes minimized. But there are a number of groups already addressing the issue and doing so effectively. Would adding ACEP's voice (and spending the resources needed to make that voice heard) realistically move the needle in a meaningful way?

We must, as a College, be careful to consider an additional limitation when we do decide to debate a given topic. There has to be a reasonable request for the College to act on. We could, for example, debate the effects of celebrities speaking out against vaccinations. We would likely all agree that those who use their fame in this way are doing a disservice to the public and we, again, are left to pick up the pieces. Ok, but then what? What is the College supposed to do about it and how many of our limited resources should we spend on it? Even more importantly, does spending those resources put us in conflict with other goals of the College. For example, we debate and pass a

resolution that directs the Board to call for and advertise for a boycott of Jenny McCarthy's films, but it turns out her latest work is a biographical film about an emergency physician and speaks favorably of ACEP. Do we still ask for a boycott? Did we even know such a film was in the works?

In short, I believe the Council should debate divisive social topics when the question directly influences the work of our membership, no one else is speaking on our behalf, and where there is a clear course of action for the College that aligns with the College's other activities and initiatives.

***Question #3*: Give an example of an issue where you had to sideline your personal viewpoints to represent the opinion of a group.**

I have served as member of the Public Relations Committee and as a spokesperson for ACEP for the last nine years. In that time, I don't think I've seen a single clinical issue as contentious as the use of tPA for acute ischemic stroke. There are strong opinions on both sides of the debate, and I've been known to make my opinion very clear - to say I'm skeptical is perhaps a bit of an understatement. At one point I had an opportunity to take that skepticism public, perhaps even to reinvigorate the debate nationally. But instead, I put the college first, and faithfully represented ACEP as a spokesperson.

In February of 2013, ACEP published a controversial guideline entitled "Clinical Policy: Use of Intravenous tPA for the Management of Acute Ischemic Stroke in the Emergency Department". This set off a firestorm. Almost immediately a Council resolution was introduced asking that the policy be revisited and that a 60-day open comment period be included. Needless to say, the Council debate was spirited, lengthy, and at times downright heated. Many Councilors had significant questions about the data used to drive the conclusions and we strongly disagreed with the determination that there was level A (by ACEP's rating scheme) evidence supporting the use of tPA. We stridently argued to rework the policy. That resolution was eventually passed by 75% of the Councilors. The policy would be revisited. The ACEP Board had a lengthy discussion regarding clinical policies in November 2013 and in January 2014 the board approved specific direction and comments to the Clinical Policies Committee regarding implementation of that resolution.

When this occurred many in the media (including some national news outlets) asked "what happened (with ACEP's policy)?" As an ACEP spokesperson I was asked to handle some of these interview requests and to help come up with talking points regarding the controversy. This was an incredible opportunity to express my opinion to reporters, to explain the limitations of the data, and to describe the concerns shared by so many of our colleagues regarding the use of tPA in acute stroke. It might've been possible to drive the tPA question into the national healthcare discussion, especially considering the cost of the drug. However, it wouldn't have benefited ACEP to revisit the Council debate in the press. Putting the use of tPA to treat acute stroke into question in the public's eye would have only served to confuse and even frighten patients, and ACEP didn't have a recent clinical policy (at that point) to fall back on. So, I helped craft a message that the debate on the resolution was a debate of methodology, about the rigor required for a Level A recommendation, and whether the meta-analyses used by the Clinical Policies Committee provided sufficient evidence. With this type of dry description and simple but truthful summation, most media outlets quickly lost interest. While I usually would wish to re-energize a debate about which I am passionate, that wasn't my role.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Howard K. Mell, MD, MPH, CPE, FACEP

Contact Information

10309 Squires Way
Cornelius, NC 10309
Phone: 740-637-1231
E-Mail: Howie.mell@gmail.com

Current and Past Professional Position(s)

Current:
National Reservist Emergency Physician
Vituity, Emeryville, CA (2017 – present)

Past:
Locum Tenens Emergency Physician
SBG Healthcare, Hollywood, FL (2016 – 2018)

Emergency Physician
Wake Forest Emergency Physicians, Winston-Salem, NC (2015 – 2016)

EMS Medical Director
Iredell County (NC) EMS (2015 – 2016)
City of Newark (OH), Division of Fire (2008 – 2015)
Ohio Ambulance (Cleveland and Cincinnati, OH) (2012 – 2015)
Trumbull Memorial Hospital (Warren, OH) EMS System (2014 – 2015)
Lake Health (Lake County, OH) EMS System (2010 – 2013)

Flight Physician
Metro Lifeflight, MetroHealth System, Cleveland, OH (2013 – 2015)

Part Time Emergency Physician
Mayo Clinic Health System, Albert Lea and Austin, MN (2013 – 2015)

Emergency Physician, Emergency Department Director, and Division EMS Director
EmCare, North Division, Multiple Cities and States (2010 – 2015)

Emergency Physician
Primus Trauma Care, LLC, Bloomington, IL (2009 - 2011)

Emergency Physician
Premier Health Care Services, Dayton, Ohio (2008 – 2009)

Emergency Physician and Director of EMS Education
Ohio State University, College of Medicine, Department of Emergency Medicine, Columbus, Ohio (2007 – 2008)

Education (include internships and residency information)

Mayo Clinic School of Graduate Medical Education, Rochester, MN - Emergency Medicine Residency Training Program, 2007

University of Illinois at Chicago, College of Medicine at Rockford - Doctor of Medicine, 2004

University of Illinois at Chicago, School of Public Heath, Department of Environmental and Occupational Health Sciences - Master of Public Health, 1999

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

Diplomate of the American Board of Emergency Medicine (ABEM)

ABEM Subspecialty Certification in Emergency Medical Services (EMS)

Certified Physician Executive (CPE) by the Certifying Commission in Medical Management

Professional Societies

Fellow - American College of Emergency Physicians

Member – The Doctors Mayo Society, Mayo Clinic Alumni Association

National ACEP Activities – List your most significant accomplishments

Awards:
A "Top Peer Reviewer" and "Top New Peer Reviewer", 2016, Annals of Emergency Medicine

Spokesperson of the Year, 2014

Positions:
Immediate Past Chairperson (2018 -), Chairperson (2016 - 2018), Member and Spokesperson – Public Relations Committee (2010 -)

Chairperson – EMS Education Subcommittee of the Education Committee (2015 -)

Member – Education Steering Committee (2015 -)

Peer Reviewer – Annals of Emergency Medicine (2015 -)

Councilor and Alternate Councilor – Tactical Emergency Medicine Section Delegation (2013 -)

Member – Emergency Medicine Services / Prehospital Care Committee (2012 -)

Member – Editorial Advisory Board, ACEP Now (ACEP News) (2013 - 2018)

Member – Council Steering Committee (2014 - 2016)

Chairman – Emergency Medicine Practice Council Reference Committee (2014)

Member – Tellers, Credentials, and Elections Committee (2013 – 2014, 2018)

Member – Emergency Medicine Practice Committee (2009 - 2014)

Councilor –Young Physician Section Delegation (2009 - 2010)

Member – National Emergency Department Categorization Task Force, Emergency Medicine Practice Committee (2009 - 2010)

Chairman, Chair Elect, Secretary, and Member-at-Large – Emergency Medical Services / Prehospital Care Section (2008 - 2015)

ACEP Chapter Activities – List your most significant accomplishments

Alternate Councilor – State of Ohio Chapter Delegation (2008 and 2012)

Ohio ACEP Leadership Development Program Class of 2008

Practice Profile

Total hours devoted to emergency medicine practice per year: **1600** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **100** % Research ____% Teaching ____% Administration ____%

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I work for Vituity (formerly CEP-America), as one of roughly 2200 physicians in a fully physician owned, fully democratic, large group practice. I serve as a reservist emergency physician, filling in for several months at a time wherever staffing needs dictate.

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 10 Cases Plaintiff Expert 2 Cases

No cases have gone to court. One defense case went to depositions, and one to formal report (but is still active). Both Plaintiffs cases are thus far advisory only. The two Plaintiff cases are against EMS Corporations. No individual persons, physicians or others, are named.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Howard K. Mell, MD, MPH, CPE, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Vituity

Address: 2100 Powell Street, Suite 400

Emeryville, CA 94608

Position Held: Reservist Emergency Physician

Type of Organization: Large, Physician Owned, Fully Democratic Group

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: NONE

Address: _____

_____

Type of Organization: _____

Duration on the Board: _____

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Howard Mell July 1 2019

Illinois College of Emergency Physicians
ADVANCING EMERGENCY CARE ICEP.org
3000 Woodcreek Drive, Suite 200, Downers Grove, IL 60515 phone: 630.495.6400 toll-free: 888.495.ICEP fax: 630.495.6404

August 15, 2019

Dear Councillors:

The Illinois College of Emergency Physicians and the ACEP Tactical Emergency Medicine Section enthusiastically endorse Howard "Howie" Mell, MD, MPH, CPE, FACEP for the position of Council Vice Speaker. Dr. Mell is a dedicated member of ACEP. He has been continuously active at the National level since he was in residency in 2006, and with the Council since 2008, when he started as a member of the Ohio ACEP Development Academy. Dr. Mell has also been a section president, committee chair, and has served on the Council Steering Committee. At the Chapter level, he consistently serves as faculty for ICEP's Oral Board Review Courses. Dr. Mell's energy and passion would be a tremendous asset to the ACEP Council.

Dr. Mell's communications and public relations activities at ACEP are numerous and demonstrate his expertise in communicating with leadership, press, and the public. Most recently, he led the #ACEP4U social media push, creating an electronic elevator speech advocating for ACEP membership. As the Immediate Past Chairman of the ACEP Public Relations Committee, he has helped lead the ACEP Social Media Communications team and PR team through several recent challenging events. He continues to be active as a Spokesperson for the College and won ACEP's award for "Spokesperson of the Year" in 2014. This background and widespread experience more than qualify him to work closely with the Board of Directors to illustrate and execute the complexities of the Council's vision.

Dr. Mell's leadership achievements demonstrate his ability to speak cohesively and transmit a message effectively. These skills are crucial for the Council Vice Speaker, as it would be his job to be a spokesperson for the Council, reminding the Board of Directors of what the Council's consensus decisions for advancing emergency care are. Dr. Mell's energy ensures that he would be a voice for the Council during the two days of the annual Council Meeting, throughout the year, and for the full duration of his term. He prides himself on his integrity and his ability to get the job done according to the will of the Council above personal beliefs and ideals. Dr. Mell has the potential to lead meaningful change on behalf of the Council to transform our specialty.

Dr. Mell's experience makes him uniquely suited to serve as Vice Speaker of the ACEP Council. With a Master of Public Health Degree from the University of Illinois at Chicago and a Certified Physician Executive through the Certifying Commission in Medical Management, he possesses all the qualifications of an organized, effective and passionate leader. We have no doubt he will coordinate the Council meeting with skill, confidence and energy and translate that ability into advancing the Council's goals after the meeting concludes. The ACEP Council will flourish under his visionary leadership.

Sincerely,

Ernest Wang, MD, FACEP
President, Illinois College of Emergency Physicians

David Callaway, MD, FACEP
Chair, ACEP Tactical Emergency Medicine Section

Howard K. Mell, MD, MPH, CPE, FACEP

"Why?" is every child's favorite question: "Mommy, why do dogs bark?"; "Daddy, why is the sky blue?"; "Why do I have to eat my vegetables?" It is a powerful, single word question that we, as scientists and healers, ask all the time. Outside of the hospital, however, we aren't as good at examining the "why?"s of our own lives. A friend was recently hiring for a prestigious, voluntary position. He was inundated with applicants but lamented after interviewing several that no one could answer the "why?"

As any election is essentially a job interview with a limited number of applicants and a huge number of interviewers, please allow me to give you my "why?".

For the past twelve years I have looked forward to the two days of Council with great anticipation. The diversity of thought and opinion throughout the Council energizes me. I've been amazed that resolutions I thought were simple cut and dry proposals destined for passage or rejection were actually nuanced issues worthy of great debate. The Councilors are an incredible font of knowledge. The passion with which the issues facing emergency medicine are discussed is invigorating. I've lost track of the number of times I read a resolution before the meeting and was certain of how I'd vote, only to find myself raising my card in the opposite manner after listening to the debate in reference committee or on the floor.

It is a challenge to lead this dynamic group in its deliberations. The need to balance the demands of the schedule with the need to allow full and robust debate, while allowing a bit of fun, is no simple task. It is, however, one I am up to.

The real "why?" for me comes in not in the two days of Council but in the other 363 days of the year. The Council is an amazing and diverse group of emergency physicians. When we come together and hammer out a decision, a direction, or an agreed-upon approach to the issues before us, we need to have those ideas represented to the Board and College staff with a strength befitting the work put into them. I will carry the voice of the Council forward throughout the year, not just during the Council meeting itself. I have spent ten years representing the College to various media outlets through my work with the Public Relations Committee. It is time for me to take those communication skills into the Board Room to represent the Council and all of your work.

So, for me, the "why?" is simple. The job of the Vice Speaker extends far beyond the Council Meeting itself. It is a commitment to be a voice representing you, the leaders of our specialty, and your decisions on the Council – all year long. I am the right person for that job. I have the strength to advocate for your positions with passion, the sense of duty to faithfully represent your will above my own, and the experience to communicate the nuanced complexities of your vision accurately. To put it succinctly – elect me for the other 363.

Howie Mell, MD, MPH, CPE, FACEP Candidate for Vice Speaker

- Practicing Emergency Physician with Vituity
  - Residency Trained at the Mayo Clinic
  - Board Certified in EM and EMS
- Proven Leadership
  - Immediate Past Chair of the Public Relations Committee
  - Past Chair of the EMS Section
  - 12 years of service as a Councilor or Alternate Councilor

Elect Me for the Other 363

The job of the Vice Speaker extends far beyond the Council Meeting itself. It is a commitment to be a voice representing you, the leaders of our specialty, and your decisions on the Council - all year long. I am the right person for that job. I will advocate for your positions with passion, I will faithfully represent your will above my own, and I will communicate the nuanced complexities of your vision accurately.

Howie Mell, MD, MPH, CPE, FACEP for Vice Speaker

Communication

I have spent the last ten years as a Spokesperson for the College and I have been at the forefront of ACEP's ventures into Social Media. I will leverage these skills to increase communication with the Council throughout the year and to advocate for the Council with the Board.

Passion

As a former firefighter paramedic, I approach everything I do with passion and drive. I will represent the will of the Council with integrity, energy, and skill. I won't stop until the job is done.

Fun

At the end of the day, the members are best served when the Council is led with a sense of levity and humor. After all, being an emergency physician is the best job in the world!

Board of Directors Candidates

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Board of Directors Candidates

Michael J. Baker, MD, FACEP

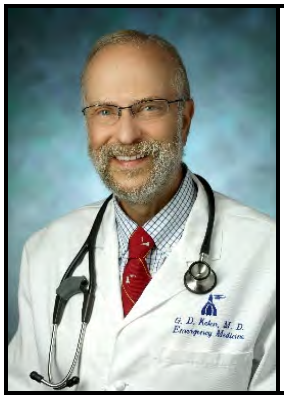
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Jeffrey M. Goodloe, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Rachelle A. Greenman, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer



Gabor D. Kelen, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Pamela A. Ross, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Gillian R. Schmitz, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Ryan A. Stanton, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Thomas J. Sugarman, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Michael J. Baker, MD, FACEP

***Question #1:* Should the evaluation of a potential Board candidate include their suitability to serve as a future ACEP president?**

The President of ACEP leads the College and serves as the public face of ACEP, but it is the ability of the President to inspire others, to empower upcoming leaders, to communicate effectively, and to demonstrate a passion for emergency medicine that propels ACEP forward. While considering the suitability of Board candidates to serve as President, we must also remember that ensuring the future of Emergency Medicine requires expert navigation through shifting obstacles and issues. Therefore, the pool of potential future candidates for ACEP president must be diverse in knowledge, background, and skills so that we can choose a president best able to face expected challenges and react thoughtfully to unexpected ones. Any Board of Directors Candidate could become a future president of ACEP, and ACEP councilors should consider a Board candidate's potential to serve in the role of President during the election process.

In general, it takes 4-6 years for an ACEP Board member to refine the skills and assemble the knowledge needed to become a great candidate for ACEP president. By investing that time into a versatile Board, we will not only ensure an adequate talent pool from which to select a future President, but also provide a framework for the maturation of that President. Board members must learn from each other as they manage the business of the College, interact with other organizations and specialties, and advocate for the declared positions of the College. Board members must also work together to refine their ability to efficiently manage and delegate the enormous volume of issues that come before it. Serving on the Board provides the opportunity to impart a deep understanding of issues of critical importance to the future of emergency medicine such as fair reimbursement, EMS, workforce, inclusiveness, patient boarding, workplace violence, and new technologies. Therefore, in addition to a candidate's suitability for the Board, councilors should also consider which potential skills will need to be added or replaced in the upcoming years.

A successful Board candidate needs to be a potential future President. A successful Board candidate must be an experienced leader whose participation on the Board makes the College, Board, and President stronger and more resilient. Finally, a successful Board candidate strives to make good use of the close relationships, knowledge, and skills among elected Board members to fully develop many potential candidates for ACEP president.

***Question #2:* Given the diverse viewpoints of ACEP members, how will you ensure that all voices within emergency medicine can be represented?**

ACEP has always faced the challenge of ensuring all voices in emergency medicine are well represented. Finding gaps in our representation so that ACEP can be the organization representing all emergency physicians is challenging. However, with experienced leadership, we can meet this challenge.

We must continually seek out missing or underrepresented voices within ACEP by engaging with members, committees, and sections. As a member of the Leadership Diversity Task Force and the Diversity and Inclusion Task Force, I learned to identify roadblocks for ACEP members that needed to be dismantled within our organization. I will continue to do so if elected to the Board of Directors. Along with other task force members, we focused on removing barriers to leadership that might limit participation by some members. We must deliberately recruit influential voices to represent our specialty. According to AAMC Diversity Engagement Surveys, we still have room to improve the diversity of applicants to medical schools and emergency medicine residencies. At the first Diversity, Inclusion, and Health Equity Section meeting, I learned of emergency medicine residents that went into urban high schools to empower young students by teaching CPR and first aid. By encouraging pipeline programs such as this and the new ACEP *Until Help Arrives* educational program, we could connect emergency medicine with many more young students and inspire some of them to seek out our specialty as a potential career choice. Additionally, I would like to see more state chapters create medical student forums or interest groups to enhance their exposure to emergency medicine and mentorship opportunities before applying for residency applications.

Besides ensuring a diverse ACEP membership, each ACEP Board member must also be capable of representing a variety of practice environments. Through my involvement with the ACEP Council, National Chapter Relations Committee (NCRC), telemedicine, and mentoring of upcoming leaders, I have strived to learn about the challenges of many different practice environments. These environments include small emergency group practices, nationwide emergency groups, urban sites, rural sites, practices within low population states, and those within high population states. Through the NCRC, I reached out to chapter leaders to identify how ACEP could support them better and understand the need to advocate for improved ACEP resources to support ACEP chapters of all sizes. As a Board member, I will continue to seek out others that can help define the needs of a wide range of practice opportunities.

ACEP is often referred to as the "Big Tent" of Emergency medicine, and the only way to retain that title is to make a conscious effort to look for gaps in our representation and take steps to close them.

***Question #3:* What do you believe is the single most divisive issue in ACEP at this time and how would you address it?**

What is the value of emergency board certification when physicians without emergency medicine (EM) certification and advanced practice providers (APPs) care for emergency patients? In the 1990s, the closure of the practice track to EM board certification created a schism within emergency medicine between boarded and non-boarded emergency physicians. Meanwhile, ACEP promoted the value of EM board certification. Today, the notable use of advanced practice providers (APPs) and non-emergency boarded physicians has re-opened the divisive debate on whether emergency board certification is required to independently care for emergency center patients.

A provider who is not boarded in emergency medicine has neither standardized education nor a certification process in the care of emergency patients, yet we are seeing these providers take an independent role in caring for emergency patients. Emergency patients in the US are seen by a mix of both emergency physicians and non-emergency providers. An *Annals of Emergency Medicine* 2018 study revealed that emergency physicians provide two-thirds of the care delivered in the emergency center. Meanwhile, the remaining 33% of care was delivered by non-emergency physicians (family medicine and internal medicine) and by APPs.

It doesn't need to be this way. No other medical provider has the mastery of boarded emergency physicians in the evaluation, diagnosis, and management of acute care issues. ACEP has remained steadfast in its statement that the independent practice of emergency medicine is best performed by a boarded (or board eligible) emergency physician. Formal residency training and board certification have both been researched and improved over the decades. As a result, emergency medicine residencies and board certification remain integral to ensuring the quality of emergency care delivery. Never-the-less, physician shortages and market pressures have encouraged the use of other care providers in many emergency centers.

To prevent this divisive issue from growing into a schism, ACEP will need insightful leadership to navigate three significant areas. We must narrow the need for providers who are not boarded EM physicians, develop a collaborative environment with such providers, and explore the efficiencies of telemedicine. We can ensure a large, diverse emergency physician workforce by advocating for funding of additional residency training opportunities (especially in underserved areas), supporting board certification improvements, and fighting the causes of burnout that lead to early retirements such as burdensome documentation and the public undervaluing of emergency services by payors. Second, ACEP needs to review its existing practice policy statements and work with key organizations to ensure policies and practice models that support an evidence-based collaborative care environment with APPs, including training and certification recommendations. Lastly, ACEP needs to explore the potential for new technologies such as telemedicine and digital health to help emergency physicians efficiently collaborate in the care of an increasingly complex emergency patient population by maximizing the ability to digitally connect emergency patients, APPs, and non-EM physicians with EM boarded physicians.

With insightful ACEP leadership on this divisive issue, we will achieve the ideal of anything, anytime, anyone emergency care provided by a board-certified emergency physician for all emergency patients.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Michael J. Baker, MD, FACEP

Contact Information

3680 Creekside Dr
Ann Arbor, MI 48105
Phone: 732-657-7072 (cell)
E-Mail: mbaker911@gmail.com

Current and Past Professional Position(s)

- Director of Telehealth, EPMG/Envision (2014-present)
- Medical Director, Munson Healthcare Cadillac (2019-present)
- Clinical Assistant Professor, Michigan State University College of Osteopathic Medicine (2018-present)
- ED Informatics Representative, Clinical Excellence Committee, Trinity-Health (2018-present)
- Chief Executive Officer, CAREnQ Telemedicine Solutions LLP (2015-2018)
- Member, Telemedicine Clinical Quality Committee, St. Joseph Mercy Hospital (2015-present)
- Chairperson, Emergency Department Information Technology Committee, Trinity-Health (2012-present)
- Medical Director, St. Joseph Mercy Hospital Saline, Maple, Canton (2010-2018)
- Director, Quality Improvement, Saline Hospital (2007-2010)
- Cerner Physician Liaison, St. Joseph Mercy Hospital (2007-present)
- Adjunct Clinical Instructor, University of Michigan College of Medicine (2003-present)
- Director, Program in Ultrasonography, St. Joseph Mercy Hospital (2002-2015)
- Chairperson, CME Committee, St. Joseph Mercy Hospital (2002-2010)
- Core Faculty, University of Michigan/St. Joseph Mercy Hospital Emergency Medicine Residency (1998-present)
- Attending Physician, Saline Hospital Emergency (1998-2015)
- Attending Physician, St. Joseph Mercy Hospital, Ann Arbor, MI (1996- present)
- Attending Physician, Providence Hospital Emergency, Southfield, MI (1996-1998)
- Representative, House Officers Association, University of Michigan (1995-1996)

Education (include internships and residency information)

- University of Michigan, Ann Arbor, MI; BS received 1989
- Ohio State University, Columbus, OH; MD received 1993
- University of Michigan, Ann Arbor, MI; Residency in Emergency Medicine completed 1996

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

- American Board of Emergency Medicine (ABEM) – Continuously certified since initial certification in 1997

Professional Societies

- American College of Emergency Physicians (FACEP)
- Michigan College of Emergency Physicians
- American Medical Association
- American Telemedicine Association

- American Institute of Ultrasound in Medicine
- Michigan State Medical Society
- Greater Detroit Area Health Council

National ACEP Activities – List your most significant accomplishments

Diversity and Inclusion Task Force (2015-2018)

- As subcommittee chair, lead team in researching and recommending the dissemination of diversity and inclusion activities in EM that educates about bias and promotes cultural competence including recommendations for
    - Implicit Bias Training every 3 years for ACEP Board (2017 BOD session)
    - Creation of an ACEP Diversity & Inclusion Section with Board liaison (Diversity, Inclusion, and Health Equity Section)
    - Creation of diversity and inclusion section grant or chapter grant
    - Addition of demographic data to future ACEP membership surveys
- Identified and submitted articles to ABEM on diversity and inclusion for future LLSA activities

Diversity Leadership Task Force (2016-2018)

- Identified barriers to diversity in leadership and actively implemented enduring solutions including council resolutions, formal recognition of the Leadership Development Advisory Group, election campaign rules, and annual award recommendations

National Chapter Relations (2013-present)

- Actively participated in the submission, review, and approval of chapter grants
- As subcommittee chair, identified and implemented leadership development opportunities including
    - Chapter forum topics
    - LAC leadership day topics
    - Sharing of state chapter leadership resources
    - Update Chapter Leadership resource web page

Council Steering (2018-19)

- Successfully served as subcommittee chair for the Annual Meeting Subcommittee
    - Planned annual council meeting
    - Reviewed ACEPs progress on past council resolutions

Telemedicine Section (2013-present)

- Authored multiple sections of section grant project examining quality measures in emergency telemedicine.
- Represented ACEP at the 2019 TelEmergency summit, New Orleans, LA.
- Connected past Ultrasound Section chair with Telemedicine section chair to aid in strategic planning due to similarities with implantation of new technologies

ACEP Chapter Activities – List your most significant accomplishments

Awards

- Ronald R Krome, MD Meritorious Service Award (2016) – "The recipient's personal leadership attributes will include one, but not limited to one of the following examples: Inspirational, Innovative, Diplomatic, Planner, Organizer, Manager/Administrator, Arbitrator, Consensus Maker, and Decision Maker"
- Chapter Service Award (2004)

President & Board of Directors/Executive Committee (2004-2010, 2012-2015)

- Successfully led a team to fight off a "three strikes rule" in Michigan by facilitating MCEP's participation in a year-long, legislature-appointed expert panel on high-utilizers and a consensus report to the state legislature.
- Created strategic planning process for committee chairs, Fostered new leader development through committee structure improvements.
- Guided college through loss of key staff member which resulted in a temporary limitation of resources.

Education chair (2009-2013)

- Guided multiple conference directors in creating multiple CME conferences in a variety of locations
- Streamlined CME development and application process
- Rebuilt annual conference from low of 40 participants to over 100 registrants
- Implemented process for reviewing and improving the sustainability of conferences

Newsletter Editor (1998-2005)

- Redesigned publication, added case studies to allow young physicians to have interesting cases published, added on-line publishing

Technology Task Force (2000-2005)

- Created and maintained original web site and e-mail addresses for MCEP
- Lead recommendations for purchase of member management system

Practice Profile

Total hours devoted to emergency medicine practice per year: **2080+** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **30** % Research **0** % Teaching **10** % Administration **60** %

Other: Administration includes Dir. of Telehealth, Site Medical Director, and Informatics **--** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I have practiced for 23 years in a variety of clinical setting from small, rural locations to high volume, urban emergency centers, all with the same emergency physician group. Currently, I am employed with a nationwide, privately-held contract management group in both clinical and leadership/administrative roles. I see patients at two main sites, an 80K ED (Level 1 trauma center, part of a large, national, multi-hospital health system) and a 100K ED (Level 1 trauma center, part of an academic university) with occasional shifts at a 35K hospital-owned urgent care 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.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Michael J. Baker, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: EPMG – An Envision Physician Services Company

Address: 2000 Green Rd

Ann Arbor, MI 48105

Position Held: Director of Telehealth and Managing Partner

Type of Organization: None

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Michigan College of Emergency Physicians

Address: 6647 W. St. Joseph Highway

Lansing, MI 48917

Type of Organization: ACEP State Chapter

Duration on the Board: 13 years

Organization: CAREnQ Telemedicine Solutions, LLP

Address: 2000 Green Rd

Ann Arbor, MI 48105

Type of Organization: Telemedicine LLP

Duration on the Board: 4 years (ended 2018)

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Michael J Baker, MD, FACEP Date May 23, 2019

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

PRESIDENT
Rami Khoury, MD, FACEP

PRESIDENT-ELECT
Warren Lanphear, MD, FACEP

TREASURER
Nicholas Dyc, MD, FACEP

SECRETARY
Gregory Gafni-Pappas, DO, FACEP

PAST PRESIDENT
Jacob Manteuffel, MD, FACEP

BOARD OF DIRECTORS
Sara Chakel, MD, FACEP
Brent Felton, DO, FACEP
Michael Fill, DO, FACEP
Michael Gratson, MD, FACEP
Therese Mead, DO, FACEP
Emily Mills, MD, FACEP
Diana Nordlund, DO, JD, FACEP
Jennifer Stevenson, DO, FACEP
Hisham Valiuddin, DO

EXECUTIVE DIRECTOR
Belinda Chandler, CAE

ASSOCIATE EXEC. DIRECTOR
Christy Snitgen

www.mcep.org

46th Michigan EM Assembly
July 28 – 31, 2019
Grand Hotel
Mackinac Island, MI

Dear Fellow Councillors:

It is with great pleasure that the Michigan College of Emergency Physicians and the Diversity, Inclusion and Health Equity Section endorse Michael Baker, MD, FACEP for a position on the ACEP Board of Directors.

Mike served with distinction as a member of MCEP's Board of Directors for twelve years. He was President of our Chapter from 2013-14, at which time he brought the College through an internal crisis. He successfully fought off an attempt to bring the "three strikes rule" to Michigan and brought national leaders into the conversation with the Michigan Department of Community Health to create a report to the legislature listing the reasons for high utilization of the emergency center by select populations. He has been a strong supporter of the MCEP Leadership and Development program and education programs. He continues his involvement as a valuable member of the College, remaining active on our Education Committee.

In addition to his work at the state level, Mike has been a tremendous asset to national ACEP. He has been active in ACEP leadership, Chapter support, as well as the ACEP Council, where he has served as a Councillor for nine years. He was appointed to help lead diversity and inclusion efforts through participation on both the ACEP Diversity and Inclusion Task Force and the ACEP Leadership Diversity Task Force. As a member of these task forces, he helped create council resolutions, enhanced the council campaign rules, supported the founding of the ACEP Diversity, Inclusion and Health Equity Section, and supported the development of an online implicit bias training activity. He also served on the diversity panel presented at LAC.

As a member of the National Chapter Relations Committee, he has been supporting chapter needs and identifying topics, speakers, and format recommendations for LAC lectures and Chapter leadership sessions. At the ACEP Council, he has actively served on reference committees, the Tellers Committee, and the Council Steering Committee, which has allowed him to cultivate successful relationships with current and past leaders. With each endeavor, Dr. Baker has built upon and proven his ability to lead by his determination and dedication to strengthening the future of ACEP.

In addition to these activities, he is a full-time active clinician and engaged academically at the University of Michigan/St. Joseph Mercy Hospital residency program. Furthermore, Dr. Baker, as the Director of Telehealth for his medical group, continues to look ahead to the future of emergency medicine and explore how technology can assist the specialty in reaching new heights.

I would respectfully ask that you join our Chapter and the Diversity, Inclusion and Health Equity Section in support of the election of Michael Baker, MD, FACEP, to the Board of Directors of the American College of Emergency Physicians.

Regards,

Rami Khoury, MD, FACEP
President, MCEP

Andrea Green, MD, FACEP
Chair, Diversity, Inclusion and Health Equity Section

Michael J. Baker, MD, FACEP

Dear Councillors,

Organizations are not static, but they change and go through phases – birth, growth, and renewal. ACEP was born in 1968 out of the necessity to support and improve emergency care throughout the country. It grew in both size and scope for decades. ACEP renewed itself with each new milestone that challenged the practice of emergency medicine. These included EM specialty recognition, board certification, EM Residencies, EMTALA, bedside ultrasound, CEDR, and much more. Today, new milestones place ACEP at yet another crossroads for renewal, which will require leadership that is innovative, focused, and diverse.

Emergency medicine physicians and the patients we serve face many high-profile challenges that affect the foundations of emergency medicine, including issues of reimbursement, workforce, and care delivery. The price-setting legislation proposed by recent attempts to fix the surprise billing issue is a significant assault on the sustainable practice of emergency medicine. Without ACEPs efforts to include reasonable concessions, such as independent binding arbitration, pending legislation would have placed patients at risk and produced drastic economic concerns for physicians. Meanwhile, many emergency centers, including rural and critical access sites, are struggling with financial viability and workforce needs. ACEP needs to develop resources for these at-risk sites to ensure access to ABEM board-certified staffing, ongoing education, and new skills training. Additionally, the growing reliance on advanced practice providers in the ED necessitates the development of recommendations for physician collaboration so that boarded emergency physicians remain the independent practitioner of choice. The shift to population health is rapidly driving innovations in telemedicine to deliver emergency care at a distance (TelEmergency), care coordination to better connect patients with growing outpatient resources including remote monitoring, and new advanced payment models. The Acute Unscheduled Care Model (AUCM) is gaining traction thanks to the efforts of many within ACEP. CMS is even looking at how patients arrive at the emergency center through the Center for Medicare and Medicaid Innovations Emergency Triage, Treat, and Transfer (ET3) model for EMS systems.

As a member of the ACEP Board of Directors, I will provide a unique perspective and skillset required to take on these and other milestones for ACEP members. I will ensure that that the College delivers value to its members by preparing for future challenges while providing support for today's needs. I have demonstrated my abilities within ACEP and other institutions. As a member of the Leadership Diversity Task Force and the Diversity and Inclusion Task Force, I learned to identify and dismantle roadblocks for ACEP members that limit participation or advancement. With my work leading the National Chapter Relations Committee objectives, we began addressing the needs of chapters, including those of small and medium chapters in training future leaders. As a health system leader, I've successfully attained hard-to-reach goals of large health system committees, including optimizing information technology and improving care quality through standardization.

ACEP leadership must be prepared to grow and renew the organization while ensuring the resources tools and support needed to provide care in an equitable, diverse, safe, and supportive environment.

Michael J Baker, MD, FACEP

Board of Directors Candidate

The Michigan College of Emergency Physicians and
The Diversity, Inclusion, and Health Equity Section

Proudly Endorses

MICHAEL BAKER, MD, FACEP

Candidate for ACEP Board of Directors

ACEP LEADERSHIP:

- ACEP Council Steering
- Subcommittee Chair – National Chapter Relations
- Telemedicine Section
- Diversity and inclusion Task Force
- Leadership Diversity Task Force
- Councilor – Michigan Chapter for 9 Years
- Past-President – Michigan Chapter
- ABEM Diplomat, Clinician, Medical Director, Telemedicine Director, Informatics Lead
- Core Faculty in Emergency Medicine Program

MEMBERSHIP:

- American College of Emergency Physicians (FACEP)
- Michigan College of Emergency Physicians
- American Medical Association
- American Telemedicine Association
- American Institute of Ultrasound in Medicine
- Michigan State Medical Society
- Greater Detroit Area Health Council

ABOUT ME

As a member of the Board of Directors, I will dedicate my leadership and innovation skills to enhancing the value of the College in meeting the significant challenges facing practicing emergency physicians. It is imperative that the College deliver the resources, tools, and support necessary to enable our members to provide access to care for all those who seek it, while allowing our members to practice in a fair, equitable, safe, and supportive environment.

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

INNOVATIVE, PROVEN, FOCUSED, DEDICATED LEADER WITH A COMMITMENT TO FULFILLING THE PROMISE OF EMERGENCY MEDICINE – ANYONE, ANYTHING, ANYTIME.

E-Mail: mbaker911@gmail.com

Twitter: @MBaker911

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Jeffrey M. Goodloe, MD, FACEP

***Question #1:* Should the evaluation of a potential Board candidate include their suitability to serve as a future ACEP president?**

No. Candidates for the ACEP Board of Directors must be elected on their willingness and ability to humbly do the work, present and future, that best serves ACEP members and their patients.

We should be suspect of candidates that already identify an intent to become a future ACEP President. Such early intent reflects focus on self, rather than on others. Any officer position on the ACEP Board of Directors represents an opportunity to provide additional service unique to that role. An officer position, including ACEP President, should not be the "destination" of ambition. Ardent service must always be the foremost goal.

In the process of serving through teamwork on the ACEP Board of Directors, an individual director may in time identify desire to commit to an officer position. Then, and only then, it is appropriate for one's colleagues on the Board to discern that individual's skill set and potential value as Secretary/Treasurer, Vice President, or Chairman of the Board. Subsequently, and consistent with its vital role, the Council determines which Board member is best suited to serve as ACEP President.

***Question #2:* Given the diverse viewpoints of ACEP members, how will you ensure that all voices within emergency medicine can be represented?**

Current diversity in viewpoints among ACEP members is unparalleled in the history of the College. Representing emergency physicians translates specifically to advocating for emergency physicians. Effective advocacy for emergency physicians is built upon understanding, tolerance, and respect for each of us.

I'm now 21 years post emergency medicine residency. Throughout my journey of growth as an emergency physician, I've been taught by generalists, other specialists, non-EM residency trained/EM boarded faculty and EM residency trained/EM boarded faculty. These mentors, teachers, and colleagues are of varying genders, ethnicities, religious beliefs, and as diverse in interests as imaginable. I've learned valuable medical and life lessons from them all.

I've worked in multiple practice settings from a rural/small suburban community hospital, with its 16 bed ED to an inner-city tertiary referral hospital with an annual ED census soaring past 100,000 patients. I've also worked at larger suburban and even urban hospitals that many assumed were "nice little places to practice emergency medicine" where my partners and I each routinely saw 4-5 patients/hour throughout 10+ hour shifts, many with patient acuities requiring invasive airway management, central lines pre-routine ultrasound guidance, and trauma/STEMI/stroke/sepsis teams all comprised of one emergency physician, 2 nurses (if we were lucky), and 1 respiratory therapist (maybe). For the past several years, I've been fortunate to share the benefits of these experiences, teaching fellows, residents, and medical students in the base hospital for an EM residency, while still learning emergency medicine advances daily, and conducting research in a historically medically underserved state.

Also, as an emergency physician, I've built upon my love for pre-hospital care I discovered as a paramedic in college and medical school. I've served in EMS for 31 years, 23 of those as a medical oversight physician, currently the clinical leader for over 4,000 credentialled professionals in the metropolitan Oklahoma City and Tulsa areas. I also find professional fulfillment in serving in special events medical planning and on-site coverage, including many NASCAR and IndyCar events as well as law enforcement tactical missions.

Each of these roles – bedside clinician, teacher, researcher, EMS medical oversight leader, special mission clinician - has at its core *being an emergency physician*. Throughout it all, I have been active in advocacy and service in state and national ACEP.

If you identify yourself with any of the above, I can effectively help represent you. If you don't, I'm sincerely willing to listen to you so I can better understand and inculcate your perspectives. If we differ in viewpoint, it is my opportunity to learn *your* understanding and beliefs about the issue. I will always have a deep respect for your beliefs and will want to understand how you formed them. Further, in representing the College, I will be faithful to representing members' views, even when they differ from my own. Where consensus exists, I will represent it. Where disparate views are tangible, I will reflect that spectrum, both in internal communications and external advocacy.

Do we all have continual challenges? Yes. Can we find the answers *together*? Yes. Between our dates of birth and death, we all have a dash. Emergency physicians make positive differences with those dashes. Part of my positive difference is a sincere desire to represent and serve you as a member of the ACEP Board of Directors.

***Question #3:* What do you believe is the single most divisive issue in ACEP at this time and how would you address it?**

I am concerned about the potential threat to civility and decorum within our College given we are increasingly exposed to ad hominem thoughts, commentary, and actions occurring in our larger society. Divisiveness itself may become the single most divisive dynamic within ACEP. We may not achieve, or even need, a formal policy on every issue that catches our attention. The manner with which we responsibly navigate our deliberations, respecting one another, being inclusive in more than words, sincerely valuing one another…the future of our College depends upon us doing so.

Firearms injuries. Gun violence. Responsible gun ownership. These phrases bring immediate emotions palpably disparate within society, which are reflected within our College. Disparity can, and often does, foster divisiveness. A trusted colleague advised, "You'll be okay in your Board candidacy as long as you stay away from firearms." Just two weeks later, I was asked a pointed question regarding gun violence. My approach to addressing this and other divisive issues as a candidate for your Board of Directors is clear. I cannot and *will not* avoid issues that so critically affect our patients and practices, particularly those that engender strong opinions from our members.

As one ACEP member, I certainly am not going to resolve such a complex issue with a few words. Surely, as emergency physicians, we can work to a point of consensus, with due concern about gun-related violence while advocating for evidence-based injury prevention, based upon scientifically valid research. As an elected ACEP Board member, I will actively engage in consensus-building on this and other polarizing issues affecting our patients, all of us, and society as a whole.

First, for ACEP to pursue formal policy on any issue, the issue must impact the health of our patients or be of legitimate interest to the practice of emergency medicine and emergency physicians. Regardless of facility size or one's practice setting, most emergency physicians manage preventable gunshot wounds. Clearly, violence involving firearms *is* an issue for us and our patients.

Second, ACEP must utilize non-biased data when constructing formal ACEP policy. Even casual consumers of media in any of its forms can be inundated with a dizzying volume of statistics regarding firearms – strongly pro, strongly con, and everywhere in between. ACEP leaders must use credible resources to parse related data carefully, exclude biased research, discard vitriolic rhetoric, confirm valid research, and advocate for research in unvetted areas of importance.

Third, ACEP must act transparently when developing formal policy. Lack of transparency begets lack of confidence begets loss of trust.

Using these tenets in drafting policy, the Board of Directors can then act responsibly in representing members.

Whether firearms injury prevention, gender-related pay and opportunities, contract management group impacts, board certification requirements, or any of the other myriad issues where opinions can vary widely, we must always remember we are *all* emergency physicians. We must genuinely respect one another, listening with an open mind, valuing the commitments each of us makes to our specialty and to humanity.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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
Item Writer, EMS Examination & EMS LLSA, ABEM

Past Positions
Attending Emergency Physician – St. John Medical Center – Tulsa, OK
Attending Emergency Physician – Saint Francis Hospital Trauma Emergency Center – Tulsa, OK
Attending Emergency Physician – Medical Center of Plano – Plano, TX
Medical Director, Plano Fire Department – Plano, TX
Medical Director, Allen Fire Department – Allen, TX

Education (include internships and residency information)

EMS Fellowship – University of Texas Southwestern Medical Center at Dallas (1998-99)

Emergency Medicine Residency – Methodist Hospital of Indiana/Indiana Univ School of Medicine (1995-98) Indianapolis, IN

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, All MOC components met for 2019

ABEM EMS Medicine Initial Certification 2013, All MOC components current

Professional Societies

ACEP member since 1991 (medical student, resident, fellow, active, FACEP)

OCEP (Oklahoma College of Emergency Physicians – State ACEP Chapter)

NAEMSP (FAEMS)

ACHE

Prior memberships in Texas College of Emergency Physicians, Indiana ACEP Chapter, AMA, Oklahoma State Medical Association, Tulsa County Medical Society, SAEM

National ACEP Activities – List your most significant accomplishments

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: **2750** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **5** % Teaching **10** % Administration **35*** %

Other: ***predominantly EMS medical oversight** ____ %

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/private group collaborative structure. I am staff credentialed at Hillcrest Medical Center in Tulsa, the base hospital for the EM residency, though I have been staff credentialed in prior years at two other teaching hospitals in Tulsa. I also serve as the Chief Medical Officer for the EMS System for Metropolitan Oklahoma City and Tulsa, clinically leading over 4,000 credentialled 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, motorsports medical support (on-site track physician) for NASCAR and IndyCar events in Ft. Worth, Texas, 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 NAEMSP Annual Meeting, EMS State of the Science – A Gathering of Eagles, EMS Today, and Emergency Cardiovascular Care Update.

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**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE 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. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: Oklahoma College of Emergency Physicians

Address: No physical office address for OCEP – Executive Director is Gabe Graham
gabegraham11@gmail.com

Type of Organization: State Chapter of ACEP

Duration on the Board: Since 2007 continuously and currently

Organization: Emergency Medical Services Authority

Address: 1111 Classen Blvd
Oklahoma City, OK 73103

Type of Organization: Public Utility Model Ambulance Service

Duration on the Board: Ex-officio as Medical Director since 2009 continuously and currently

Organization: Emergency Medicine Residents Association

Address: 4950 W. Royal Lane
Irving, TX 75063

Type of Organization: Professional medical association

Duration on the Board: 1995-1998

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Jeffrey M. Goodloe, MD Date June 9, 2019

August 1, 2019

Re: Endorsement for Jeffrey M. Goodloe, MD, FACEP for the ACEP Board of Directors

Dear Councillors

On behalf of the Oklahoma College of Emergency Physicians, I write to enthusiastically endorse the current Oklahoma Chapter President, Dr. Jeffrey M. Goodloe, for the ACEP Board of Directors.

Dr. Goodloe is already well known nationally within ACEP, starting prior to his EMRA presidency in the late 1990s. He is an active councillor, with service on the Council Steering Committee and Reference Committees, including chairing a 2012 Reference Committee. He is active in advocacy activities at the federal level, respected among Oklahoma's US Representative and Senators. Dr. Goodloe is an active promoter of our specialty's future through support of the Emergency Medicine Foundation and recruitment of ACEP members to join him in the Wiegenstein Legacy Society. He is a voice trusted by ACEP leaders, including multiple ACEP presidents, evidenced in part by a two-year term as Chair of the EMS Committee and appointments to the Bylaws Committee.

Dr. Goodloe has effectively led the Oklahoma College of Emergency Physicians as a Board Member since 2007 and as President since 2016, helping lead a resurgence in activity and interest at our local level.

Dr. Goodloe moved to Tulsa in the Summer of 2007 and was promptly elected to our Board of Directors as a councillor, in part due to his experience and expertise representing EMRA for several years on the ACEP Council and his activity within the Texas College of Emergency Physicians. Dr. Goodloe has represented us well throughout the years, helping our councillors understand the history behind many resolutions and the intricacies often involved when contemplating the full impact of resolutions on ACEP members. He is a consummate team player and leader--encouraging involvement of any OCEP member willing to serve and mentoring younger members. OCEP membership is growing in significant part due to Jeff Goodloe's dynamic vision to make OCEP more effective, more tangible, and more fun!

Dr. Goodloe leads our federal legislative action arm, yet remains very active with our state legislative priorities, including testimony at the Oklahoma State House. He formed a coalition of medical specialists, including emergency physicians, internists, stroke neurologists, and EMS professionals to oppose a problematically worded stroke care bill. This coalition was able to effectively work with the American Stroke Association and Oklahoma legislators to craft a bill that truly strengthens stroke care capabilities for Oklahomans, from first medical contact by EMTs and paramedics to Emergency Department care, carrying through to inpatient and rehabilitation therapies. Without Dr. Goodloe's

President
Jeffrey M. Goodloe, MD, FACEP

Vice-President
James Kennedye MD, MPH, FACEP

Treasurer
Timothy Hill, MD, PhD, FACEP

BOARD
Miranda Phillips, DO, FACEP
Lance Watson, MD, FACEP
Dana Larson, MD, FACEP
Cecilia Guthrie, MD, FACEP
Craig Sanford, MD, FACEP
Jeffrey Johnson, MD
Juan Nalagan, MD, FACEP
Carolyn Synovitz, MD, MPH, FACEP

Executive Director
Gabe Graham, CPA gabegraham11@gmail.com

timely actions and leadership, Oklahoma would not have the stroke legislative remedies our patients enjoy today.

Dr. Goodloe most recently activated OCEP membership to stand ready to oppose a last-minute state legislative session bill that would have banned out-of-network/balance billing by Oklahoma's emergency physicians. Based in part upon perceived strong opposition by emergency physicians and EMS professionals, Oklahoma's Insurance Commissioner influenced the withdrawal of the bill.

Dr. Goodloe is a wise steward of OCEP finances and consistently accomplishes proposed events and initiatives under budgetary targets.

Simply put, OCEP enjoys—at the local level--the same committed, vibrant leadership that Dr. Goodloe brings to national ACEP.

We are certain that Dr. Goodloe would verify the above, though reluctantly, given his modest, servant-oriented leadership style. You, and ACEP, will not 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 to the ACEP Board of Directors.

Kindest professional regards,

James R. Kennedye, MD, MPH, FACEP
Vice-President, Oklahoma College of Emergency Physicians

President
Jeffrey M. Goodloe, MD, FACEP

Vice-President
James Kennedye MD, MPH, FACEP

Treasurer
Timothy Hill, MD, PhD, FACEP

BOARD
Miranda Phillips, DO, FACEP
Lance Watson, MD, FACEP
Dana Larson, MD, FACEP
Cecilia Guthrie, MD, FACEP
Craig Sanford, MD, FACEP
Jeffrey Johnson, MD
Juan Nalagan, MD, FACEP
Carolyn Synovitz, MD, MPH, FACEP

Executive Director
Gabe Graham, CPA gabegraham11@gmail.com

Jeffrey M. Goodloe, MD, FACEP

Fellow councillors, colleagues, and friends, I am Jeffrey Goodloe. I'm honored and incredibly excited to be a candidate for the ACEP Board of Directors.

Many emergency physicians are disenchanted with government and healthcare industry leaders. This is decidedly not the time to lose momentum in what we believe best advances our beloved specialty. We and our patients deserve good leaders. Energized leaders. Enthusiastic leaders. Ethical leaders. Servant leaders. Strong leaders. Vocal leaders.

Current diversity in viewpoints among ACEP members is unparalleled in the history of the College. Representing emergency physicians translates specifically to advocating for emergency physicians. Effective advocacy for emergency physicians is built upon understanding, tolerance, and respect for each of us.

I'm now 21 years post emergency medicine residency. Throughout my journey of growth as an emergency physician, I've been taught by generalists, other specialists, non-EM residency trained/EM boarded faculty and EM residency trained/EM boarded faculty. These mentors, teachers, and colleagues are of varying genders, ethnicities, religious beliefs, and as diverse in interests as imaginable. I've learned valuable medical and life lessons from them all.

I've worked in multiple practice settings from a rural community hospital, with its 16 bed ED to an inner- city tertiary referral hospital with an annual ED census soaring past 100,000 patients. I've also worked at suburban hospitals that many assumed were "nice little places to practice" where my partners and I each routinely saw 4-5 patients/hour throughout shifts, many with patient acuities requiring invasive airway management, central lines and trauma/STEMI/stroke/sepsis teams all comprised of one emergency physician, two nurses (if we were lucky), and a respiratory therapist. For the past several years, I've been fortunate to share the benefits of these experiences, teaching fellows, residents, and medical students in an EM residency program, while still learning emergency medicine advances daily, and conducting research in a medically underserved state.

Also, as an emergency physician, I've built upon my love for pre-hospital care discovered as a paramedic in university and medical school. I've served in EMS for 31 years, 23 of those as a medical oversight physician, currently the clinical leader for over 4,000 credentialled professionals in the metropolitan Oklahoma City and Tulsa areas. I also find professional fulfillment in serving in special events medical planning and on-site coverage, including many NASCAR and IndyCar events as well as law enforcement tactical missions.

Each of these roles – bedside clinician, teacher, researcher, EMS medical oversight leader, special mission clinician - has at its core *being an emergency physician*. Throughout it all, I have been active in advocacy and service in state and national ACEP.

If you identify yourself with any of the above, I can effectively help represent you. If you don't, I'm sincerely willing to listen to you so I can better understand and inculcate your perspectives. If we differ in viewpoint, it is my opportunity to learn *your* understanding and beliefs about the issue. I will always have a deep respect for your beliefs and will want to understand how you formed them. Further, in representing the College, I will be faithful to representing members' views, even when they differ from my own.

Where consensus exists, I will represent it. Where disparate views are tangible, I will reflect that spectrum, both in internal communications and external advocacy.

Do we have continual challenges? Yes. Can we find answers *together*? Yes. Between our dates of birth and death, we have a dash, figurative and literal. Emergency physicians make positive differences with our dashes. Part of my positive difference is a sincere desire to represent and serve you as a member of the ACEP Board of Directors.

JEFFREY M. GOODLOE, MD, FACEP

For ACEP Board of Directors

Accountable
service
Consensus
builder
Enthusiastic
commitment
Proven
leadership

Council Steering Committee Member
Council Reference Committee Chair
EMS Committee Chair
State Chapter President & Councillor
Past EMRA President & Councillor

Proudly endorsed by:

Oklahoma College of Emergency Physicians

Jeffrey M. Goodloe, MD, FACEP

1145 S. Utica Ave, Suite 600 | Tulsa, OK 74104 |918-704-3164 (Cell)

jeffrey-goodloe@ouhsc.edu

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Rachelle A. Greenman, MD, FACEP

Question #1: Should the evaluation of a potential Board candidate include their suitability to serve as a future ACEP president?

The short answer to this question is that all board candidates should absolutely be suitable to run for president. That is, there are certain minimum criteria that any candidate for board or president should fulfill. These include Fellowship status, ABEM certification, proven leadership qualities and service to the college. But not every board candidate is going to possess the traits that are required to be president. The president must be the public spokesperson and advocate for ACEP and our profession, be available to travel with little notice and have the ability to maintain a rigorous and demanding schedule. Not all have this sort of professional or personal flexibility.

Obviously, all of the presidential candidates must have served on the board but not every board member runs for president. Certainly one can be an outstanding contributor to the board but not possess the qualities that make a great president. Being good at one job doesn't necessarily mean that one will have what it takes to do another. The president must be able to inspire, motivate, mentor and direct. The qualities needed to roll up ones sleeves and do the heavy lifting that is done by the board are not necessarily the same ones that translate to those required of a president.

The talents of our board members are diverse and impressive, each excelling in different areas and contributing in their own way. However, not every board member aspires to be president. I am sure there are board candidates that run for board intent on eventually becoming president. Others may view a seat on the board of directors as their final goal, with no ambition to run for president. By the time a board member considers a run for the presidency they are usually in their second term and have successfully weathered two elections and most certainly evolved as a person and a leader.

As we are all well aware, things often change in our lives. What once seemed untenable and out of reach, becomes an exciting challenge worthy of pursuit. It is conceivable to me that one may start out not feeling suitable for the presidency and then over the next four or five years grow into the role, working on weaknesses, identifying new strengths, and finding one's voice. As Vince Lombardi said, "Leaders are made, they are not born."

On the surface this seems to be a simple question with a straightforward answer. But really it's much more complicated. Suitability is different from intent or desire and does not necessarily consider appropriateness. While the quick answer to this question is "Yes, all board candidates should have checked off the boxes that would be required of a presidential candidate." In reality the answer is "Well, not so fast, maybe the answer is no, not necessarily." Much more goes into consideration for a position than just fulfilling certain requirements. There are many qualities that we want our president to possess that aren't necessary to be a successful and productive board member. I believe our board would suffer and lose a great deal of talent if we eliminated any potential candidates who were not, at least initially, "presidential." In any given year there are always several board members who prefer to keep a lower profile and work "behind the scenes." This does not in any way detract from their significant contributions or hard work. Preferring to avoid the limelight does not negatively impact one's ability to perform as a board member but may not serve well for a president.

***Question #2:* Given the diverse viewpoints of ACEP members, how will you ensure that all voices within emergency medicine can be represented?**

The ACEP community has evolved considerably since I first joined as a resident. There has been a significant increase in the number of women, younger members, people of color and different ethnicities participating in Council and attending Scientific Assembly. As we grow in numbers, strength, and diversity it is vital that we continue to address and respect the concerns of all members.

I believe that in order to stay relevant, it is imperative that ACEP continually and actively reach out to members to ensure their voices are being heard and their needs are being met. The many benefits offered by ACEP, both tangible and intangible, need to be delineated clearly and promoted enthusiastically. Connecting with members and listening to their concerns and issues should be a priority for leadership.

In my years of active engagement with ACEP I have noticed a common hallmark of strong leaders is their ability to listen to and connect with others. Specifically, there are two kinds of listening that strong leaders display. One of those communication skills is "active listening," a cornerstone of emotional intelligence, and includes being mindful of body language, facial expression and mood. The other, "listening with empathy", encourages us to connect with a person's feelings and thoughts. These are some of the most challenging skills to develop. I've observed many past and present ACEP leaders and have always been impressed by their laser-sharp focus and deep concentration while conversing with others.

to be delineated clearly and promoted enthusiastically. Connecting with members and listening to their concerns and issues should be a priority for leadership.

In my years of active engagement with ACEP I have noticed a common hallmark of strong leaders is their ability to listen to and connect with others. Specifically, there are two kinds of listening that strong leaders display. One of those communication skills is "active listening," a cornerstone of emotional intelligence, and includes being mindful of body language, facial expression and mood. The other, "listening with empathy", encourages us to connect with a person's feelings and thoughts. These are some of the most challenging skills to develop. I've observed many past and present ACEP leaders and have always been impressed by their laser-sharp focus and deep concentration while conversing with others.

The importance of reaching out to new and potential members cannot be over emphasized, as it is essential to the growth and mission of ACEP. In my tenure as president of NJ ACEP, (2014-2015), I made it one of my priorities to increase membership. I enlisted board members from different types of practices, recent grads, and residents, to join me in visiting every medical school and residency program in the state. We introduced EMRA and ACEP to these future EM physicians, and fielded their many questions. These sessions were extremely successful, well attended, and greatly appreciated.

Recently, I have spearheaded the creation of several successful events designed to welcome new members and encourage their participation. These included a networking seminar and "Women in EM" dinner programs.

As a result of these endeavors we have increased our membership by over 24% and significantly diversified the make-up of our board of directors. We now have representatives of many different ethnicities and backgrounds attending our meetings, running for board and participating in Council. In addition, I am proud to say; over half of our board is female, which is a significant change from a decade ago, when I was often the only woman at the table. Diversity and equitable representation make for a stronger, more vibrant ACEP and enhance our ability to respond to the many challenges we face today.

We have made a deliberate effort, in NJ, to engage new members, reframing our board of directors meetings and medical directors dinner as "membership" events. Those who attend meetings find a welcoming group. We value the opinions of medical students and residents as much as those of our veteran members. Our leaders make a point of individually engaging newcomers in conversation and ensuring they feel welcomed and valued.

At the end of a recent event a young woman about to begin her EM residency came over to me and said she had been quite nervous about attending, as she knew virtually no one. But, she went on to say, she had a wonderful evening, met many people, found everyone to be warm, friendly and inclusive. She was thrilled she had decided to attend, expressed gratitude for the invitation and enthusiasm for future events.

In order to attract attendance and encourage higher participation from those who are under-represented, conferences and meetings should feature speakers from diverse backgrounds. Panels and events that address the specific needs or challenges facing physicians of marginalized identities must also be included in the agenda.

The creation of a welcoming, safe, and inclusive atmosphere with leaders that actively listen to a range of opinions and concerns without interruption or judgment will ensure that no one feels intimidated about expressing their view and that all know their opinions and experiences will be respected. Taking care to keep verbiage, attitudes, and media neutral will demonstrate that ACEP is sincere in its endeavor to represent all members. Most importantly, by creating clear, open channels for feedback and demonstrating a commitment to integrating these insights, ACEP will ensure it remains responsive to the needs of all members.

***Question #3*: What do you believe is the single most divisive issue in ACEP at this time and how would you address it?**

While there are many issues confronting us that are controversial and divisive, there are few that rival the topic of gun control in its ability to create contention and instigate dispute, as evidenced by two articles published in the May 2019 issue of ACEP Now.

The front- page article by Dr. Megan Ranney emphasized that, as professionals, firearm injury affects us all, outlining actions already undertaken by ACEP, including education and advocacy efforts to improve public safety. Several pages later, Dr. Marco Coppola's response suggested that the firearm issue is "less about patient safety than about furthering a political agenda." He writes that ACEP "runs the risk of alienating a good number of members " and "should stay out of divisive issues".

A 2018 NBC/Wall Street Journal poll found that 80% of registered voters believed the country was divided. So it would come as no surprise that ACEP members are also divided on many issues. As Emergency Medicine physicians our obligation is to safeguard and protect our patients and our communities. Patient welfare must always be our top priority even though this may require putting aside partisan leanings and influences.

In a 2018 WSJ op-ed, James A. Baker III said, "we have become an evenly divided red-state, blue-state nation more intent on waging political battles than finding ways to advance the common good."
One need simply recall the straw polls taken at Council preceding the last few presidential elections and note that we, in ACEP, were split virtually down the middle. Despite this, we seem to be able to put aside our differences and focus on doing the right thing for public health and safety.

If we approach any rift with an "us" vs. "them" attitude, it is unlikely progress will be made. Reframing the gun control discussion as one aimed at reducing injury and death by addressing firearm safety and gun violence without infringing upon the right to own and use firearms will encourage bipartisan conversation and meaningful compromise.

Fortunately there is history of reaching common ground that can be used as a template for further progress. A 2018 ACEP member survey found that almost 70% of respondents supported the current ACEP policy on firearm safety and prevention with an additional 21% supporting some of the policy.

There will always be issues that we disagree on, but with identification of common ground, calm discussion, mutual respect, education, and sincere effort to understand each other's perspectives we can work together to effect constructive change. Much can be gained by creating a safe, non-judgmental environment to express opinions, focusing on big-picture, long-term goals by making small mutually agreeable compromises. Rather than a "winner take all" mentality there must be recognition that we are all on the same team working towards a mutual goal. ACEP must work with all concerned to develop a consensus approach incorporating the many different viewpoints in an effort to move forward toward meaningful progress.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Rachelle A. Greenman, MD, FACEP

Contact Information

122 Renaissance Drive
Cherry Hill, NJ 08003
Phone: Mobile (609) 313-5889
Home (856) 489-0113
E-Mail: greenman.shelley@gmail.com

Current and Past Professional Position(s)

6/2013 to Present	Assistant Professor Of Emergency Medicine Cooper Medical School of Rowan University
7/2012 to 6/2013	Adjunct Assistant Professor of Emergency Medicine UMDNJ/Robert Wood Johnson Medical School
4/1994 to 6/2012	Assistant Professor of Emergency Medicine UMDNJ/Robert Wood Johnson Medical School

Education (include internships and residency information)

1977 to 1981	Brandeis University, Waltham, MA, (B.A. cum laude)
1981 to 1985	New Jersey Medical School University of Medicine and Dentistry, Newark, NJ MD 1985
1985 to 1986	Internship in Internal Medicine, Montefiore Hospital, Bronx, NY
1986 to 1988	Residency in Internal Medicine, Montefiore Hospital, Bronx, NY
1988 to 1991	Residency in Emergency Medicine, Jacobi Hospital/Bronx Municipal Hospital Center, Albert Einstein College of Medicine, Bronx, NY

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

1989 to Present	American Board of Internal Medicine
2012 to Present	American Board of Emergency Medicine

Professional Societies

1989 to Present	ACEP
1989 to Present	NJ ACEP

National ACEP Activities – List your most significant accomplishments

6/1989 – Present	Member, American College of Emergency Physicians
1998 – Present	Member, American College of Emergency Physicians, Well-being Committee
2007 – 2009	Alternate Councilor, American College of Emergency Physicians
2009 – 2011	Wellness Committee Chair, American College of Emergency Physicians
2010-2015, 2017 & 2018	Councilor, American College of Emergency Physicians

2011 – 2012	Committee Co-Chair, ACEP Wellness Committee
2012 – 2015	Member, American College of Emergency Physicians Membership Committee
2013 – 2015	Member, American College of Emergency Physicians Council, Steering Committee
2014 – 2015	Member, American College of Emergency Physicians Candidate Forum Subcommittee
2017 – 2018	Member, American College of Emergency Physicians Nominations Committee
2017 – 2019	Member, American College of Emergency Physicians National/Chapter Relations Committee
2013 – Present	Subcommittee Chair American College of Emergency Physicians Wellness Booth/Center

ACEP Chapter Activities – List your most significant accomplishments

2010 – 2015	New Jersey Chapter of the American College of Emergency Physicians Board of Directors
2011 - 2012	Secretary Treasurer, New Jersey Chapter of the American College of Emergency Physicians
2012 – 2013	New Jersey Chapter of the American College of Emergency Physician's representative to "Kitchen Cabinet" with New Jersey Assemblyman Gary Schaer
2012 – 2013	President Elect, New Jersey Chapter of the American College of Emergency Physicians
2013 – 2014	President, New Jersey Chapter of the American College of Emergency Physicians
2014 – 2015	Immediate Past President, New Jersey Chapter of the American College of Emergency Physicians
2019 – Present	Member, Board of Directors of the New Jersey Chapter of the American College of Emergency Physicians

Practice Profile

Total hours devoted to emergency medicine practice per year: **1300+** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **85** % Research ____ % Teaching **10** % Administration **5** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Hospital employee

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	Cases	Plaintiff Expert	Cases

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Rachelle A. Greenman, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Cooper University Hospital

Address: 1 Cooper Plaza, Camden, NJ 08103

Position Held: Assistant professor of Emergency Medicine, Clinical Educator

Type of Organization: University Hospital

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: NJ ACEP

Address: PO Box #266

272 Dunns Mill Road, Bordentown, NJ 08505

Type of Organization: Professional Society

Duration on the Board: 2010-2015, 2019 to present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

   ☒ NONE

   ☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

   ☒ NO

   ☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Rachelle Greenman June 5, 2019

NEW JERSEY CHAPTER
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

ACEP
WELLNESS
SECTION

August 15, 2019

Dear Councillor:

The New Jersey Chapter of the American College of Emergency Physicians (NJ-ACEP) and Wellness Section of ACEP would like to provide our wholehearted support of **Rachelle "Shelley" Greenman, MD, FACEP** for the national ACEP Board of Directors. It is without reservation and with considerable enthusiasm that we endorse Shelley's candidacy because we know that her presence on the Board will immensely benefit our college for years to come.

Shelley's career spans 30+ years ranging from bedside ED physician to an Assistant Professor of Emergency Medicine. But that isn't what sets her apart from the others. What makes her unique is her ability to make others feel a sense of worth in the emergency medicine world. When Shelley began her first NJ-ACEP Board term in 2010 there were only two other women at the table - out of nineteen Board of Directors. From day one, Shelley made it her mission to encourage women to attend the quarterly Board meetings, and eventually run for Board seats. There are currently eleven women at the table. Shelley has demonstrated her strength as a spiritual leader by encouraging diversity, inclusiveness, and wellness.

Shelley is an effective communicator at both the state and national levels. She represented NJ-ACEP at several legislative hearings in Trenton, addressing the flu pandemic and access to healthcare for women. She also represented the Chapter on several telephone and on-camera interviews during the 2014 release of the National Report Card.

She served as President of NJ-ACEP from 2014-2015 and made it her mission to encourage medical student participation within the Chapter. Following her tenure as Past President she continued to attend each Chapter Board meeting and volunteered as the Membership Chair. She created the medical student outreach program, visiting each medical school where she created an open dialogue outlining the value of ACEP. Since the start of the program, the candidate membership has grown from 277 members to 433 members. This growth is a direct result of her efforts. In 2018, she created the Medical Student Leadership Fund which provides scholarships for medical students to attend the ACEP Leadership and Advocacy Conference and ACEP Fall Conference.

She has been an ACEP member since 1988 and has embraced service to ACEP with passion and determination over the last two decades. She has served on multiple ACEP committees including Membership, Steering, Nominations, National Chapter Relations, and Well-Being of which she chaired from 2009-2011 and co-chaired from 2011-2012. Through these committees she has helped guide not only ACEP's positions on important matters but also many members with similar interests.

Her strongest qualities are her highly collaborative management style, sincere desire to champion for physician wellness, and her profound enthusiasm for our specialty. Dr. Greenman was honored with the American College of Emergency Physicians "Wellness Award" in 2003, and since 2013, has been serving as the subcommittee Chair for the American College of Emergency Physicians Wellness Center, while being a long-standing member of ACEP's Wellness Section. Shelley has a sophisticated, broad based and profound understanding of the complex nature of our specialty and its relationship to all of medicine. It also must be noted that she can plan one heck of a party, taking the lead with reception planning since 2014 when she served as President. The NJ-ACEP reputation for a great event has only grown with her guidance!

We welcome the opportunity to talk with you at any time to discuss our enthusiastic support of Dr. Shelley Greenman to serve on the ACEP Board of Directors. We are proud to stand behind her as she aims to advance emergency medicine through our valuable organization.

Sincerely,

Thomas Brabson

Thomas Brabson, DO, MBA, FACOEP, FACEP
President, New Jersey Chapter

Randall Levin

Randall M. Levin, MD, FACEP - Life
Chair, ACEP Wellness Section

SHELLEY GREENMAN MD, FACEP

Candidate for Board of Directors, 2019

Board Certified EM/IM

PROVEN LEADERSHIP

Past President of NJ ACEP
Past Chair of Wellbeing Committee
Steering Committee
Membership Committee
Councillor
Nominating Committee
National Chapter Relations Committee

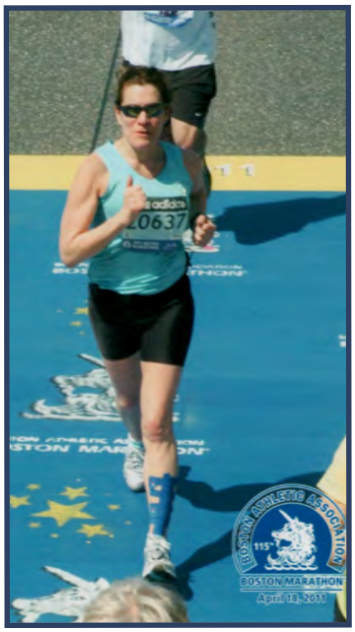
Now, when we need it most:

Membership

1. Increased membership in NJ ACEP by over **25%**
2. Doubled candidate membership
3. Increased participation and membership of students, residents and young physicians

Wellness

1. Chaired Wellbeing Committee 2009-2011
2. Co-chaired Wellbeing Committee 20011-2012
3. Wellness Booth/Center Sub-Committee Chair 2013-Present



Impact

"Shelley is an effective communicator at both the state and national levels. She has a sophisticated, broad based and profound understanding of the complex nature of our specialty and its relationship to all of medicine.

But that isn't what sets her apart from the others.

What makes her unique is her ability to make others feel a sense of worth in the emergency medicine world. Her strongest qualities are her highly collaborative management style, a desire and willingness to improve physician wellness, and a passion for our specialty."

- NJ ACEP/WELLNESS SECTION

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Gabor D. Kelen, MD, FACEP

***Question #1:* Should the evaluation of a potential Board candidate include their suitability to serve as a future ACEP president?**

No.

The Board exists as a learned experienced body, hopefully representing the entire broad constituency and each member bringing diversity of experience and skill. Not all BODs aspire to be president, nor are all presidential material. There has never been a shortage of qualified presidential candidates identified by the nominating committee. The Council always has the right to nominate from the floor as well. The BODs are there to serve, and not to launch a presidential run.

***Question #2:* Given the diverse viewpoints of ACEP members, how will you ensure that all voices within emergency medicine can be represented?**

ACEP represents the largest group of emergency physicians, thus, diverse perspectives are not only inevitable but highly welcomed. Unpopular views today, may be the prevailing views of tomorrow. Given the question above it should be clear that an individual member of the ACEP Board of Directors (BOD) does not have powers to *ensure* anything other than their own conduct. However, individual BOD members can champion, promote and otherwise advocate for what they believe is in the best interests of ACEP members. There are several means to encourage that diverse viewpoints be aired. The first of course is actually more up to the Council than any elected officer of ACEP. Ideally, the individuals elected by ACEP Council to the BOD would represent the broad constituency of EM, including those that question the status quo.

From a personal responsibility perspective, a BOD member should read blogs and social media postings of members to have access to views that may not arise from Council, State and other chapters. Other media (ACEP news, scientific and quasi-scientific publications, education blogs, tweets etc.) also inform. It would be important to be knowledgeable about diverse views. BOD members should appropriately consider all rationally voiced perspectives during BOD deliberations, regardless of personal views or positions. Understanding alternate perspectives is likely to strengthen ACEP positions. At the least, airing of all views offers assurance other perspectives were considered, with an explanation of why such views did not prevail. As in all aspects of professional life, rational members whose views do not prevail, will respect decisions if they believe their views were appropriately considered and respected.

Although the two-day annual Council meeting certainly requires considerable time to get through the agenda, however, debate is frequently prematurely cut-off when a large majority does not want to hear from an unpopular minority view with little hope of persuasion. While within the rules of order, we have seen unpopular views cut by debate closure, become acceptable ACEP mainstream perspectives within a decade. I would work to expand the ability to better voice minority views on the Council floor, while mindful of time. We don't come to Council once a year to rush through an agenda as fast as possible, but rather for meaningful deliberation—even for issues where the outcome is all but assured.

Finally, we should also remember there remain large numbers of emergency physicians who are not members that continue to feel estranged from ACEP. If ACEP is to truly aspire to represent interests of all of emergency physicians and the discipline, we would do well to listen beyond our membership as well. My representation on the board can be very helpful in this regard, as I have access, trust, and can reach out to virtually all EM societies and groups through affiliations cultivated over the years.

***Question #3:* What do you believe is the single most divisive issue in ACEP at this time and how would you address it?**

I don't much like focusing on issues that divide us and would rather spend the energy on promoting factors that unite us and keep us as a cohesive body to further the field of emergency medicine for the betterment of patients, physicians and our allied staff.

That said, there is an issue, perhaps so permeating, that most do not recognize that it is an issue at all--or that it is divisive.

Emergency Medicine no longer has a unifying defining purpose. There is a multiplicity of purposes, each organization coveting and protective of its uniqueness or niche. There are over 225 EM residencies, and over 75% of universities have established autonomous academic departments. Today EM personalities can dominate an institution. EM has been a primary specialty now for more than 30 years. EM physicians are health system CEOs, state and national surgeon generals, deans of medical schools, entrepreneurs, etc. More and more distinct niche societies allied or stemming from EM wish a strong degree of autonomy and identity.

In its most formative days, pressing the advancement of, and seeking recognition as a respected specialty was the clarion call that united virtually all of EM in a singular purpose. In many ways this was akin to pursuing legitimacy and acceptance, the basis for most social and civil rights movements. This purpose drove the founders and legacy physicians and influenced at least 2 generations to advance the field. Today, the ascendancy of EM and its rightful place in medicine are not questioned any more than the usual (and unfortunate) disparagement of some specialty members toward another specialty—and sometimes we ourselves give as much as we take.

So, what does this have to do with divisiveness? Since we are not all rowing in the same direction, and don't particularly have unifying purpose for the specialty, many of our members are adrift. Those of us on Council and leaders of ACEP are generally driven by a strong purpose to improve the lives of our patients and members. But a pursual of EM blogs, and other social media discourse reveal that many in EM (including many ACEP members), are adrift. Many feel like they are simply a cog in some organization, without voice and without meaning in their work, simply "processing" patients while having to perform to various metrics—many which have nothing to do with clinical acumen or patient engagement.

Reinvigorating commonality of purpose such that daily lives of emergency physicians have meaning is not a simple task. However, given the enormity of the situation, even if very under-recognized, solutions are worth exploring. We could start by soliciting suggestions from our members and reaching out to other EM-linked societies. One option would be to convene a summit of sorts with leaders and constituents from the various EM entities (big and small) to allow us to take stock, reaffirm commonality and develop a new shared vision that a strong majority of emergency physicians can back with energized conviction.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Gabor D. Kelen, MD, PGY40, FRCP(C), FACEP

Contact Information

G. D. Kelen, MD, FRCP(C), FACEP
Department of Emergency Medicine
1830 E Monument Street, Suite 6-100
Baltimore, Maryland, 21287

Phone: 410-955-8191 (W); 410-404-8640 (C)
E-Mail: gkelen@jhmi.edu

Current Professional Position(s)

Chair	Department of Emergency Medicine, Johns Hopkins University
Physician-in-Chief	Emergency Medicine, Johns Hopkins Medicine
Director	Johns Hopkins Office of Critical Event Preparedness and Response
Chair	Board of Directors; Johns Hopkins Emergency Medicine Service, LLC
Principal Staff	Applied Physics Laboratory, Johns Hopkins University (2008-present)
Professor	Emergency Medicine, Johns Hopkins University School of Medicine Anesthesiology, Critical Care Medicine, JHU School of Medicine, Health Policy and Management, JHU School of Public Health

Past Professional Position(s)

Program Director	Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1986-2010)
President	Society of Teachers of Emergency Medicine (1988-90)
Chair	Medical Board, Johns Hopkins Hospital (2005-08)
Vice Chair	Medical Board, Johns Hopkins Hospital (2002-05)
Member	Board of Trustees (ex officio), Johns Hopkins Hospital (2005-08)
Research Director	Department of Emergency Medicine, Johns Hopkins University (1984-2005)
President	Association of Academic Chairs of Emergency Medicine (2005-06)
Chair	Cedar Emergency Services Board of Directors (2000-01)
Board of Advisors	Johns Hopkins Clinical Practice Association (1997-2000)
Board of Directors	Baltimore Substance Abuse Systems, Inc. (1997-2001)
Board of Directors	Johns Hopkins Bayview Physicians Association (1996-2001)
Board of Directors	Emergency Medicine Foundation (1993-95)
Program Director	Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1984-86)
Chief Resident	Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1983-84)

Education (include internships and residency information)

MD	University of Toronto (1979)
Internship	University of Toronto; St. Michael's Hospital (1980)
Residency	University of Toronto; St Michael's Hospital (1981-82)
Residency	Emergency Medicine; Johns Hopkins Hospital (1982-84)

List Medical Degree (MD or DO) and Year Received Here

MD	University of Toronto (1979)

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.)

ABEM	(1985, 1995, 2005, 2014)
FRCP(C)	(1986-present)

Professional Societies

American College of Emergency Physicians (1983-present)
Society for Academic Emergency Medicine (1989-present)
Association of Academic Chairs of Emergency Medicine (1993-present)
Society for Disaster Medicine and Public Health Preparedness (2015-present)
National Academies of Science--Elected (2005)

National ACEP Activities – List your most significant accomplishments

EMRA (1983-84)
Academic Affairs Task Force (1987-88)
Congressional Testimony on HIV and HCWs (Subcommittee on Health and Environment) for ACEP (1990)
AIDS Task Force Committee (1987-92)
EMF Board of Directors (1988-90)
Society of Teachers of Emergency Medicine (was part of National ACEP until 1989)
- STEMLetter Editor-in-chief (1984-88)
- Faculty Development Committee (1985-88)
- Board of Directors (1987-90)
- President (1988-90)

Testimony to National Commission on AIDS on behalf of ACEP (1991)
Chair, AIDS Task Force Committee (1991-92)
EMF Board of Directors (1993-95)
EMF Centers of Excellence Grant Panel (1994-95)
Chair, Infectious Disease Committee (1992-93)
Chair, Public Health Committee (1993-95)
Designated Spokesperson (1991-present)
ACEP Council Steering Committee (2017-present)
Councilor (AACEM) (2010-present)
ACEP Workforce Task Force (2018-present)

National ACEP Awards

Outstanding Contribution to Research Award

ACEP Section Activities (AACEM) – List your most significant accomplishments

Representative to Council of Academic Societies of AAMC (2000-10)
Membership Task Force (2003-04)
Board of Directors (2003-07)
President (2005-06)
Lead effort to create AACEM Section in ACEP (2009)
ACEP inaugural Council Representative (2010-present)

Maryland ACEP Awards

Emergency Medicine Award, Maryland Chapter (1994)
Chairman of the Year Award, Maryland Chapter (2019)

Practice Profile

Total hours devoted to emergency medicine practice per year: **2800** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 25 % Research 10 % Teaching 10 % Administration 50 %

Other: EM National Organizations 5 %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Large inner-city, tertiary care teaching, safety-net hospital; multi-hospital (no partners, not for profit) salaried group.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 2 Cases Plaintiff Expert 1 Cases

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Gabor D. Kelen, MD, PGY40, FRCP(C), FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Johns Hopkins University

Address: 3400 N. Charles Street

Baltimore, MD 21218

Position Held: Chair, Department of Emergency Medicine

Type of Organization: Academic Medical Center

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Society for Teachers of Emergency Medicine (BOD)

Address: Now SAEM (see below)

Type of Organization: Academic Society (Merged with UAEMS=SAEM)

Duration on the Board: 4 years (1987-90)

Organization: Society for Academic Emergency Medicine (BOD)

Address: 1111 East Touhy Avenue, Suite 540

Des Plaines, IL 60018

Type of Organization: Academic Society

Duration on the Board: 2 years (1989-91)

Organization: Emergency Medicine Foundation (BOD)

Address: (Part of ACEP)

Type of Organization: Research Foundation (run by ACEP)

Duration on the Board: Two separate non-contiguous 2-year terms. (1988-90) (1993-95)

Organization: Johns Hopkins Hospital (Board of Trustees—ex officio)

Address: 1800 Orleans Street

Baltimore, MD 21287

Type of Organization: Not for profit hospital

Duration on the Board: 3 years (2005-08)

Organization: Johns Hopkins Emergency Medical Services, LLC

Address: 1830 E. Monument Street

Baltimore, MD 21287

Type of Organization: University owned LLC, providing physician services to a community hospital

Duration on the Board: 18 years (2001-)

Organization: Johns Hopkins Hospital (Medical Board)

Address: 1800 Orleans Street

Baltimore, MD 21287

Type of Organization: Not for profit hospital

Duration on the Board: 27 years (1992-); executive (2002-08)

Organization: Baltimore Substance Abuse Systems, Inc

Address: 1 N. Charles Street, Suite 1600

Baltimore, MD 21201

Type of Organization: Not for profit

Duration on the Board: 4 years (1997-2001)

Organization: Johns Hopkins Bayview Physicians Association

Address: No longer in existence

Type of Organization: Not for profit physician services to Johns Hopkins Bayview Medical Center

Duration on the Board: 5 years (1996-2001)

Organization: Association of Academic Chair of Emergency Medicine

Address: 1111 East Touhy Ave, Suite 540

Des Plaines, IL 60018

Type of Organization: Medical Society

Duration on the Board: 4 years (2003-7)

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ YES, Please Describe:

I disclosed above that I am the Chair of the Board of Directors of Johns Hopkins Emergency Medicine Services (JHEMS), LLC. This is a not for profit organization. I hold no equity in this company. The company is owned by Johns Hopkins University. The Company was created to provide physician (and NP/PA) to staff the Johns Hopkins Howard County Hospital (a community hospital owned by Johns Hopkins). As the Director of Emergency Medicine for Johns Hopkins Medicine a small portion of my university salary is supported by JHEMS. This is not additional to my regular salary. My salary is not tied to any performance or financial metrics of JHEMS. Thus, I have no personal financial interest in JHEMS, LLC.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO

I certify that the above is true and accurate to the best of my knowledge:

G. D. Kelen, MD, FRCP(C), FACEP Date June 12, 2019

AACEM
Association of Academic Chairs of Emergency Medicine

Executive Committee
Michael D. Brown, MD, MSc
President

Peter Sokolove, MD
President-Elect

Deborah Diercks, MD, MSc
Secretary-Treasurer

Andrew S. Nugent, MD
Immediate Past President

Richard J. Hamilton, MD
Member-at-Large

Lewis S. Nelson, MD
Member-at-Large

Megan Schagrin, MBA
Chief Executive Officer

August 12, 2019

John McManus, MD, FACEP
Chair, Nominating Committee
ACEP
PO Box 619911
Dallas, TX 75261-9911

Dear Dr. McManus,
It gives me great pleasure on behalf of the Association of Academic Chairs of Emergency Medicine (AACEM) to endorse Gabe Kelen, MD as a candidate for the ACEP Board of Directors at the upcoming elections during the ACEP Council meeting in 2019.

Dr. Kelen has had a long and distinguished career as a board-certified Emergency Physician. He has been a member of ACEP since 1983, and has chaired and led multiple ACEP initiatives and committees. He has served the specialty of EM by being a leader of SAEM, ACEP, AACEM, and STEM. He has also held leadership positions in multiple other national agencies and societies all while running one of the most successful academic departments of Emergency Medicine, with multiple clinical enterprises for over 25 years. We have known him personally to be one of the hardest working, knowledgeable, approachable and brilliant individuals in our specialty today.

AACEM is proud to endorse Dr. Kelen for the Board of Directors, and feel his vast experience as department chair and his work with ACEP, SAEM and multiple other organizations have more than prepared him for the rigors of this role. He will bring seasoned perspective and balance to the board as a voice of reason and experience, while representing the best interests of emergency physicians and the specialty.

Sincerely,

Michael D Brown MD

Michael D. Brown, MD, MSc
AACEM President

AACEM | 1111 East Touhy Ave., Suite 540 | Des Plaines, IL 60018
Tel: (847) 813-9823 | Fax: (847) 813-5450
www.saem.org/aacem | aacem@saem.org

Gabe D. Kelen, MD, FRCP(C), FACEP

"An idea, if at first does not seem absurd, then there is no chance for it."
--Albert Einstein

Dear Friends,

It's time for me to give back. I was the first recipient of the EMF career development grant. Due to that pivotal opportunity, my career took off and I have been privileged to serve in leadership roles within ACEP and in many other organizations.

My last shift (literally 2 days ago), like pretty much all my shifts, was burdened by: too many patients, overwhelming boarding, multiple critical ill patients, endless distractions, trying to meet a plethora of externally imposed metrics, a frustrating EMR, the easy dismissiveness of a consultant, and patients with poor health and health care access. This is a particularly challenging era in medicine for emergency patients and practitioners alike. In my recent travels, I have talked to numerous practicing emergency physicians throughout the country. Among many, there is a striking sense of disconnectedness and even isolation. While not expressed in those exact words, there is a sense that EM physicians' hard efforts are underappreciated by employers, other specialties, institutional leaders, and sometimes even patients. Many express a lack of control over their work environment, whether ivory tower academia or smaller community clinical practice. We are being overwhelmed by chasing too many metrics and short-sighted patient safety policies focused on specific conditions that, by diverting our attention, overall increases risk among other patients—*and thus*—actually heightens our exposure to litigation. EMR has done anything but make us more efficient (we log 4,000 clicks a shift). Federal and state initiatives frequently threaten our income stream. While ACEP members may have divergent views on a number of social and public health challenges, we are fortunate to be united in pushing for the highest realizable safety climate for all our patients (cue ED boarding), a positive efficient working environment, fair compensation given the risk of error (no do overs in EM), decreasing clinician safety risk, and in addressing the specific challenges of our work that affect longevity and wellness.

It was ACEP that created the specialty and fought the difficult political battles. The first phase, 50+ years ago, was the creation of the specialty. After achieving specialty status, the next phase was the further ascendance, stability, and acceptance of the specialty. As dynamic as we have been, we are entering a new challenge—i.e., what will emergency medicine now become. If we stand still, the world will pass us by. While it is important to address today's challenges, it is also time to determine what we can be in the future. In the famous words of Wayne Gretzky*, "I skate to where the puck is going to be, not where it has been."* Coupled with the Einstein quote above, this is how we must think about the future of our specialty. Indeed, we strive to move the symbol on the ACEP logo, currently somewhat off to the side, right smack in the middle, where it should belong.

I'll end where I started. Time for me to give back. I have been fortunate to have broad clinical, business, administrative, teaching, academic, and research experience. I have a strong advocacy background having testified before several congressional subcommittees and other federal and state agencies. I am seeking the privilege to represent you on the board. With you, I will tackle our current challenges, always consider all voices of our membership, particularly dissenting views, and work for the continued ascendency of our specialty.

"**If you want to make important contributions, do important work."**
--Dan Nathans, Nobel Laureate

Gabe Kelen, MD, FRCP(C), FACEP

ACEP BOD Candidate

ACEP Leadership

- Councilor (10 years)
- Steering Committee
- PA/NP Task Force
- Academic Affairs Task Force
- Chair, AIDS Task Force
- Chair, Public Health Committee
- President STEM
- National ACEP Speaker
- Congressional Testimony (X 4)
- ACEP Designated Spokesperson
- EMF BOD (two terms)
- EMF Center of Excellence Panel
- EMF External Reviewer
- White House Representative (GWB)
- Editor, Tintinalli
- Annals Reviewer

Clinical Leadership

- Full-Time Clinician
- Emergency Physician-in-Chief, JHM
- Best Physicians in Region (Baltimore Mag)
- Board of Trustees, Johns Hopkins Hospital
- Chair, JH Emergency Physicians, LLC
- JHHS/JHU Disaster Director

Administrative Leadership

- Department Chair
- Residency Director
- Research Director
- Center Director (CEPAR and PACER)
- President, STEM
- President, AACEM
- Board of Directors, SAEM
- Chair, Medical Board JHH

Recognition

- National Academies of Science (elected)
- ACEP Research Award
- MD ACEP Emergency Medicine Award
- MD ACEP Chairman of the Year
- EMF Legacy Grantee
- Academic Excellence (SAEM)
- Leadership Award (SAEM)
- Distinguished Service Award (AACEM)
- Teacher of the Year (JHU EM Residency)

Leadership, Experience, Expertise

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Pamela A. Ross, MD, FACEP, FAAP, FAAEM

***Question #1:* Should the evaluation of a potential Board candidate include their suitability to serve as a future ACEP president?**

History has shown virtually all candidates who have been elected to the ACEP Board of Directors possess the necessary ability to be a Board Officer and/or ACEP President. Actual Board service also helps to enhance these abilities and I believe it is the responsibility of all Board members to prepare for future leadership regardless of the direction that may actually be taken by any given elected board member. In addition to evaluation of board candidates for a variety of skill sets and expertise for board representation, I agree that it is important that any board member candidate be suitable to serve as a future ACEP president.

***Question #2:* Given the diverse viewpoints of ACEP members, how will you ensure that all voices within emergency medicine can be represented?**

Methods I believe useful for enhancing member engagement include but are not limited to:

1. ACEP Member/Section Forums through EngagED. Our member-only online community officially launched in August 2018 and we should continue to educate our membership about its presence and utility for bringing a larger voice to the collective discussion of ACEP matters. Hopefully, this will grow to become a significant member value and the preferred ACEP tool for electronic interactions between members, leadership and staff. #MemberVoice
2. Chapter initiatives for member engagement. Encourage and facilitate regular and frequent ACEP board member videoconference/teleconference participation at local state chapter meetings. #ChapterVoice
3. Given continued advancements in modern technology, revisit Council resolutions that allow for the President-Elect of ACEP to be elected by the entire membership. #MemberVoice
4. Engage and financially support sections to facilitate addressing special needs of the members based on their passions and interest in Emergency Medicine. #SectionVoice
5. Research implementing a "Camp ACEP for Kids" to facilitate work life balance by allowing opportunity that make it more feasible for members to attend ACEP Scientific Assembly with their families. #FamilyVoice
6. Implement exploration and study of "moral injury" among ACEP members and work to address the findings. Burnout has often been categorized as a phenomenon that involves emotional exhaustion, de-personalization and reduced personal accomplishment. While I do not deny that burnout is a real phenomenon, I never felt the term 'burnout' applied to most of us. Emergency Physicians are uber resilient - but it is impossible to measure health as being well adapted to a toxic environment. This is the everyday challenge that we all face dealing with EMRs, regulatory paperwork, board certification, merit badge courses, regulatory compliance, increased patient loads, and decreasing clinical autonomy to name a few. It is more fitting to describe what was happening to Emergency Physicians as "moral injury" which has been set into motion by an overall imploding health care system. #MoralVoice
7. Consult with EMRA regularly and FOLLOW THEIR LEAD! Continue to assure that EMRA members are active and engaged at all levels in chapters, committees and sections. EMRA was my entry into board service in Emergency Medicine. EMRA is the future of Emergency Medicine and many of your current ACEP leaders are a testament to that. I am proud to be an EMRA legacy. #EMRAVoice

My rationale for my response follows. I am a two term past president and member of the Virginia College of Emergency Physicians and our chapter is serviced by an outstanding Executive Director who is a Certified Association Executive with over 50 years of experience in organizational management. At our chapter level, Mr. Bob Ramsey (VACEP Executive Director) has been a tremendous resource for facilitating chapter growth and development. Based on work facilitated by Mr. Ramsey under the direction of the current outstanding leadership in the VACEP chapter, I consider VACEP to be a highly successful chapter that has grown from being officially categorized as a small chapter with less than 500 members to over 959 current members. Furthermore, our past Chapter President, Dr. Bruce Lo won ACEP's coveted "Champion of Diversity & Inclusion award for 2019". It is with a sense of pride that I say that Virginia ACEP is making a difference for ACEP and provides a strong template for chapters working to build and engage its membership.

Mr. Ramsey summarizes Avenue M Group's ACEP's marketing research perspective: "although, most individuals who work in emergency medicine are likely to be familiar with ACEP, their immediate interests, needs, motivations and behaviors often play a bigger role in the decision to join, engage and feel connected to the organization. With a rapidly changing workforce, the factors that influence the decision to belong to a medical society have changed."

The Melos Institute is another applied research center for membership-based organizations. Virginia ACEP has also worked with this organization and gained following wisdom evidence-based wisdom: "The inability to increase member engagement is less related to members' time and more due to the strategies employed to encourage their involvement. Treating members as customers has generated customer-like behavior; treating members as citizens transforms their role, relationship, and involvement."

***Question #3:* What do you believe is the single most divisive issue in ACEP at this time and how would you address it?**

ACEP operates democratically by majority vote of ACEP members present and participating in the ACEP Council. The Council is the collective representation of our membership and includes all states, sections and other similarly aligned EM organizations like EMRA. The Council democratically elects, advises and instructs the Board of Directors regarding any matter of importance to any ACEP member. The Council accomplishes this through by-laws, resolutions and any other action the Council deems necessary. Once elected, management and control of the organization is officially vested in the Board of Directors. If there be any confusion or concern for how we have arrived to where we are on any issue in ACEP today, remember that power in ACEP (as it historically and currently stands) is held solidly in the proceedings of the ACEP Council.

Based on the proceedings of the last official meeting of the Council held October 2018 in San Diego, bearing witness to the political nature of debate and the deeply divided Council deliberations, the single most divisive issue in ACEP at this time is our ACEP Policy on Firearm Safety and Injury Prevention where Council directed this already existing policy be updated. There were 51 Resolutions presented. While there were about 7 other resolutions that rose to similar levels of contention, my selection is validated by opposing articles written by Drs. Megan Ranney and Marco Coppola, published in the May 2019 issue of *ACEP Now*.

We won't get around divisive topics within our organization by carrying on as if they did not exist. We are equally challenged if we try to ignore one side of an issue. We are currently living in deeply divided times and, in the wisdom of Gandhi, world renown activist, "*unity, to be real, must stand the severest strain without breaking*." It is important to exercise due diligence to identify all the ways we can stand united. My methods as a leader to address issues of deep organizational division in search of organizational unity include, but are not limited to:

- Start with me as a leader - poised, open-hearted, collaborative, diplomatic, respectful, strong and committed to the vision and values of ACEP.
- Conduct well researched, unbiased, scientifically validated surveys of Council and/or membership.
- Promote *EngagED* member feedback and discussion in our 38.7 thousand ACEP members-only online community. https://engaged.acep.org/home
- Facilitate town halls or other meeting forums where members can engage through activities like opposing panel presentations, group discussions, round-tables, etc.
- Feature opposing articles, research, letters to the editor, etc. in ACEP publications.
- Support and facilitate communication between ACEP Board, committees, task forces, chapters, sections, etc. to assure alignment of referred resolutions with ACEP mission/vision.
- Systematically review and facilitate exploration/development of resolutions that change organizational operations in ways that most effectively meet member needs and bring the largest possible collective member voice to ACEP.
- Continually support and encourage member patience and participation in the process.
- Courageously lead in the direction that Council/Membership would have our organization go.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Pamela Andrea Ross, MD, FACEP, FAAP, FAAEM

Contact Information

4807 Shellbark Court, Glen Allen VA 23059 / 807 Partridge Circle, Mount Juliet, TN 37122
Phone: 804-836-9571 (cell) / 434-589-8642 (home)
E-Mail: ceo.hmclc@gmail.com

Current and Past Professional Position(s)

CEO, Holistic Medical Consultants, LLC – Sole Proprietor, Independent Contractor 2013 to present
Assistant/Associate Professor Emergency Medicine and Pediatrics, University of Virginia 1996 to 2013

Education (include internships and residency information)

University of Tennessee @ Chattanooga, William E. Brock Scholar, BA Chemistry 1987
Emory University School of Medicine, MD 1991
St. Vincent Medical Center, Emergency Medicine Residency 1994
Inova Fairfax Pediatric Emergency Medicine Fellowship 1996
Arizona Center for Integrative Medicine Fellowship 2011

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

Emergency Medicine ABEM
Pediatric Emergency Medicine ABEM/AAP

Professional Societies

American College of Emergency Physicians
American Academy of Emergency Medicine
American Academy of Pediatrics
National Medical Association
American Public Health Association

National ACEP Activities – List your most significant accomplishments

ACEP Council, Delegate/Alternate (Chapter and Sections) 1992-2009, 2011, 2013-Present
Council Reference Committee, Steering Committee and Tellers & Credentials Committee
Immediate Past Chair, Wellness Section
Past Chair, Young Physicians Section
By-Laws, Public Relations, Pediatric EM and Academic Affairs Committees
Six Section Membership: American Association of Women Physicians, Diversity, Inclusion & Health Equity, EM Locum Tenens (Founding Member), Pediatric EM, Quality Improvement & Patient Safety, and Wellness.

ACEP Chapter Activities – List your most significant accomplishments

Virginia College of Emergency Physicians – Past President, Served 2 terms

By-Laws Committee Chair

Technology Task Force Chair – *Established chapter website

VACEP Rep to State Fatality Child Review Team Appointments by Governors Gilmore, Warner and Kaine

Practice Profile

Total hours devoted to emergency medicine practice per year: **1600** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **90** % Research ____% Teaching **10** % Administration ____%

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Sole Proprietor, Independent Contractor, Locums/Traveling EM Physician licensed in the states of VA, TN, OH, MD, ND with Interstate Medical Licensure Compact Licensing in AL, MS, SD, WI, and WV.

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 1 Cases**

2011 VA Board of Medicine

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Pamela Andrea Ross, MD, FACEP, FAAP, FAAEM

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Holistic Medical Consultants, LLC Sole Proprietor

Address: 5570 Richmond Road, Suite 203

Troy, VA 22974

Position Held: Founder & CEO

Type of Organization: Emergency Medicine Independent Contractor, Sole Proprietor

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Charlottesville Free Clinic Board of Directors

Address: 1138 Rose Hill Drive, Suite 200

Charlottesville, VA 22903

Type of Organization: Healthcare Services Board

Duration on the Board: 2014 - 2016

Organization: Region Ten Community Services Board

Address: 800 Preston Avenue

Charlottesville, VA 22903

Type of Organization: Mental Health, Intellectual Disability, and Substance Abuse Services Board

Duration on the Board: 2012 - 2015

Organization: Fluvanna County Library Board of Trustees, Palmyra District

Address: 132 Main Street

Palmyra, VA 22963

Type of Organization: Governing Board of Library

Duration on the Board: 2011 - 2015

Organization: Delta Sigma Theta Sorority, Inc.

Address: 1707 New Hampshire Avenue, NW

Washington, DC 20009

Type of Organization: Civic, Public Service

Duration on the Board: 1986 – 1989, 2004 - 2008

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Pamela A. Ross, MD Date 06/07/2019

VIRGINIA COLLEGE OF EMERGENCY PHYSICIANS

2019 Board of Directors

Kenneth Scott Hickey, MD, FACEP
President
Cameron Olderog, MD, FACEP
President-Elect
Todd Parker, MD, FACEP
Secretary-Treasurer
Bruce Lo, MD, MBA, FACEP
Immediate Past President

Kirk Cumpston, DO, FACEP, FACMT
Jon D'Souza, MD, FACEP
Josh Easter, MD, FACEP
Randy Geldreich, MD, FACEP
Jared Goldberg, MD, FACEP
Christopher Hogan, MD, FACEP
Phillip Jordan, MD
Scott Just, MD, MBA, FACEP
Sarah Klemencic, MD, FACEP
Joseph Lang, MD, FACEP
Jessica Nguyen, MD, FACEP
Rob Solberg, MD
C. Christopher Turnbull, MD
Shanon Walsh MD, FACEP
Lauren Wingfield, MD

Executive Director
Bob Ramsey, CAE
Cell: (804) 814-9350

Headquarters

2924 Emerywood Pkwy., Suite 202
Richmond, VA 23294

Tel: (804) 297-3170
Fax: (804) 747-5022
www.vacep.org

July 26, 2019

RE: Joint Endorsement of VACEP and ACEP Wellness Section
Dr. Pamela Ross, MD, FACEP, FAAP, FAAEM
Candidate for ACEP Board of Directors

Leadership is about mastering the art of influence. Dr. Pamela Ross has impacted emergency medicine in so many ways at the local, state and national level. It is our pleasure to jointly endorse the nomination of Dr. Ross as a candidate for the Board of Directors of the American College of Emergency Physicians.

Dr. Ross is the only emergency physician to be elected twice by her peers as VACEP President. She likes to explain that her way of leading is "not always 'out front or at the top,' but present, knowledgeable and participating," and she continues to engage in our chapter, serving as a councilor since 1999. Dr. Ross is a fierce advocate for our specialty and was even featured in *Escape Fire: The Fight to Rescue American Healthcare,* which premiered at the Sundance Film Festival in 2012.

Dr. Ross has blazed her own trail in emergency medicine, and is today a locums tenens traveling EP, splitting her practice across multiple states. Her life's story — straight A student, valedictorian, from a loving and healthy home yet included the challenges of a mother living with schizophrenia — is equally as impressive.

Dr. Ross is a long-standing, active member of the Wellness Section and ACEP. Her involvement is well documented through her multiple roles and positions. As the current Chair of the ACEP Wellness Section, I had the privilege to meet Dr. Ross when she was elected to the Chair-Elect position in 2015. Along with her second-to-none expertise in policy and procedural matters, she excels in her organizational and people skills as a leader. Dr. Ross is a strong advocate and champion for physician wellness and for the success of ACEP. She is a mentor and role model to all of those who have the privilege of working with her, as she brings out their strengths with her positivity and career-coaching skills.

It is our privilege, on behalf of VACEP and the Wellness Section, to endorse Dr. Pamela Ross for the ACEP Board of Directors.

K. Scott Hickey, MD, FACEP
President

Randall M. Levin, MD, FACEP-Life
Chair, ACEP Wellness Section

Pamela A. Ross, MD, FACEP, FAAP

I look forward to the opportunity to demonstrate my absolute worthiness of your VOTE.

I attended the June meeting of the ACEP Board of Directors at our beautiful headquarters building in Dallas. I am proud and inspired by all the incredible work and accomplishments of our Board of Directors (present and past) and outstanding ACEP staff. [*It was the best of times…*]

At that same meeting, there were two solemn statements I heard that humbled me. One came from our President's remarks about our crucial efforts on balanced billing where he expressed that "as a profession, we are being demonized." The other, from the report of the Executive Director that included a statement along the lines that "our financials are the worst they have been in the history of the organization." [*It was the worst of times…*]

By the time we arrive to Council meeting, who knows? Perhaps we will have many answers based in our victories or perhaps more questions based in our challenges. But, here's the thing - I believe I am the type leader called to serve at such a time as this. I am committed to continuing to advance the practice of Emergency Medicine through education and advocacy for the highest quality of patient care. Having started my EM leadership in EMRA, I am dedicated to the continued mentoring, listening, and uplift of our undisputable future. Fully trusting them to care for me with excellence and compassion if I am ever transformed into the 90 yo lady who toddles past the nurse's station with the back of her gown wide open. Finally, I believe in the power to build a better organization from a leadership style based in listening, empathy, integrity, member engagement/empowerment, awareness with action, and perseverance - because it won't always be easy, things change, and we may not always get it exactly right the first time.

I joined ACEP in July 1990. My first battle for EM started with the strong counter stance I had to take with my medical school Dean who called me in to discourage me from pursuing a residency in EM. My medical student ACEP membership prepared me with information that made it clear that Emergency Medicine was a unique medical specialty of unique skill/expertise, physicians who practice Emergency Medicine should be residency trained, and EM residency training would be the only path to become board certified in EM. I was there to pursue and spread that gospel truth. The Dean made every effort to warn me of the waste of my time, assuring me that I could do a residency in any specialty and work in an Emergency Department. We agreed to disagree and I went on to my EM residency - "ADA" (against Dean's advice.)

From EM residency training, a Peds EM Fellowship, double board certification in EM and PEDS, an Integrative Medicine Fellowship, 17 years of Academic EM Practice (rising in academic rank from assistant to associate professor) and on to the life of a full time independent contracting Traveling Locums Emergency Physician - these 29 years as an ACEP member have ushered me into a place of being at peace with the Emergency Physician I have become. I am proud to do the work I do in a healthcare system that seems to be imploding right before our eyes. The best of times? The worst of times? Only time will tell.

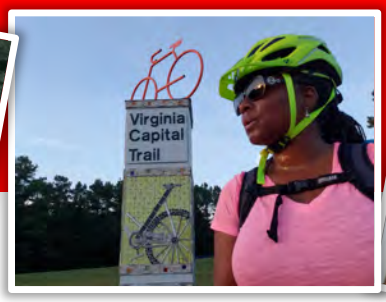
No matter what, we are better together and I am here to be of service to YOU.

Sincerely,

Pamela A. Ross, MD, FACEP, FAAP

Pamela A. Ross, MD, FACEP, FAAP

Candidate: ACEP Board of Directors 2019



Experienced Leadership & Strong Character

I joined ACEP in July 1990 and my leadership in Emergency Medicine began when I was elected to the EMRA Board of Directors, serving as the Academic Affairs Representative.

Since that time, I have been active and involved. My greatness is determined by my service where I have been present and participating in various aspects of the organization and working with many outstanding people over the past 29 years.

I am a natural born leader and my personal style is that of servant leader. I understand that leadership is not always about title or position – but about awareness, insight, inspiration, selflessness, strategy, fiscal responsibility and outcomes that serve the best interests of our membership.

A listening servant leader who is poised, collaborative, diplomatic, fiscally responsible, respectful, strong and committed to the vision and values of the Council.

Unique Skillset & Expertise

Pediatric EM: EM and PEM Board Certified, PEM Section member, Past Councilor PEM Section, Past member ACEP PEM Committee.

Locums: Entering 6th year of active clinical practice as full-time traveling EM Doc following 17yr academic career. Founding Member of EM Locums Section with first seat on Council this year!

Wellness: Immediate Past Chair, Wellness Section

Overall healing, scientific, and life philosophies that are evidence based and open to new paradigms.

Graceful & Strong

A powerful presence given to sharpen, uphold and protect our mission, deliver our vision, and lift the voice of Emergency Medicine and Emergency Physicians across the globe.

Long history of Council involvement over the years. Includes Councilor/Alternate Councilor representing EMRA, Virginia, Pediatric EM Section, Wellness Section, Young Physicians Section, and AWEP.

Socially Conscious

A tenacious advocate and insightful voice for legislation, regulation and policies that are in the best interest of Emergency Physicians, our patients and the communities we serve. EM also means Essential Medical Public Service - 24/7/365.

http://vacep.org/stories/the-socially-conscious-physician-on-leadership-and-taking-control/

.

Diplomatic & Collaborative

A positive, graceful presence believing in the power of community. Working in community and with other civic and professional organizations to find the common ground, advance the common good for our specialty and create the best possible outcomes and careers for Emergency Physicians.

Servant Leader

Committed to listening and following the wisdom and will of the Council. Committed to empowering members through mentorship, advocacy, and facilitation of full member engagement. Capable, dedicated, fiscally responsible, strategic, innovative, prepared and willing to serve as a 2019 member of the ACEP Board.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Gillian R. Schmitz, MD, FACEP

***Question #1:* Should the evaluation of a potential Board candidate include their suitability to serve as a future ACEP president?**

No. Board candidates should be evaluated on their qualifications and skill set to serve as a Board member. Period. Half of elected Board members will not serve in the role of President, but all elected members have an important role to serve and represent the College. The efficacy and cohesiveness of a team depends wholly on the diversity of talents, skill sets, backgrounds, work experience, and personalities of its leadership.

The characteristics and traits that make a strong ACEP President are not necessarily the same things that make a good Board member. Leadership for the Board is often best demonstrated by individuals who don't always want to be in the spotlight, who provide expertise in certain niches, who build relationships with other organizations, and who present unique perspectives to best represent our members. If candidates are pre-selected based on their suitability to serve as a future ACEP president, it would change the dynamic of the Board, potentially disincentivize individuals who do not have aspirations of running for president, and devalue the very important role that every other Board member plays as a member of the team.

***Question #2:* Given the diverse viewpoints of ACEP members, how will you ensure that all voices within emergency medicine can be represented?**

One of the biggest challenges ACEP continuously faces is how to best advocate for the broad range of issues that fall under the umbrella of emergency medicine and how to best represent the diverse viewpoints of the nearly 40,000 physicians that comprise its membership.

ACEP continues to develop new sections each year to represent the diverse interests of our membership. As examples, we have seen the formation of several new sections in the past few years due to interest and growth in a variety of areas including locum tenens, aerospace, and social medicine. Sections provide a forum where members can have a voice, a vote in the Council, staff support, and a connection with other members with similar interests.

ACEP has also incorporated various formats for members to express their opinions on controversial topics to ensure both sides are represented. We have seen this in townhall forums and ACEP Now articles to give both sides an opportunity to present their ideas and viewpoints. ACEP has also created a number of task forces to study issues and make recommendations to the Board of Directors. Task forces are often intentionally filled with members of divergent opinions to ensure we are hearing both the majority and minority opinions of our diverse groups and members. We have healthy debates on both the Council floor and Boardroom as members of all backgrounds provide testimony and input into the direction and future of the College.

Ensuring that all voices within emergency medicine are represented also means expanding our outreach to non-members and finding what components of membership hold value for them. The membership committee has worked incredibly hard and worked with Avenue M, a consulting firm, to evaluate new tiers of membership models to incentivize non-members to join and subsequently have an opportunity to participate and have a voice in the College.

I would continue to explore options for better communication with emergency physicians and make sure there is an outlet for disseminating information and receiving member feedback. I would like to increase communication between the national and state level and identify strategies to increase collaboration and improve the value of residency and chapter visits. I would like to get more objective data on what is working and what is not working with membership outreach and engagement. I would expand our social media presence, explore options of virtual meetings and discussion forums, and create a phone-based application that would make ACEP more accessible and relevant, and give members an alternative forum to share their voices.

***Question #3:* What do you believe is the single most divisive issue in ACEP at this time and how would you address it?**

The single most divisive issue in ACEP is our response, as an organization, to address firearm safety. Many members feel this is an important public health issue that ACEP should take the lead on. Others feel this is a political topic that is outside the scope of the College and any action has the potential to alienate members on both sides. Historically, ACEP members have been split on this issue, which has been reflected in the passion and emotionally charged discussions of our members and debate on 23 prior Council resolutions.

This is not about furthering a political agenda, but rather addressing a national public health issue. This does not need to be a partisan clash of ideals. The American College of Surgeons (ACS) recently tackled this by surveying all of its members with a robust survey method to guide their advocacy efforts and found their members agreed on much more than they disagreed on. Having objective data with high response rates will help ACEP have better direction and transparency about the current viewpoints of our members. Heaven forbid…if the *surgeons* can agree and make decisions without a white blood cell count or pan scan, imagine what we can do!

ACEP is composed of a politically diverse membership. The College aims to support bipartisan advocacy issues that impact emergency medicine, our patients, and our members. We don't take sides or support "red" or "blue" issues unilaterally. We support patients, our colleagues, and our specialty. Sometimes the lines of what falls under the EM umbrella can be blurred with politically charged topics, but I believe public health and patient safety are core elements of emergency medicine, and we can find solutions and common ground if we focus on what is best for patients. That's what we do best.

Rather than fighting over 20% of firearm issues where we disagree, we should be spending more time and energy moving the ball forward on the 80% of solutions we all agree on. The focus is not on gun control, but rather preventing firearm injury. Whether you own a gun or not, we should all be on the same side here. We are industry leaders in addressing other public health issues including reducing mortality from opioids and car accidents. Investing in research, studying the impact of legislation in several states that enacted extreme risk protection orders (ERPOs), enforcing existing laws on firearm safety, and reviewing the data in the medical, economics, and criminal justice literature are objective ways we can be proactive. Studying and enforcing interventions that improve outcomes for patients is "our lane". We need to work together, collaboratively and respectfully, to understand our differences, find common ground, and advocate for what will enhance our ability to care for our patients.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Gillian R. Schmitz, MD, FACEP

Contact Information

111 Ottawa Run
Shavano Park, TX 78231
Phone: 210-542-7783
E-Mail: GillianMD@gmail.com

Current and Past Professional Position(s)

Current Academic Appointments

Associate Professor
Department of Military and Emergency Medicine
F. Edward Hébert School of Medicine
Uniformed Services University

Adjunct Associate Professor
Department of Emergency Medicine
University of Texas Health, San Antonio
San Antonio, TX

Employment Experience

Vice Chair of Education
Department of Emergency Medicine
Brooke Army Medical Center (BAMC)
Ft. Sam Houston, TX

Associate Medical Director
Executive Director for Policy and Advocacy
Spectrum Healthcare
San Antonio, TX

Associate Professor
Associate Program Director
Department of Emergency Medicine
University of Texas, San Antonio
San Antonio, TX

Assistant Professor
Department of Emergency Medicine
UCSD Medical Center
San Diego, CA

Assistant Professor
Department of Emergency Medicine
Georgetown University/Washington Hospital Center, Washington, DC

Curriculum Director
Department of Emergency Medicine
Wilford Hall Medical Center, Lackland AFB, TX

Education (include internships and residency information)

Emergency Medicine Residency
University of North Carolina
Chapel Hill, NC (2007)

Loyola Stritch School of Medicine
Maywood, IL
Degree: Doctor of Medicine (2004)

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

ABEM – 1992-2022

Professional Societies

ACEP
Government Services ACEP
Texas ACEP
Council of Residency Directors (CORD)
Texas Medical Association (TMA)
EMRA Alumni

National ACEP Activities – List your most significant accomplishments

American College of Emergency Physicians, Board of Directors (2016-present)
Board Liaison to Membership & Chapter Relations Committee (2018-present)
Board Liaison to Rural EM, Tactical EM, Freestanding, Dual Certification, and Locum Tenens Sections (2018-present), Board Liaison to Academic Affairs and Residency Visit Program (2016-2018)

ACEP Academic Affairs Committee
Committee Chair (2013-2015)
Sub-committee chair (2005-2016)

ACEP Medical Legal Committee
2011-2014

Annals of Emergency Medicine Editor in Chief Task Force 2014, 2018

ACEP Young Physicians Section
Chair 2008-2010
Member 2007-present

Technical Advisory Group (TAG) Workforce Task Force
2006-2009

ACEP Chapter Activities – List your most significant accomplishments

Government Services State Chapter of American College of Emergency Physicians
President 2015-2016

President Elect 2014-2015
Board of Directors 2011-present
Membership Chair 2011-2013
Councilor 2011-201621

Texas ACEP Chapter
Texas Leadership and Advocacy Fellow (TLAF)
Residency Visit Committee

Practice Profile

Total hours devoted to emergency medicine practice per year: **2100** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **10** % Teaching **10** % Administration **30** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I work clinically at a military academic training site that is a Level 1 Trauma Center and an emergency medicine residency training program. I am employed through the Department of Defense and teach at Brooke Army Medical Center, the Uniformed Services University of the Health Sciences, and the University of Texas Health in San Antonio, TX.

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 **X** **Cases 3** **Plaintiff Expert** **Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Gillian R. Schmitz, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Department of Defense/ Uniformed Services University of the Health Sciences

Address: 4301 Jones Bridge Rd, Bethesda, MD 20814

Position Held: Associate Professor, Department of Military and Emergency Medicine

Type of Organization: Government/ Academic Training Center

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: American College of Emergency Physicians Board of Directors

Address: 4950 W. Royal Lane, Irving, TX 75063-2524

Type of Organization: National Membership Organization

Duration on the Board: 3 years

Organization: Government Services ACEP

Address: PO Box 19233, Portland, OR 97280

Type of Organization: Chapter Board of Directors

Duration on the Board: 6 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Gillian R. Schmitz Date 5/27/19

GSACEP

Government Services Chapter of ACEP
PO Box 19233 // Portland, Oregon 97280
www.GSACEP.org

2 August 2019

RE: Endorsement for Gillian Schmitz, MD, FACEP for the ACEP Board of Directors

On behalf of the Government Services Chapter of ACEP, It is my great honor and pleasure to forward this letter of endorsement for Gillian Schmitz, MD, FACEP as candidate for the ACEP Board of Directors. I have known Gillian professionally and personally for over 12 years. Her dedication, drive and commitment to furthering the field of Emergency Medicine is staggering and a role model for all of us. Throughout her career, she has distinguished herself in every facet of Emergency Medicine to include clinical practice, academic contributions as well as hospital leadership.

Gillian is a true visionary leader who embodies the principles of service and selflessness. Within our chapter she has served as Past President, Membership Committee Chair, and Scholarship and Awards Committee Chair. Under her leadership she helped guide our chapter to the next level advocating for military and government Emergency Physicians at every turn.

Gillian is a recognized national leader of our specialty who has held numerous leadership positions throughout her career. She is a current Member of the ACEP Board of Directors under which role she has worked tirelessly for the advancement of our specialty. She is a former Chair of the Academic Affairs Committee, subcommittee Chair for the Medical Legal Committee, Chair for the Young Physicians Section, and former Board member for the Emergency Medicine Resident's Association (EMRA).

Gillian's contributions to academic Emergency Medicine embody her commitment to helping develop the next generation of physicians within our specialty. She currently holds the academic rank of Associate Professor, Department of Military and Emergency Medicine, Uniformed Services University of the Health Sciences helping to mold our future military Emergency Physicians. In addition, she also serves as the Vice Chair of Education, Brooke Army Medical Center. She is a former EMF grant recipient, published author, and reviewer for several medical journals. Gillian has also served as a national speaker for ACEP, EMRA, CORD and SAEM.

Gillian's track record and commitment to our specialty highlights why it is imperative that we re-elect her to ACEP Board of Directors. Going forward our specialty will continue to face new challenges and obstacles. Gillian's leadership within the ACEP Board of Directors will ensure success for our college and our specialty.

In closing, the Government Services Chapter of ACEP fully endorses and strongly encourages the ACEP Council to re-elect Gillian Schmitz, MD, FACEP to the ACEP Board of Directors.

Respectfully Submitted,

Julio Lairet, DO, FACEP
President GSACEP

Julio Lairet, DO, FACEP – Chapter President
Andrea Austin, MD, FACEP – President Elect
Melissa Givens, MD FACEP – Past President
David S. McClellan MD, FACEP – Treasurer
Liz Mesberg, Executive Director

GILLIAN SCHMITZ, MD, FACEP

Incumbent Candidate for the
ACEP Board of Directors

Endorsed by the
Government Services Chapter

National Leadership

- ACEP Board of Directors
- Chair, ACEP Academic Affairs Committee
- ACEP Medical Legal Committee
- Annals of Emergency Medicine Editor in Chief Task Force
- ACEP Technical Advisory Group (TAG) Workforce Study
- Chair, ACEP Young Physician Section
- EMRA Board of Directors
- National Speaker for ACEP, CORD, SAEM, and EMRA
- ABEM EM Model Workgroup
- Chair, Joint Milestone Task Force Chair (CORD)

Clinical

- Experience in Military, Academic, Community, and Rural Emergency Departments

Academic and Hospital Leadership

- GME and UME Director
- Associate Medical Director
- EMF Grant Recipient
- National Early Career Award
- National Mentorship Award
- Committee Chair of Faculty Development and Career Advancement of Women and Minorities

Chapter Activity

- Government Services Chapter
  Past President, Membership Chair, Scholarship and Awards Chair
- Texas Chapter
  TX Leadership & Advocacy Fellow
  Membership and Education Committee

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Ryan A. Stanton MD, FACEP

***Question #1:* Should the evaluation of a potential Board candidate include their suitability to serve as a future ACEP president?**

I believe that it is a consideration, but we need men and women of various talents serving on the ACEP Board. Diversity of backgrounds, thoughts, and skills should be the goal of a strong Board of Directors. This diversity is key for the debate of ideas and course of ACEP. However, not all of these attributes are those that will produce a successful president. We need to keep potential future office in mind and ensure we have members involved that would excel at the role, but this by no means is the primary or most important role of the ACEP Board. Witl all of that said, I believe one of the charges of the Board and those that guide the election slate should consider all aspects of the presidential candidate, understanding the position and how each candidate will reflect on the college and what ACEP represents.

***Question #2:* Given the diverse viewpoints of ACEP members, how will you ensure that all voices within emergency medicine can be represented?**

Some of the greatest strengths and challenges facing ACEP revolve around the wide breadth of thoughts, beliefs, and ideas of our members. It is integral that we do everything in our power to support the independent voices of our members and use that to guide the decisions of the college based on the overall best course for our physicians and our patients. I grew up in a family in which I was always taught to respect opinions, to keep an open mind, to listen, and be willing to challenge my own thoughts and beliefs based on input from others. Every person has the potential to add value through experience and perspective. We must produce an environment where those thoughts and input are valued and heard. Unfortunately, the current environment of discussion and social media in this country make respectful discourse and discussion challenging and often hostile. My background in communications allows me to promote an environment that makes everyone comfortable to express their opinions and thoughts. That being said, it is also very important for those in leadership positions to address and prevent others from demeaning or attempting to quiet any voice without adequate opportunity and time to voice their opinions. ACEP has traditionally done a very good job at allowing anyone to speak at settings such as the Council. Microphones where anyone and everyone in emergency medicine can step up, from the staff and stakeholders, to physicians of all ages and backgrounds. Some of the opinions can be frustrating and occasionally off topic, but it is important enough to be said and thus the platform to be heard and considered.

I was surprised at my first ACEP council many years ago to find that the representatives of emergency medicine from across the country were split almost 50/50 with regard to political beliefs and leanings. I always assumed that most other physicians "thought like me". This realization allowed me to understand one level of diversity that allows emergency medicine to be so good at treating an incredibly diverse population. This is key to properly addressing challenges throughout our practices and to promote healthy debate. Sometimes, what we need to hear is not necessarily what we want to hear. We will never be challenged and advance by ALL thinking and saying the same thing.

***Question #3:* What do you believe is the single most divisive issue in ACEP at this time and how would you address it?**

Wow, to pick one single issue is a challenge in itself. We have so many challenges with varying degrees of divisiveness, angst, and potential among our members and leadership. Several recurring themes include diversity, guns, politics, wellness and of course, the annual discussions on marijuana. Thankfully, I believe the majority of our members and leadership are working diligently to address many of these issues and find common ground to move forward. Bold discussions and growing diversity within our college are a couple of our greatest strengths and working to address many of these challenging topics within emergency medicine. However, I believe the most widespread area of divisiveness across the country specifically related to ACEP and our members is the future direction of healthcare with regard to politics, structure, and our role in that future. The political environment within the United States is a potential powder keg at every turn and conversation. With the history of emergency medicine and evolution over the last number of years, we are now at a tipping point where change MUST happen. We are clearly

in a place in the US healthcare system where change will be required to address cost, regulation, and payment. Unfortunately, there are pretty defined lines within the political world based on right and left with special interests at every turn. One of the greatest gifts of ACEP is the diversity of beliefs, but this also means that the debate on direction of the healthcare system can be a very contentious topic.

Over the last 8+ years that I have attended LAC, I have gotten to see the differences in beliefs and ideas, but also how we can come together in emergency medicine to fight for common goals. Also, on these visits to Washington DC, we see the wide spectrum of politics in leadership positions and the challenges we face moving forward. Emergency medicine is the hub of the entire healthcare system, and thus, we are a focus of many discussions and often the direction of many criticisms from inside and outside healthcare. ACEP must come together to fight for our profession and our patients. This can be challenging when we have so many ideas on what that direction should be.

Talking with members and leaders, we discuss the free market, competition, private insurance, public interests, and various levels of "single payer" medicine. Many have very strong opinions on some or all of these options. So, how do we move forward and where should we advocate as the premier organization of emergency medicine? The key is that we come together and build on our diversity to best advocate and legislate for our patients, emergency medicine, and emergency physicians. This is not to say that other areas are not important, but we see over 145 million patients every year in thousands of hospitals by tens of thousands of emergency physicians. We are the home of acute care medicine in the United States and must protect that access to care and our ability to provide that care. There are countless individual considerations within this topic, from EM staffing and groups, to payment and tort reform. Working together, we may not be able to achieve perfection, but may be able to design and promote a system that positions emergency medicine for the future of US healthcare.

I don't completely know what the best system looks like, and that's why I turn to the broad knowledge, experience, and diversity of ACEP to come together and help drive the future of healthcare in this country. We may not all agree and may occasionally disagree strongly, but by having an open mind, bold discussions, continuing to focus on our patients and profession, I think we can find common ground with adequate consensus to move forward. We have the best leaders in medicine within our ranks. We must use these talents to help guide our future, educate our colleagues/patients, and advocate for the future of emergency medicine. I fully believe that emergency medicine is at the point that we need to take our position as the key player in this healthcare system and our physicians as the leaders within US healthcare and beyond. I am proud of who we are in ACEP and look forward to where we can go. I hope that you will join me, investing in our differences and diversity, coming together to have the tough discussions and debates promoting a great future for our patients and physicians.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Ryan A. Stanton, MD, FACEP

Contact Information

106 Stonewall Dr.
Nicholasville KY 40356
Phone: 859-948-2560
E-Mail: ryanastanton@gmail.com

Current and Past Professional Position(s)

Central Emergency Physicians- 2013-Current
MESA Medical Group/TeamHealth- 2008-2014
University of Kentucky Emergency Medicine- 2008-2013
Lexington Fayette Urban County Government- EMS Medical Director- 20013-Current
Bluegrass Airport- Public Safety Medical Director- 2019-Current
AirMed International- Kentucky and Florida Medical Director- 2014-Current
AMR/NASCAR Safety Team- 2017-Current
WKYT TV-27- 2018-Current
WTVQ TV-36- 2008-20018

Education (include internships and residency information)

Internship- James H Quillen College of Medicine- Surgery- 2003-2004
Residency- University of Kentucky- Emergency Medicine- 2005-2008

MD- James H. Quillen College of Medicine- 2003

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

ABEM- EM- 2009-Current
ABEM- EMS Board Eligible- 2019

Professional Societies

ACEP, AAEM, KACEP, AMA

National ACEP Activities – List your most significant accomplishments

Public Relations Committee
Public Relations Committee
ACEP Frontline Podcast- Creator and Host
EDPMA/ACEP- Public Relations Chair
Spokesperson of the Year
9-1-1 Advocacy Member of the Year

ACEP Chapter Activities – List your most significant accomplishments

KACEP President

KACEP President-Elect
KACEP Education Chairman
KACEP Public Relations Chairman- 2008-Current
Started the KACEP annual education conference.

Practice Profile

Total hours devoted to emergency medicine practice per year: **1600** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **80** % Research **0** % Teaching **15** % Administration **5** %

Other: **Does not include media and podcast production.** ____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Private single hospital democratic physician owned group- community hospital

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 5 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE 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 Emergency Medicine Group

Employer: Lexington Fayette Urban County Government

Address: 219 E 3rd St.

Lexington KY 40508

Position Held: Medical Director

Type of Organization: Fire Department- EMS

(If additional space is needed, attach an additional sheet – see page 3.)

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: KACEP- President, BODs, and several committee positions

Address: PO Box 2831

Louisville KY 40201

Type of Organization: State ACEP Chapter

Duration on the Board: 2008-Current

Organization: Emergency Medical Advisory Board- LFUCG

Address: 200 E. Main St

Lexington KY 40504

Type of Organization: Urban-County Government

Duration on the Board: 2008-Current

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:

Clinical medical advisor for Teleflex performing education at labs around the country.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Ryan A. Stanton MD. FACEP 6/27/19

Continued from page 1 – current employer.

Employer: American Medical Response/NASCAR

Address:

Arlington, TX

Position Held: Safety Team Track-on-Track Physician

Type of Organization: Event Medicine – EMS

Employer: AirMed International

Address:

Birmingham, AL

Position Held: Kentucky and Florida Medical Director

Type of Organization: Air medical transport

Employer: Lexington Bluegrass Airport – KLEX

Address: 4000 Terminal Drive

Lexington, KY 40510

Position Held: Public Safety Medical Director

Type of Organization: Regional Airport

Employer: Teleflex

Address:

Wayne, PA

Position Held: Clinical Medical Advisor

Type of Organization: Medical Devices

KENTUCKY CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Dear ACEP Councillors:

The Kentucky Chapter of ACEP proudly and enthusiastically endorses Dr. Ryan A. Stanton as a candidate for the American College of Emergency Physician Board of Directors. Ryan Stanton has been a true leader over the past ten years. He has shown exemplary state and national involvement in ACEP. Ryan has held many state leadership roles; Counselor, Public Relations Committee Chair, Vice President as well as President of KY ACEP. He remains an integral member of the state Board of Directors.

Ryan has a unique blend of qualities that allow him to thrive in a multitude of settings. His background in television and radio make him very comfortable in front of crowds and the camera. He has natural leadership ability and is very charismatic. He is medical director or has a leadership role with; 1) Lexington Fire and EMS, 2) AirMed International, and 3) Kentucky Motor Speedway EMS.

He works a full schedule in the emergency department and yet he always finds time to travel to the state capital to engage the legislators, often at the "drop of a hat". Many times I've been called with an "emergency" legislative committee meeting and I know I can always count on Ryan finding a way to be there to testify on behalf of emergency physicians throughout the state. He is essential in the success of our chapter. He will push up his sleeves and do whatever is needed for meetings, CME, Hill visits, financial support, and really anything else the chapter needs.

Dr. Stanton is active at the national level including serving as chair of the ACEP PR committee from 2014 through 2016. Ryan's curriculum vita illustrates his numerous achievements during his career. He has touched many lives through his medical work, Fire/EMS leadership as well as media. I strongly recommend his nomination!

Sincerely,

Timothy G. Price, MD, FACEP
President, Kentucky Chapter of
American College of Emergency Physicians

Ryan A. Stanton MD, FACEP

ACEP Council,

First and foremost, thank you for everything that you do for our college and specialty. I also want to thank you for the opportunity and consideration of the ACEP Board-of-Directors. I am a full time emergency physician for an independent single hospital democratic group in Lexington KY. Over the years, I have worked in academia, a small CMG, large CMG, and now independent group. I have spent the last 10+ years working with ACEP public relations as a member, chair, and spokesperson to tell the stories of EM and all of the great work our physicians perform every day for the benefit of our patients. That has developed into the ACEP Frontline and Everyday Medicine podcasts to help educate physicians and others in EM on the changes and evolution of our practice. As someone who grew up in media, transitioned to medicine, and now combining the two, I cherish the ability to communicate and advance the cause of EM.

We are currently facing one of the greatest assaults and challenges to the practice of emergency medicine. The battle over Out-of-Network/Surprise Billing legislation that is being driven through a well-funded and organized campaign from the insurance industry and others. There is potential for catastrophic impact to our specialty and to the safety net that emergency medicine provides. I have spent countless hours working through the OOB task force as well as advocacy locally and in Washington DC. Through various channels, we have emboldened emergency physicians and others to fight like never before. Election to the Board-of-Directors would allow me to escalate the fight and efforts that I have been building over the past couple of years as well as others to come in the future.

As a board member, my goals are to utilize my talents in communication, education, advocacy, and experience to help guide emergency medicine and ACEP into the future where EM is the hub of the healthcare community, positioned as a leader in acute care medicine but also in helping patients navigate the system to get the right care, when and where they need it. I also feel that ACEP must advocate for the individual physician to promote the rights, freedoms, and protections of EVERY emergency physician, no matter the setting they choose to practice. Over the years, we have seen hospitals, insurers, and some groups devalue the individual physician and we MUST re-establish our position among our departments, groups, hospitals, and systems. We must foster physician ownership, leadership, and development. Emergency medicine is the ideal specialty to lead the house of medicine and is perfectly positioned as the primary advocates of the lay public and our patients. My goal is to push that role and further grow our specialty as leaders throughout medicine and beyond.

We have faced a number of challenges over the years and the EM landscape has been shifting. Our priorities must focus on the patients, access to care, and the highest trained specialists in EM to provide the care necessary. We must ensure that the medical team is well defined under active physician oversight and leadership. With the board and our leadership, we will continue to advocate and fight for emergency physicians, emergency medicine, the patients that seek our care, and the overall public good through our experience, education, research, safety, and prevention.

Thank You,

Ryan A. Stanton MD, FACEP

RYAN A. STANTON, MD, FACEP

ACEP Leadership

- Councillor for 10 years
- ACEP Public Relations Committee
- National Spokesman, ACEP
- Past President, Kentucky Chapter of ACEP
- Chair, Public Relations Committee, Kentucky Chapter of ACEP

ACEP Board of Directors Candidate

Experience/Leadership

- Emergency physician with community and academic experience
- Medical Director, Lexington KY Fire/EMS
- Medical Director, Airmed International
- AMR/NASCAR Safety Team
- Founder/CEO, Everyday Medicine LLC

My goals are to utilize my talents in communication, education, advocacy, and experience to help guide emergency medicine and ACEP into the future where EM is the hub of the healthcare community, positioned as a leader in acute care medicine but also in helping patients navigate the system to get the right care, when and where they need it.

Advocacy → Leadership → Service

Dear Fellow Councillors and ACEP Colleagues;

Thank you for all of your service to ACEP, the Council and to the practice of emergency medicine. It is both my privilege and honor to work with you. I respectfully request your vote for the ACEP Board of Directors.

I currently work for an independent single hospital democratic group in Lexington KY. Over the years, I have worked in academia, a small CMG, large CMG, and now independent group. I have spent the last 10+ years working with ACEP public relations as a member, chair, and spokesperson to tell the stories of EM and all of the great work our physicians perform every day for the benefit of our patients. That has developed into the ACEP Frontline and Everyday Medicine podcasts to help educate physicians and others in EM on the changes and evolution of our practice. As someone who grew up in media, transitioned to medicine, and now combining the two, I cherish the ability to communicate and advance the cause of EM.

As a board member, my goals are to utilize my talents in communication, education, advocacy, and experience to help guide emergency medicine and ACEP into the future where EM is the hub of the healthcare community, positioned as a leader in acute care medicine but also in helping patients navigate the system to get the right care, when and where they need it. I also feel that ACEP must advocate for the individual physician to promote the rights, freedoms, and protections of EVERY emergency physician, no matter the setting they choose to practice. Over the years, we have seen hospitals, insurers, and some groups devalue the individual physician and we MUST re-establish our position among our departments, groups, hospitals, and systems. We must foster physician ownership, leadership, and development. Emergency medicine is the ideal specialty to lead the house of medicine and is perfectly positioned as the primary advocates of the lay public and our patients. My goal is to push that role and further grow our specialty as leaders throughout medicine and beyond.

We have faced a number of challenges over the years and the EM landscape has been shifting. Our priorities must focus on the patients, access to care, and the highest trained specialists in EM to provide the care necessary. We must ensure that the medical team is well defined under active physician oversight and leadership. With the board and our leadership, we will continue to advocate and fight for emergency physicians, emergency medicine, the patients that seek our care, and the overall public good through our experience, education, research, safety, and prevention.

RAS Goals for Board Service

1) **Communication talents for advocacy, messaging, and education.**
2) **Advocate for the emergency physician- rights, protections, safety, and environment**
3) **Advocate for the future legislation that will impact our practice and patients**
4) **Continue to advance diversity, inclusion, and equality throughout EM and medicine in general.**
5) **Advance the role of EM as the hub of the healthcare system, maximizing our skills to evaluate, stabilize, manage, and disposition or patients to the best possible settings.**
6) **Continue the growth of EM innovation, research and development.**
7) **Foster the future leaders of our specialty.**

Ryan A. Stanton, MD, FACEP, FAAEM
Candidate for the ACEP Board of Directory
Past President, Kentucky Chapter of ACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Thomas J. Sugarman, MD, FACEP

***Question #1:* Should the evaluation of a potential Board candidate include their suitability to serve as a future ACEP president?**

Since the job descriptions and responsibilities are different, suitability as a future president is not necessary for Board members. The bylaws make the Board responsible for "the management and control of the College." To best accomplish this mission, the Board members should be diverse in terms of backgrounds, types of practice, expertise and skill sets. All board members must be informed on the College's issues and able to articulate them. As Councilors consider whom to elect, they should strive for a well-rounded Board that represents the entire College and that can effectively manage the organization.

The President is the leader of the College and speaks on behalf of the College. During their term on the Board, members grow, gaining experience and knowledge to prepare them for a possible presidency. Due to the structure of the Board and the presidential election cycle, generally only half of the ACEP members elected to the Board of Directors eventually become President. Not all Board members run for president and of those that run, not all are elected. Many past Board members contributed greatly to the College without becoming President. Councilors should elect a president who has been an effective Board member, can lead the College, and be ACEP's public face.

***Question #2:* Given the diverse viewpoints of ACEP members, how will you ensure that all voices within emergency medicine can be represented?**

As a Board of Directors member, I promise:

- To seek out, listen to, and consider diverse viewpoints
- To be available to all members
- To focus ACEP's efforts on issues both directly relevant to emergency medicine and of common interest to our members
- To improve ACEP's communication to members, particularly the reasoning behind Board decisions

I endorse ACEP's mission statement: "The American College of Emergency Physicians promotes the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public." ACEP represents members, both regular members and candidate members—emergency physicians with board certification/eligibility or on a path (residency or medical student) towards certification.

The house of emergency medicine has many voices. ACEP should be aware of and consider multiple perspectives regarding emergency care. To effectively meet ACEP's mission, all members views must be represented. However, we all win by focusing on our patients. By putting the patient first, ACEP "wears the white hat." Our patients' needs are paramount; they are what binds us together as Emergency Physicians.

Question #3: **What do you believe is the single most divisive issue in ACEP at this time and how would you address it?**

ISSUE:

ACEP's most divisive issue is that many members and potential members perceive that partisan interests drive ACEP's agenda. Interestingly, many of the partisanship concerns are contradictory with some believing ACEP is biased in one direction and some seeing prejudice on the other side. Distress over partisanship manifests as a sense of anger or apathy—"it does not matter, it's out of my control." This limits both member engagement and ACEP membership.

Emergency physicians often have different viewpoints based on practice setting—rural vs. urban, tertiary hospital vs. referral hospital, big group vs. small group, doctor owned v. non doctor owned group, or academic vs. nonacademic. Like all specialists, emergency physicians' divergent views reflect the highly partisan national political environment that engenders political gridlock. I observe some physicians not supporting or joining ACEP because they disagree with ACEP's position/lack of a position on a particular issue or politician. But ACEP cannot be a single-topic organization because all of our members have different single issues.

SOLUTIONS:

ACEP must evaluate issues and our agenda using 2 principles. First, is it of primary importance to emergency physicians' practices? Second, is the topic particular to providing emergency care, rather than an interest of just some emergency physicians? If other organizations can address a problem, then ACEP should tread carefully. Since everybody is potentially an emergency patient, all issues are significant to some emergency physicians. But, by focusing on concerns meeting the criteria of both directly relevant to emergency physicians and limited to emergency medicine, ACEP can be more effective. We cannot allow ACEP's efforts to be undermined by partisanship nor distracted by issues not unique to emergency medicine.

Transparent decision making is paramount. Over the last few years ACEP markedly improved its communication and messaging to members. ACEP redesigned its website, distributes multiple newsletters, and maintains a strong social media presence. ACEP does a great job reporting its activities and positions. Going forward we should better explain the process, criteria, and reasoning behind our decisions. This will dispel the notion that ACEP makes partisan decisions. ACEP's goals are to ensure emergency physician practices remain economically viable and fulfilling, allowing us to provide our patients quality emergency care.

As a member of your Board of Directors, I pledge to improve transparency, so all members feel they have influence and access to the reasoning behind ACEP's decisions. I will work for ACEP to target matters of common interest to all board-certified emergency physicians. This will improve our cohesiveness and increase membership making ACEP more effective at representing emergency physicians' issues.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Thomas J. Sugarman, MD, FACEP

Contact Information

1569 Solano Avenue, #463, Berkeley, CA 94707
Phone: 510-219-7261
E-Mail: tjsugarman@gmail.com

Current and Past Professional Position(s)

Current:

Emergency Physician (2001) and Chair of Emergency Services (2013), Sutter Delta Medical Center (FT)

Senior Director Government Affairs, Vituity (formerly CEP America) (2016) (PT)

Urgent Care Physician, East Bay Physicians Medical Group (2014) (PT)

Past:

Emergency Physician, Alameda Hospital (2003-2015) (PT)

Fire Brigade Emergency Physician for Vituity, California and Illinois hospitals (FT)

Emergency Physician, Illinois, Kentucky and California hospitals for Team Health (and precursors) (1992-3 and 1995-2001) (FT and PT)

Emergency Physician St Mary Medical Center and San Pedro Peninsula Hospital (1993-1994) (FT)

Clinical Faculty, Harbor UCLA Department of Emergency Medicine (1993-5) (PT)

Education (include internships and residency information)

Harbor UCLA Emergency Medicine Residency and Internship, 1989-1992

MD with Honors, University of Illinois at Chicago, 1989

Certifications

ABEM certified 1994, recertified 2004 and 2014

Professional Societies

ACEP

California ACEP

AAEM

CalAAEM

AMA

CMA (California Medical Association)—member Council on Legislation, 2010-current

ACCMA (Alameda Contra Costa Medical Association)—President, Nov 2017-Nov 2018, BOT, 2014-current.

National ACEP Activities – List your most significant accomplishments

ACEP Councillor, 2007-current, Alternate, 2006

Emergency Practice Committee, 2010-current

State Legislative/Regulatory Committee, 2016-current

ACEP Sedation Task Force, 2013-2016

Mobile Integrated Healthcare/Paramedicine Task Force, 2016-2017

Contract Transitions Task Force, 2017

Joint ACEP/EDPMA Task Force on Reimbursement, 2017-current

NEMPAC BOD member, 2017-current

Emergency Medicine Action Fund BOD, 2018-current

Emergency PA/NP Utilization Task Force, 2018-current.

Invited speaker at ACEP Leadership and Advocacy Conference: "Taking the Lead: Essential Skills to Becoming a Highly Effective Chapter Leader," 2014

ACEP Chapter Activities – List your most significant accomplishments

California ACEP:

President, 2013-2014, BOD, 2006-2015

Chair Government Affairs Committee, 2013

Walter T. Edwards Meritorious Service Award, 2015

Chapter Service Award, 2012

Practice Profile

Total hours devoted to emergency medicine practice per year: **2400** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **0** % Teaching **0** % Administration **10** %

Other: **Advocacy** **40** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

My clinical practice is at suburban non-profit community hospital. Our ED sees 60,000 pt/year and the hospital has 145 beds. My group, Vituity, is a multi-state, multi specialty, but predominantly emergency medicine physician partnership. All physicians (working the required hours) become full partners with equal ownership after 4 years. We own our billing company and practice management company and we have no outside investors.

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 1 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Thomas J. Sugarman, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Vituity

Address: 2100 Powell, #900

Emeryville, CA 94608

Position Held: Emergency Physician and Senior Director of Government Affairs

Type of Organization: Physician partnership

Employer: East Bay Physicians Medical Group

Address: 3687 Mt Diablo Blvd.

Lafayette, CA 94549

Position Held: Urgent Care Physician

Type of Organization: Physician group contracting with Sutter East Bay Medical Foundation

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: California ACEP

Address: 1121 L Street, #407

Sacramento, CA 95814

Type of Organization: State Chapter of ACEP

Duration on the Board: 2006-2015

Organization: Alameda Contra Costa County Medical Association

Address: 6230 Claremont Avenue

Oakland, CA 94618

Type of Organization: County component society of California Medical Association

Duration on the Board: 2014-current

Organization: NEMPAC

Address: 2121 K Street, NW, Suite 325

Washington, DC 20037

Type of Organization: ACEP's Political Action Committee

Duration on the Board: 2017-current

Organization: Emergency Medicine Action Fund

Address: 2121 K Street, NW, Suite 325

Washington, DC 20037

Type of Organization: ACEP's Advocacy fund addressing emergency medicine issues

Duration on the Board: 2018-current

Organization: Physicians for Fair Coverage

Address: 8400 Westpark Drive, 2nd Floor

McLean, VA 22102

Type of Organization: Advocacy organization focusing on surprise insurance gaps/billing

Duration on the Board: Alternate BOD member 2018-2019, BOD member 2019-current

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:

I am a physician partner with < 1% equity interest with Vituity. I am the Senior Director of Government Affairs. Vituity has a quality clinical data registry and offers physician (and other providers) CME. Vituity owns a billing

company and a practice management company. Vituity physicians, including me, are members of The Mutual Risk Retention Group which provides professional liability insurance to both Vituity and non-Vituity physicians.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☐ NONE

☒ If YES, Please Describe:

I am a member of AAEM, California Medical Association and AMA. I am immediate past-President of Alameda Contra Costa Medical Association (term ends November 2019).

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Thomas J. Sugarman Date June 11, 2019

CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

1121 L Street, Ste 407
Sacramento, CA 95814

PH 916.325.5455
FX 916.325.5459
TF 800.735.2237
E-Mail info@californiaacep.org

www.californiaacep.org

August 15, 2018

Dear Colleagues:

The California Chapter is pleased to give its enthusiastic endorsement to Thomas J. Sugarman, MD, FACEP for ACEP Board of Directors and strongly urges your support of his candidacy.

Dr. Sugarman's career demonstrates his steadfast commitment to emergency medicine and his relentless pursuit to make a difference in the lives of his fellow pit doctors and the patients they care for.

Dr. Sugarman is a Past President of the Chapter and has served with incredible enthusiasm and dedication in a variety of leadership roles for more than a decade. At the Chapter, group, and national level, Dr. Sugarman has been involved in fair payment issues for many years. During and after his service on the Chapter's Board, he testified before legislators in support of fair payment for emergency physicians. His deep understanding of fair payment issues and extensive experience during multiple legislative attempts and legal battles to ban surprise billing will be a tremendous asset to the College at this time when we face serious threats. Dr. Sugarman is uniquely qualified to assist the College in the current climate.

Additionally, his numerous accomplishments, many years of service, and diversity of clinical experience ranging from Base Station EMS Medical Director, to International Medical Corps volunteer physician, to Sepsis Champion at his community ED, will bring a broad and knowledgeable perspective to the Board. He truly understands the challenges emergency physicians face in all practice settings and has dedicated his career to removing practice barriers.

Dr. Sugarman is a tireless and passionate advocate for emergency physicians, with several decades of commitment at every level of organized medicine. In addition to being a Past President of the Chapter, he is the Immediate Past President of his local medical society and is a delegate to the California Medical Association (CMA) House of Delegates. For nearly a decade he has served as a representative to the CMA's Council on Legislation, where he has ensured that the positions taken adequately represent the uniqueness of our specialty. He is also the Co-Chair of the East Bay Safe Prescribing Coalition and has testified before the California Medical Board on behalf of the Chapter, helping ensure safe prescribing efforts are tailored toward the unique needs of the ED.

Dr. Sugarman's advocacy leadership is always focused on improving the practice of emergency physicians. His work not only includes advocacy on fair payment, but regulatory efforts on procedural sedation and legislation relating to psychiatric holds. He also initiated and led efforts to create PECARN and safe prescribing tools for emergency physician use at the bedside. He also serves on ACEP's State Legislation and Regulatory Committee and is currently the Senior Director of Government Affairs for Vituity.

Dr. Sugarman's dedication to emergency medicine and unique skill set embodies precisely the kind of person we need leading and serving us on the ACEP Board of Directors. Our Chapter has been witness to his ability to inform and influence legislators, lobbyists, and regulators one day and turn around the following day to treat and care for patients. Dr. Sugarman has received numerous awards acknowledging his contributions to emergency medicine, including the Chapter's highest award, the Walter T. Edwards Meritorious Service Award, for a career's worth of exceptional contributions to the Chapter.

Dr. Sugarman is an unwavering advocate for emergency physicians. His expertise, experience, and desire to serve the College will prove invaluable to the Board of Directors. The California Chapter is extremely proud to endorse and respectfully request your support of Dr. Tom Sugarman for the Board of Directors.

Respectfully,

CHI PERLROTH, MD, FACEP
President

Thomas J. Sugarman, MD, FACEP

August 15, 2019

Fellow Councillors:

I am honored to be nominated for the ACEP Board, the preeminent organization representing emergency physicians. I love taking care of my patients and practicing emergency medicine. I devote about half my professional time to clinical care and the other half to advocating on behalf of emergency medicine. Right now, surprise billing legislation moving through both the Senate and the House presents an extreme threat to emergency medicine. If passed, emergency physicians will suffer dramatic pay cuts. Worsening staffing ratios will lead to longer emergency wait times, more limited on-call specialist availability, and less time per patient encounter.

Like you, I am honored to provide emergency care to all patients. Unfortunately, EMTALA is an unfunded mandate. Although emergency physicians comprise only 4% of physicians, we provide over 60% of uninsured care and over 50% of underfunded Medicaid care. The surprise billing solutions currently moving through Congress do not acknowledge the tremendous amount of charity care emergency physicians proudly deliver. Insurance companies focus on their profits by vilifying emergency physicians, while we focus on taking care of patients and providing the safety net.

The drive to lower health care costs on the backs of the only specialty providing exclusively EMTALA mandated care will continue. Surprise billing is not our only threat. For profit insurance companies are violating the prudent layperson standard. States and the federal government threaten to deny or reduce Medicaid payment in the emergency department.

Advocacy

At the 2018 Leadership and Advocacy Conference, Surgeon General Jerome Adams told us that "advocacy is looking beyond the problem in front of you...it's figuring out how to prevent the problem. It's more than clinical excellence." ACEP allows emergency physicians to harness the collective power of a united voice to benefit our patients.

Starting in 2006 when California ACEP Board sponsored a bill to solve the balance billing problem using a fair payment standard and arbitration, I developed expertise in advocating for fair reimbursement. I worked with ACEP, EDPMA and PFC in developing model legislation. My experience advocating in California on balance billing, with the State Legislative/Regulatory Committee, and working with partner organizations is needed on the Board now.

Representation

As an organization representing member emergency physicians, ACEP must ensure its programs and policies serve members in multiple settings (rural, suburban, urban, academic, non-academic) and group structures (partners, employed, independent contracting). We must continue to wear the white hat, always striving to improve the emergency care system for our patients. As your Board member, I will always put the emergency physician's interests first when considering policy.

Councillors:

My ACEP service on committees and task forces, presidency of California ACEP and the Alameda Contra Costa Medical Association demonstrate my long-term passion and ability to collaborate, innovate and co-develop practical solutions to real-world problems. **As a board member, my main goal for ACEP will be to protect and empower emergency physicians so they can focus on providing patient care and maintain economically viable practices.**

I humbly ask for your vote to represent current and future ACEP members.

Sincerely,

Thomas J. Sugarman, MD, FACEP
Thomas.Sugarman@Vituity.com
510-219-7261

collaborate, innovate and co-develop practical solutions to real-world problems. **As a board member, my main goal for ACEP will be to protect and empower emergency physicians so they can focus on providing patient care and maintain economically viable practices.**

I humbly ask for your vote to represent current and future ACEP members.

Sincerely,

Thomas J. Sugarman, MD, FACEP
Thomas.Sugarman@Vituity.com
510-219-7261

- Ensure sustainable and fulfilling EM practices
- Advocacy, reimbursement, and surprise billing expertise
- Active Clinician

Thomas J. Sugarman, MD, FACEP
for
ACEP Board of Directors

I am the candidate ACEP needs now on the BOD because I am a clinician with an in depth understanding of the impact of healthcare policy on our practices, particularly the surprise billing issue. I have frontline experience protecting patient and physician interests. I always keep in mind that Emergency Medicine's value is created by the individual physician providing bedside care. I humbly ask for your vote to represent current and future ACEP members.

- Actively practicing in California, past practices in Illinois and Kentucky
- Experiences range from tertiary care to rural hospitals, academic and non academic
- Worked as a partner, independent contractor and employee in various group structures
- Currently a partner in Vituity (formerly CEP America), a democratic, 100% physician owned partnership
- Senior Director of Government Affairs, Vituity (formerly CEP America)
- Chairman of Emergency Services at Sutter Delta Medical Center

Selected Experience and Service

ACEP

- Emergency Medicine Action Fund BOD, 2018-current
- NEMPAC BOD, 2017-current
- Joint ACEP/EDPMA Task Force on Reimbursement, 2017-current
- Writing Committee: Regulatory Challenges to Procedural Sedation, 2019-current
- Emergency PA/NP Utilization Task Force, 2018-current
- Emergency Practice Committee, 2010-current, Contractual Relationships Subcommittee Chair
- State Legislative/Regulatory Committee, 2016-current, Advocacy Objective Subcommittee Chair
- ACEP Sedation Task Force, 2013-2016
- Mobile Integrated Healthcare/Paramedicine Task Force, 2016-2017
- Contract Transitions Task Force, 2017
- Councillor, 2007-current; Alternate, 2006
- Invited speaker, ACEP 2014 Leadership and Advocacy Conference: "Taking the Lead: Essential Skills to Becoming a Highly Effective Chapter Leader"

California ACEP

- Lobbied successfully for expansion of 'temporary mental health hold" in CA resulting in less EP frustration and decreased mental health boarding
- **President California ACEP (2013-2014)—** during presidency, led California ACEP's development of implementation toolkits for Safe Prescribing and for PECARN CT guidelines for minor pediatric head injuries, during time on BOD actively involved in surprise billing issues, legislation and regulation
- **Awarded Walter T. Edwards Meritorious Service Award, 2015**

Physicians for Fair Coverage

- BOD member, 2019-current; alternate 2018-2019

California Medical Association

- Council on Legislation and House of Delegates—active member
- **Collaborated with multiple specialties to modernize CMA policy to support a fair payment standard and dispute resolution with arbitration for out of network services**

Alameda Contra Costa County Medical Association

- **President, 2017-2018**
- Co-chair East Bay Safe Prescribing Coalition—physician, hospital, pharmacist, community and government coalition –achieved 50% decrease in Alameda County opioid related mortality.

My vision is that collaboration, innovation and redesign—facilitated and supported by ACEP—will make our system of care healthier for everyone. As a clinician, I understand the pressures on the practicing emergency physician. **As a board member, my main goal will be for ACEP to protect and enable emergency physicians so they can focus on providing patient care and maintain economically viable practices.**

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Board of Directors Candidates

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 Board of Directors Candidates

L. Anthony Cirillo, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Kathleen J. Clem, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Francis L. Counselman, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

John T. Finnell, MD, FACEP, FACMI

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Jeffrey M. Goodloe, MD, FACEP

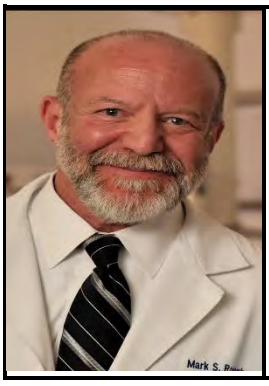
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Christopher S. Kang, MD, FACEP, FAWM

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Michael J. McCrea, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer



Mark S. Rosenberg, DO, MBA, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Thomas J. Sugarman, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

L. Anthony Cirillo, MD, FACEP

***Question #1:* Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

The simple answer to this question is "everywhere"! With advances in technology and the ability to provide and direct patient care remotely, emergency medicine will be practiced wherever there are patients who have acute illness or injury. As a specialty, emergency medicine is uniquely positioned to expand our day-to-day work from the physical confines of the emergency department to patients everywhere. Fundamentally, emergency medicine is *the* specialty equipped to rapidly assess a patient and to deploy the resources they need within the appropriate time frame. The practice of emergency medicine has evolved over the past 50 years to meet the needs of our patients and the healthcare system. We are the 24/7/365 healthcare safety net for the nation, filling the gap for the US healthcare system's inadequacies. While insurance companies and some policymakers characterize us as being "the expensive emergency department", patients and office-based providers choose us because they know that we are the experts in quickly and accurately evaluating acute illness and injury.

The opportunities to provide care remotely present both the greatest opportunity and the greatest challenge for the specialty of emergency medicine for the next 10 years. We must seize the opportunity to redefine paradigms of care based upon evolving technology that provides the ability to remotely "see" patients and to have access to data that previously accessible only when the patient "came" to the emergency department. However, because some patients won't physically come to the ED, we must reaffirm our standing within the house of medicine as the only specialists who are qualified to evaluate and treat patients presenting with acute illness and injury. Our training, through its rigorous and well-defined curriculum, enables us to expertly care for patients with undifferentiated illness and injury. This is emergency medicine's great differentiator - a truly unique fund of knowledge and the skill to make efficient and definitive management decisions abilities, inside or outside the physical confines of the emergency department.

As part of the evolution of the practice of emergency medicine, we will need to ensure that the laws, regulations, and policies that govern the care we provide adapt to the needs of our patients, and the practice of emergency medicine. Working in the advocacy arena over the past 25 years, I have had the opportunity to work at the federal, state, and local level to ensure that emergency physicians are recognized for the quality care we provide, and compensated appropriately for that care. As models of healthcare delivery evolve, ACEP will need to be vigilant and defend the specialty and practice of emergency medicine, regardless of where our patients are.

***Question #2:* Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

My active involvement and leadership within ACEP began twenty-five years ago with my role as an EMRA Board member serving as the representative to ACEP, and the ACEP Board of Directors. I am incredibly fortunate to have had the opportunity to work with many amazing people within ACEP. Through my work on various committees and task forces, I have listened to, and learned from, emergency physicians who truly represent the breadth and depth of our specialty. In my time serving on, and chairing, the Membership, State Legislative/Regulatory, and Federal Government Affairs Committees I learned of the unique challenges faced by the various emergency medicine practices as they provide care to our patients. Personally, I have practiced clinically and administratively in a variety of emergency medicine settings and groups. During my career, I have worked as an academic faculty member at a residency training site, in a single coverage tiny community hospital ED, and pretty much every size ED in between. This variety of experiences helps me to be able to better understand and appreciate the unique perspectives of the emergency physicians who care for patients on a daily basis. During my time in service of ACEP, especially in the advocacy arena, I strived to become a better listener in order to be able to better represent our specialty in discussions within the house of medicine and with healthcare policy makers.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**
Since its' creation 50 years ago, ACEP has been the organization that best represents the specialty of emergency medicine, and the physicians who are the experts in the specialty. In today's evolving U.S. healthcare system, there will be persistent and growing external pressures to provide emergency care that is high-quality and cost effective. It is emergency physicians who must remain the leaders and drivers of the practice and scope of emergency medicine. By virtue of our focused training and the unique body of knowledge that has defined emergency medicine as a specialty, emergency physicians are the true experts in the evaluation and management of acute illness and injury. As part of the evolution of healthcare delivery, there are other providers who today, together with the emergency physician, comprise the "emergency department team" caring for patients. Just as the emergency physician is the leader of the emergency department team, emergency physicians must remain the leaders of the specialty and practice of emergency medicine. As such, I believe that ACEP must remain the organization that represents emergency physicians, while also retaining its authoritative voice for the specialty and practice of emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

L. Anthony Cirillo, MD, FACEP

Contact Information

91 Woodridge Drive
Saunderstown, RI 02874
Phone: 401-465-0806 (cell) / 401-294-2415 (home)
E-Mail: acirillo@usacs.com

Current and Past Professional Position(s)

Director of Health Policy & Legislative Advocacy, US Acute Care Solutions
Medical Director, Pequot Emergency Department, Groton, CT
Site Quality Director, US Acute Care Solutions (multiple sites)
Physician-in-Chief, Department of Emergency Medicine, Memorial Hospital of RI
Chief, Center for Emergency Preparedness & Response, Department of Health, State of Rhode Island

Education (include internships and residency information)

George Washington University Hospital, Washington, DC
Preliminary Year, Internal Medicine (1990-91)

UMASS Medical Center, Worcester, MA
Residency in Emergency Medicine (1991-94) / Chief Resident 1993-94

University of Vermont College of Medicine (M.D.) May 1990

Certifications

ABEM (1995, 2005, 2015)

Professional Societies

ACEP – RI Chapter, AMA, RI Medical Society

National ACEP Activities – List your most significant accomplishments

Chair, Federal Government Affairs Committee
Chair, State Legislative & Regulatory Committee
Chair, Membership Committee
Member, NEMPAC Board of Trustees
Member, Alternative Payment Model (APM) Task Force, Workgroup Chair
Member, Single Payer Task Force
Member, ACEP*Now* Editorial Board
Member, Communications Plan Task Force
Member, Core Curriculum Task Force
Member, Section Grant Task Force
Member, Board Nominating Committee

Member, Council Steering Committee
Member, Council Tellers & Credentials Committee

ACEP Chapter Activities – List your most significant accomplishments

Chapter President, 1998-1999
Councilor/Alternate Councilor 1998-Present

Practice Profile

Total hours devoted to emergency medicine practice per year: **2400** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **0** % Teaching **0** % Administration **50** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

For the past 14 years I have been employed by Emergency Medicine Physicians (EMP) and its successor company US Acute Care Solutions (USACS), which is a national emergency medicine group that is primarily physician owned. I have practiced clinically every year and continue to provide direct patient care on average of 100 hours per month. During my time at EMP/USACS I have worked at a variety of clinical sites in many states, providing care in a variety of clinical settings. Since joining EMP/USACS I have served as the Director of Health Policy & Legislative Advocacy at a national level, coordinating our advocacy efforts and educating physicians on the importance of advocacy to improve our healthcare system. In addition to my clinical responsibilities, I have also served as both a Medical Director capacity for one of our freestanding hospital affiliated emergency departments and as a Site Quality Director overseeing quality improvement activities at three of our emergency department sites.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert **0** **Cases** **Plaintiff Expert** **8 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

L. Anthony Cirillo, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: US Acute Care Solutions, LLC

Address: 4535 Dressler Road, NW

Canton, OH 44718

Position Held: Director of Health Policy & Legislative Advocacy
Medical Director, Pequot Emergency Department

Type of Organization: Emergency Medicine / Hospitalist Multi-site Group

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: RI Chapter – American Heart Association

Address: 1 State Street, Suite 200

Providence, RI 02908

Type of Organization: Not-for-profit chapter of the American Heart Association

Duration on the Board: 1998-99

Organization: Safer Institute, LLC

Address: 31 Elbow Street

Providence, RI 02903

Type of Organization: For profit company providing digital personnel security and data services

Duration on the Board: October 2011 - Present

Organization: US Acute Care Solutions Political Action Committee (USACS PAC)

Address: 4535 Dressler Road, NW

Canton, OH 44718

Type of Organization: Company affiliated federally qualified political action committee

Duration on the Board: 2013 – Present (Chair of the Board)

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

√ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

√ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

√ NONE

☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

√ NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

√ NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

L. Anthony Cirillo, MD, FACEP Date July 12, 2018

American College of Emergency Physicians®

RHODE ISLAND CHAPTER

BOARD OF DIRECTORS
President
CATHERINE CUMMINGS, MD, FACEP
Vice President
JAMIESON COHN, MD, FACEP
Secretary-Treasurer
ALEXIS LAWRENCE, MD, FACEP
Immediate Past President
CHRISTOPHER P. ZABBO, DO, FACEP
Councilors
L. Anthony Cirillo, MD, FACEP
ACHYUT KAMAT, MD, FACEP
JESSICA SMITH, MD, FACEP

OFFICE
405 PROMENADE STREET, SUITE A
PROVIDENCE, RI 02908
TEL (401) 331-3207
FAX (401)751-8050
WWW.RIACEP.ORG
EMAIL MBIALEK@RIMED.ORG

Director
MARC BIALEK

John McManus, Jr., MD, MBA, FACEP
Speaker of the Council

Dear Dr. McManus,

On behalf of the Rhode Chapter of the American College of Emergency Physicians, it is my privilege and honor to provide this Letter of Endorsement in support of the candidacy of ***L. Anthony (Tony) Cirillo, MD, FACEP*** for the ACEP Board of Directors. Dr. Cirillo exemplifies the qualities and qualifications that ACEP desires for the Board of Directors. Dr. Cirillo has been a true leader and advocate in the state of Rhode Island and nationally, and is extremely motivated to serve our specialty.

I've known Dr. Cirillo a long time and first met him when he interviewed me for a job in 2001. Even then, he was advocating for my involvement in Emergency Medicine issues at the hospital, state, and national ACEP level. "You have got to get involved" and "You can make a difference" are what I remember from that interview. I'm sure others have similar stories as he continues to reach out and encourage "the next generation" to get involved.

As an example of the depth of Dr. Cirillo's contribution to Emergency Medicine on just one issue, take "Surprise" legislation. Several years ago, Dr. Cirillo identified this problem and has since been leading multi-year effort to pass reasonable legislation in Rhode Island, working with the Rhode Island Medical Society and in doing so, bringing other medical specialty societies to the battle. His experience and expertise have been leveraged to help other states directly, and indirectly by helping craft the ACEP position.

"Surprise" legislation is just one of Dr. Cirillo's interests. He has a breadth and depth of knowledge and experience in areas of particular relevance. Tony has been active in many other payment issues, such as MIPS, MACRA, alternative payment models, and single payer models. Tony also works on issues related to insurance practices like downcoding and denial of coverage. Importantly, he is also looking forward at cutting edge issues that are developing in providing emergency care outside of physical EDs – like telemedicine. His position is that even in these realms, Emergency Medicine must be steadfast that acute injuries and illness are the domain of our specialty.

In addition to the leadership in advocacy and mentoring described above, Dr. Cirillo has taken on other roles in Rhode Island including being a Past President of the Rhode Island Chapter of ACEP and a long time Chair of Rhode Island Medical Society's Political Action Committee.

Dr. Cirillo has been successful not only because of his knowledge but also because of his care toward personal relationships. Whether they be medical students or Senators, his genuine passion for getting the right thing done is obvious. This is clearly evident in his involvement at the ACEP Leadership and Advocacy conference where it's also apparent that he makes extra efforts to involve and help the "smaller" states who don't have the depth of resources, navigate the proceedings and understand the issues.

It is difficult to summarize such a long and varied career as Dr. Cirillo's in a page or two. Even though I've known Dr. Cirillo for a long time, I continue to discover and appreciate the multitude of contributions he has made to Emergency Medicine. He is clearly devoted to the betterment of Emergency Medicine as a specialty and is the type of colleague who ACEP will be proud to have leading us into the future.

Sincerely,

Catherine A. Cummings, MD, FACEP
President

cc: Mary Ellen Fletcher

L. Anthony Cirillo, MD, FACEP

Dear Fellow Councilors and ACEP Colleagues,

Thank you for your service to the Council, the College and the specialty of Emergency Medicine. It is my great honor and privilege to work with you on behalf of our patients, our physicians, and our specialty. At this time, I respectfully ask for your vote to represent you on the ACEP Board of Directors.

The healthcare landscape is evolving at an incredible pace. Changes in clinical medicine, technology, and the healthcare delivery system guarantee that the future practice of emergency medicine will be markedly different than it is today. While these changes present challenges to our specialty, they also present incredible opportunities for us to build a future of patient-focused, technology-enhanced, high-quality emergency care. Just as the founders of ACEP did 50 years ago, today's ACEP Board must be willing to envision and articulate the next generation of emergency medicine and be the leading advocates for the future of emergency healthcare.
As a member of the ACEP Board, I will emphasize my vision of a **MAP** for the future of emergency medicine. I believe we must work diligently on behalf of current and future emergency physicians on ***Mentorship, Advocacy, and Policies*** that will ensure a viable and rewarding practice of emergency medicine for generations to come.

- ***Mentorship for the Future***

As ACEP celebrates its 50th anniversary there is a powerful lesson to be remembered. Those of us who are practicing emergency medicine today have an obligation to the future generations of emergency physicians. We are, in essence, the founders of the next 50 years of this specialty. The relationship between ACEP and EMRA, a profoundly effective resident organization, is a strong and productive one. As delivery models for emergency medicine evolve, ACEP must work collaboratively with all emergency medicine organizations to ensure that the education and training of emergency physicians parallels our workforce needs and the needs of our patients.

- ***Advocacy for the Specialty***

In the rapidly evolving healthcare system environment, ACEP must remain the leading voice advocating for our patients, our physicians, and our practice. Emergency medicine truly is the safety net of the U.S. healthcare system and this pivotal role must be broadcast continually to policymakers and healthcare leaders. We care for patients who seek our services because they are injured, ill, or afraid, and we turn no one away. Emergency departments are the social safety net of our nation and it is we who provide care to patients when the rest of society and the healthcare system can't, or won't, help them. Emergency physicians should be proud of the role we play in the healthcare system and society, and policymakers need to acknowledge and respect the invaluable role we play.

- ***Policy Development for the Practicing Physician***

Every day, there are new issues and challenges facing the specialty of emergency medicine. As ACEP addresses these issues and develops policy for the specialty, our guiding principle must be a focus on improving the ability of emergency physicians to care for our patients. The unpredictable and often chaotic nature of emergency medicine is challenging and difficult. ACEP must prioritize those issues that enhance our ability to care for patients and reduce the unnecessary distractions from patient care. Issues of fair reimbursement for the services we provide, reduction in administrative burdens and ensuring that emergency physicians remain the recognized leaders in the evaluation and management of acute illness and injury must be our priority as the leading physician organization in emergency medicine.

L. Anthony Cirillo, MD, FACEP
Candidate for the ACEP Board of Directors
Past President, Rhode Island Chapter

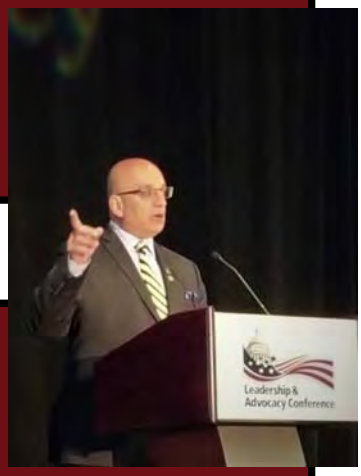
TONY CIRILLO, MD, FACEP

Candidate for the ACEP Board of Directors

Sponsored by the Rhode Island Chapter

ACEP Leadership

- Councilor / Alternate Councilor, 25 Years
- Federal Government Affairs Committee, Chair
- State Legislative & Regulatory Affairs Committee, Chair
- Membership Committee, Chair
- Alternative Payment Method Task Force, Workgroup Chair
- Healthcare Financing/Single Payer Task Force
- ACEP*Now* Editorial Advisory Board
- Council Steering / Tellers & Credentials Committees
- Board Nominating Committee



Advocacy for Emergency Medicine

- 2018 Recipient of the ACEP Rorrie Health Policy Award
- Emergency Medicine Action Fund, Board of Governors
- ACEP / EDPMA Balance Billing / OON Joint Task Force
- NEMPAC Board of Trustees
- EMRA / ACEP Health Policy Mentor

Active Clinical Practice

- Medical Director - Community Hospital based Freestanding ED
- Clinically Practicing 100 hours/month at 3 community hospital sites, 25-50k
- Previous academic appointments and faculty teaching positions

Dear Fellow Councilors and ACEP Colleagues,

Thank you for your service to the Council, the College and the specialty of Emergency Medicine. It is my great honor and privilege to work with you on behalf of our paeąnts, our physicians, and our specialty. At this time, I respec. ully ask for your vote to represent you on the ACEP Board of Directors.

The healthcare landscape is evolving at an incredible pace. Changes in clinical medicine, technology, and the healthcare delivery system guarantee that the future practice of emergency medicine will be markedly different than it is today. While these changes present challenges to our specialty, they also present incredible opportunie s for us to build a future of paent -focused, technology-enhanced, high-quality emergency care. Just as the founders of ACEP did 50 years ago, today's ACEP Board must be willing to envision and articulate the next generation of emergency medicine and be the leading advocates for the future of emergency healthcare.

As a member of the ACEP Board, I will emphasize my vision of a **MAP** for the future of emergency medicine. I believe we must work diligently on behalf of current and future emergency physicians on ***Mentorship, Advocacy, and Policies*** that will ensure a viable and rewarding practice of emergency medicine for generations to come.

Mentorship for the Future

As ACEP celebrates its 50th anniversary there is a powerful lesson to be remembered. Those of us who are practicing emergency medicine today have an obligation to the future generations of emergency physicians. We are, in essence, the founders of the next 50 years of this specialty. The relationship between ACEP and EMRA, a profoundly effecve resident organizaon, is a strong and productive one. As delivery models for emergency medicine evolve, ACEP must work collaboratively with all emergency medicine organizaon s to ensure that the educa on and training of emergency physicians parallels our workforce needs and the needs of our patients.

Advocacy for the Specialty

In the rapidly evolving healthcare system environment, ACEP must remain the leading voice advocang for our patients, our physicians, and our prac ce. Emergency medicine truly is the safety net of the U.S. healthcare system and this pivotal role must be broadcast con nually to policymakers and healthcare leaders. We care for patients who seek our services because they are injured, ill, or afraid, and we turn no one away. Emergency departments are the social safety net of our nation and it is we who provide care to patients when the rest of society and the healthcare system can't, or won't, help them. Emergency physicians should be proud of the role we play in the healthcare system and society, and policymakers need to acknowledge and respect the invaluable role we play.

Policy Development for the Practicing Physician

Every day, there are new issues and challenges facing the specialty of emergency medicine. As ACEP addresses these issues and develops policy for the specialty, our guiding principle must be a focus on improving the ability of emergency physicians to care for our pae nts. The unpredictable and often chaotic nature of emergency medicine is challenging and difficult. ACEP must prioritize those issues that enhance our ability to care for patients and reduce the unnecessary distractions from paent care. Issues of fair reimbursement for the services we provide, reduco n in administrative burdens and ensuring that emergency physicians remain the recognized leaders in the evaluaon and management of acute illness and injury must be our priority as the leading physician organizao n in emergency medicine.

L. Anthony Cirillo, MD, FACEP

Candidate for the ACEP Board of Directors

Past President, Rhode Island Chapter

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Kathleen J. Clem, MD FACEP

***Question #1:* Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

In 10 years Emergency Medicine will increasingly be at the center of US healthcare. People want their health care to be immediately accessible, connected electronically, easy to use, and yet have a human touch. No other specialty comes as close as Emergency Medicine does to meet this public demand. No other specialty is as integrated as Emergency Medicine. We practice at the interface of the inpatient and outpatient world, work with all specialties, and within and for our communities. Our residencies will become even more competitive. We will continue to provide access to emergency health care and we will be empowered to integrate care across the continuum. We will no longer simply generate discharge instructions, we will be empowered to get our patients access to the next appropriate level of care. We will continue to embrace evidence-based technology and be a leader in implementation.

Our electronic connectivity with the inpatient and outpatient worlds will enable us to navigate the system seamlessly to effect health care. When we admit patients, it will be a smooth process with warm-handoffs as the electronic medical record will automatically glean and format the information necessary for admission. We will continue to be the place for emergency care, and our expertise for emergency medicine will continue to be excellent.

My skill set includes clinical Emergency Medicine, academic leadership, and healthcare system leadership. All are crucial as we lead our specialty into the future. I recognize and understand the challenges facing our specialty. ACEP needs experienced leaders to lead through this critical time in health care. I have been an involved ACEP member since 1993 and have over 20 years of experience in community, academic, and now health system leadership. I will use my skills to keep Emergency Medicine's excellence within complex systems as we shape the future of our specialty.

***Question #2:* Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

I work clinically in a high-volume community ED and teach EM residents. I have served as a medical director, tackled reimbursement issues for my group, tort reform at the state level, and understand that unnecessary requirements of our time and energy matter. I have worked to decrease documentation requirements that do not add to patient care.

As a past academic chair, I bring additional experience to navigate challenges to our specially and residency support
I also understand the challenges associated with addressing these issues.

As a current health system executive vice president and Chief Clinical Officer, overseeing 47 hospitals and over 1.5 million ED visits per year, I have led efforts for hospitals to be incentivized to rapidly admit patients, supported resources for timely consults, and worked to build bridges with other specialties, and am actively involved in improving electronical medical record use.

My experience as ACEP Steering Committee member, Committee Chair for Public Relations, Chair National Chapter Relations, AAWEP Chair, and Membership Committee Chair have provided key leadership opportunities and understanding of ACEP administration and positive change.

I value, seek out, and treasure opportunities to listen to physicians. The importance of listening-to-understand cannot be overstated. I would continue to seek these opportunities as a member of the BOD and collaborate with the board to incorporate the concerns and solutions offered by our members into the work we do in our state chapters and nationally to advance Emergency Medicine.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**
ACEP is THE umbrella organization for the house of emergency medicine. Collaboration with other Emergency Medicine organizations is a laudable ACEP goal. ACEP provides mentorship for the next generation of emergency physician. It is our professional home and the premier organization to provide guidance, support, mentoring and professional networking throughout our careers. ACEP is the best source for the ongoing career needs of emergency physicians.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Kathleen J. Clem, MD, FACEP

Contact Information

169 Vista Oak Drive, Longwood, Fl 32779
Phone: (919) 599-9660
E-Mail: kathleen.clem@ahss.org

Current and Past Professional Position(s)

HOSPITAL APPOINTMENTS
Loma Linda University Medical Center 1992-1998
Kaiser Permanente Riverside 1991- 1992 (during residency)
Riverside General Hospital 1992-1998 (per diem)
San Antonio Community Hospital – 1991-1998 (per diem)
Suburban Hospital, Maryland 1993-1998
(per diem to care for family member with terminal illness)
Duke University Medical Center 1998 – 2007
Loma Linda University Medical Center 2007-2016
Loma Linda University Children's Hospital 2016
Florida Hospital – 2017-present
Adventist Health System – 2018-present

CURRENT ACADEMIC APPOINTMENTS
Professor Emergency Medicine, University Central Florida, College of Medicine

PAST ACADEMIC APPOINTMENTS

1992 Instructor LLSOM- Department of Emergency Medicine
1994 Assistant Professor LLSOM – Department of Emergency Medicine
1999 Associate Professor Duke University SOM – Department of Surgery
2007 Professor Emergency Medicine and Pediatrics, LLU School of Medicine

LEADERSHIP POSITIONS
Chief, Division of Emergency Medicine, Department of Surgery, Duke University 1999-2007
Chair, Department of Emergency Medicine, Loma Linda University 2007-2016
Chief Medical Officer, Vice President, Florida Hospital East Orlando 2016-2017
Executive Vice President Chief Clinical Officer Adventist Health System 2018-present

Education (include internships and residency information)

EDUCATION AND TRAINING

ASN	Loma Linda University School of Nursing
BSN	Tennessee Technological University
1989	Loma Linda University School of Medicine
1989- 1992	Residency Loma Linda University- Emergency Medicine

MD 1989

Certifications

ABEM
1994 Emergency Medicine – initial
2004 Emergency Medicine – recertification
2013 Emergency Medicine – recertification

Professional Societies

ACEP
Florida Chapter
Vermont Chapter
SAEM

National ACEP Activities – List your most significant accomplishments

American College of Emergency Physicians (ACEP) Steering Committee 2016-2018
ACEP Well Being Committee – 2015-2016
Wellness Week Task Force **Chair** 2016
Association of Women Emergency Physicians (AAWEP) – **Chair** 2013-2015
American College of Emergency Physicians (ACEP) 1992-present

ACEP International Section Councilor 2000-2001
ACEP American Association of Women in Emergency Medicine 1992-present
ACEP Public Relations Committee member 2002-2008 **Chair** 2002-2004
ACEP Council Awards Committee 2008-2009
ACEP Membership Committee 2014-2016
Chair 2016-2017
ACEP Reference Committee Chair - 2014
ACEP National Chapter Relations Committee 2008-2015 **Chair** 2008-2010
ACEP Speakers Bureau Subcommittee – 2006
ACEP Geriatrics Subcommittee – 2006 - 2007
ACEP Candidate Forum Subcommittee 2005-2006
ACEP Council Steering Committee 2005-2007, 2017-present
ACEP Emergency Preparedness Steering Committee 2007
ACEP State Chapter Grants in Public Relations and Chapter
Grant Review for National/State Chapter Relations Committee 2004-to present

ACEP Chapter Activities – List your most significant accomplishments

North Carolina Chapter of ACEP - Councilor 2005-2008
North Carolina Chapter ACEP – Board Member 2001-2007
California Chapter ACEP Education Committee 1996-1998, 2008
Florida Chapter – Task Force to implement statewide implementation of EDIE and Opioid Task Force

Practice Profile

Total hours devoted to emergency medicine practice per year: **432** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care **7** % Research **1** % Teaching **2** % Administration **80** %
Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.) Group Employment – multi-hospital -community hospital with affiliated ACGME accredited EM residency.

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 2 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Kathleen J. Clem, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Adventist Health System

Address: 900 Hope Way

Altamonte Springs, FL 32714

Position Held: Executive Vice President/Chief Clinical Officer

Type of Organization: Health System

Employer: TeamHealth

Address: 265 Brookview Centre Way Suite 400

Knoxville, TN 37919

Position Held: Part-time attending physician

Type of Organization: CMG

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: SAEM - Board of Directors Member-at-Large 2013-2016

Address: 1111 East Touhy Ave. Suite 540

Des Plaines, IL 60018

Type of Organization: Emergency Academic Medicine Society

Duration on the Board: 3 years

Organization: Loma Linda University School of Medicine Alumni Association

Address: Loma Linda, California

Type of Organization: Alumni Association

Duration on the Board: 2 years

Organization: Loma Linda University Board of Directors

Address: Loma Linda California

Type of Organization: University

Duration on the Board: 3 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

X NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

X NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

X NONE

☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

X NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

X NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Kathleen J Clem, MD Date July 10, 2018

Florida College of Emergency Physicians

July 13, 2018

The Florida College of Emergency Physicians (FCEP) is extremely pleased to endorse the candidacy of Kathleen Clem, MD, FACEP, for a position on the American College of Emergency Physicians Board of Directors.

Over the past 25 years, Dr. Clem has dedicated her career to building up organizations and individuals. The notable number of "firsts" among her many accomplishments speak to a combination of superlative leadership skills and infectious passion. Examples include inaugural Division Chief of Emergency Medicine at Duke University, first female Division Chief within Surgery at Duke University, first female Chair of a Department at Loma Linda University School of Medicine, and founding president of the AAWEP's sister organization, the Academy for Women in Academic Emergency Medicine (AWAEM).

Reviewing her accomplishments, it should come as no surprise that Dr. Clem has established a reputation as a worthy role model for women in Emergency Medicine, and her award-winning service as Chair of the AAWEP Section is yet further evidence of her broad impact. Beyond her work with AAWEP, Dr. Clem's contributions to ACEP over the last two decades also include Chair roles for the Public Relations Committee, the Wellness Week Task Force, the Membership Committee, and the National Chapter Relations Committee. Additionally, her experience as Councilor for both the ACEP International Section and the North Carolina Chapter, her service on the North Carolina Chapter Board of Directors, as well as her extensive committee work all demonstrate an in-depth understanding of ACEP policies and priorities befitting a candidate for the Board of Directors.

Since taking the Chief Clinical Officer at Adventist Health, Dr. Clem has become very active in ensuring quality measures and patient satisfaction measures are in place at the multiple emergency departments under her jurisdiction with the hospital system. Dr. Clem is also participating in a Task Force working for the establishment of opioid addiction treatment centers. Dr. Clem is also working clinically and has developed great relationship with the EM residents at Florida Hospital East.

Dr. Clem's leadership, passion, and experience make her a uniquely qualified candidate for the ACEP Board of Directors, FCEP is very pleased to fully and enthusiastically endorse her candidacy.

Joel Stern, MD, FACP
President, FCEP

Kathleen J. Clem, MD, FACEP

ACEP needs experienced leaders to guide us through this critical time in health care. I have been an involved ACEP member since 1992 and have over 20 years of experience as a leader for community and academic Emergency Medicine. I know how to work within and for complex systems as we shape the future of our specialty.

I have served as an ED medical director, tackled reimbursement issues, fought for tort reform at the state level, advocated for residency support, and I understand the burdens and obstacles to efficient use of our time and energy, whether you are a young physician just out of residency or in the middle of your career. I continue to work clinical shifts and teach EM residents. As a past academic chair, chief medical officer and now health system executive vice president, I bring additional experience in knowing how to work with others to obtain the resources we need to both give great care and enjoy our practice. I value, seek out, and treasure opportunities to listen to physicians.

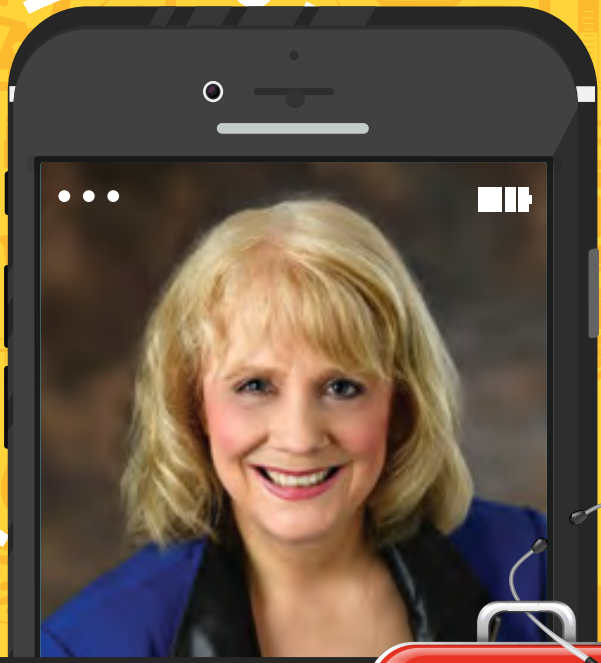
I have designed specific strategies to recruit and retain young physicians by defining designated chapter leadership positions for residents and specific leadership development tracks. Our youngest members need increased opportunities for mentorship and connectivity. I continue to nurture strong professional relationships and believe this is one of the best ways to insure ongoing success of our young EPs. As a past AAWEP Chair, I am the inaugural leader for the AAWEP Leadership Pipeline initiative and continue to serve as a mentor for women in EM.

We need to further leverage and build on the work that ACEP has initiated to address burnout and resiliency. I was Chair for the inaugural ACEP Wellness Week and I am proud of the programs we have put into place. ACEP must continue to address unnecessary stressors such as: nursing staff shortages, unreasonable documentation demands, unrealistic expectations for EDs to solve hospital throughput issues without administrative commitment/action, and inappropriate patient satisfaction demands. As a Department Chair, and health system leader, I am experienced in putting solutions into place – and getting them to stick!

I understand that when we can deliver the excellence that we expect of ourselves within a supportive system, the true joy of practice will be realized. I want to be at the forefront to promote our core values and continue to deliver the highest quality of care for our patients by serving as a member of the ACEP Board of Directors. I am ready to give back and I have the support and time to serve. Now is the right time for me to bring my skills and experience to the ACEP BOD and I am asking for your vote

Thank you!

Kathleen Clem, MD, FACEP



KATHLEEN J CLEM
MD, FACEP

ACEP Board of Directors Candidate
Endorsed by The Florida Chapter of Emergency Physicians

- Gets things done in our complex and changing healthcare environment
- Strong track record as a physician advocate and mentor
- Experienced leader within,
  - Academic Emergency Medicine
  - Community Emergency Medicine
  - System Health Care

I am proud to be an emergency physician and will work relentlessly on your behalf to make our specialty stronger. I am honored and grateful to have served ACEP throughout my career. My focus has been on ensuring that we have the resources we need to enjoy our practice and continue to give outstanding patient care. My experience has given me the skills essential to serve capably on the ACEP BOD as we lead our specialty into the future. It would be my privilege to advocate for you as a member of the ACEP BOD. I ask for your support. I will make your vote count.

Kathleen Clem, MD, FACEP

ACEP SERVICE HIGHLIGHTS

- Membership Committee Chair
- Diversity and Inclusion Task Force
- Wellness Week Task Force Chair
- International Section, SAEM, International Section Councilor
- AAWEP Chair
- Public Relations Committee Chair
- Council Awards Committee
- National Chapter Relations Committee Chair
- Speakers Bureau Subcommittee
- Spokespersons Network
- North Carolina (NCEP) Board member
- Emergency Preparedness Steering Committee
- Candidate Forum moderator
- ACEP Steering Committee member

CLINICAL EXPERIENCE/ LEADERSHIP

- 18 years leadership Level 1 trauma centers
- Community EDs- single and double coverage
- Community ED Directorships in CA and NC
- CMO at community hospital
- Current Executive VP/Chief Clinical Officer Advent Health System
- Current clinical practice community ED >120K/yr with EM residents

PROFESSIONAL SERVICE HIGHLIGHTS

- Works for hospitals to be incentivized to rapidly admit patients and support resources for timely consults
- Fights against inappropriate demands on physician time
- Experienced in reimbursement, tort reform, residency support
- Focus on diversity and inclusion
- Developed leadership pipeline for women via AAWEP
- Focus on physician wellness
- Developed structured opportunities for physician mentors

ACADEMIC LEADERSHIP

- Founding Chief- Division of Emergency Medicine -Duke University
- Emergency Medicine Department Chair- Loma Linda University (LLU)
- International EM Fellowship Director- LLU
- Administrative Fellowship Director- LLU
- National speaker for ACEP, SAEM, Joint Commission
- Women Executives in Science and Healthcare – Board of Directors
- Society for Academic Emergency Medicine – Board of Directors
- Professor of Emergency Medicine – LLU, University Central Florida

AWARDS

- Distinguished Faculty Award – Duke University
- ACEP Hero of Emergency Medicine
- SAEM Founders Award – Academy for Women in Academic Emergency Medicine (AWAEM)
- Outstanding Reviewer – Academic Emergency Medicine
- SAEM Global Emergency Medicine Academy International Collaboration
- SAEM Advancement of Women in Academic Emergency Medicine
- SAEM Outstanding Department
- Physician Leadership – LLU
- AAWEP Leadership
- SAEM Academy for Diversity and Inclusion in EM Service

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Francis L. Counselman, MD, CPE, FACEP

***Question #1:* Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Forecasting the future is no easy task. We know change is inevitable, and that successful organizations adapt to it- it is a constant and dynamic process. Having been practicing Emergency Medicine for the past 32 years, I have learned the importance of keeping a moral compass to guide me, while adapting to the surrounding environment. I have proven to be someone that can evolve with change and become a better physician and leader over time. I look forward to the challenges and opportunities the future will offer.

The good news is, 2028 will still need Emergency Medicine and emergency physicians. In fact, our role in the house of medicine will continue to expand, just as it has over the past decade. Artificial intelligence will play a very large role in the practice of medicine, and Emergency Medicine in 10 years. Historically, and even today, a physician subconsciously runs through their personal database after performing a history and physical examination, determining pretest probabilities and differential diagnoses. In ten years, we will have devices that will scour enormous, national databases, to assist us with testing and treatment decisions. We will have significantly better information on risk/benefit ratios regarding treatment and patient disposition decisions. We will be able to inform our patients much better regarding prognosis and what to expect. To be clear, this "new' information will not be correct 100% of the time, but much better than what we currently possess.

Laboratory testing and imaging study turn around times will be improved in the future, decreasing some of the current bottlenecks present in ED patient throughput. This will be one of those rare achievements that makes emergency physicians, patients and hospital administrators all happy.

I suspect we will see a shift in the type of patients we see in the ED, with a significant trend toward high acuity. Low acuity patients will have many more efficient and cheaper alternatives. Emergency physicians will get to treat the type of patients they specifically trained for- acute MIs, stroke, DKA, severe asthma attacks, penetrating trauma- the list is long.
As a physician and leader that has been practicing for over three decades, I know and have experienced significant change- I look forward to it because with it, there is always the opportunity to do things even better.

***Question #2:* Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

Professionally, I'm a hybrid - equal mix community and academic EM physician. After Emergency Medicine residency graduation, I joined Emergency Physicians of Tidewater (EPT) - a private practice, democratic group of board-certified emergency physicians. In addition, I began serving as an Assistant Program Director of the EM residency program from which I graduated.

In 1990, I was appointed the Program Director of the EM residency. I served in this role for the next 20 years, and oversaw its growth and maturation. In many ways, it's the best job in all of EM. This job only deepened my commitment to quality EM education; it is part of my DNA.

When I started, EM was a division of the Department of Family Medicine at Eastern Virginia Medical School (EVMS). It was clear to me we should to be an academic department. I spent one year meeting with every department chair, explaining why we deserved such status. In 1992, we were granted academic departmental status, becoming the first in Virginia and only the 26th in the nation; I was appointed the inaugural chair and continue to serve today. This taught me how to effectively deal and negotiate with other departments, advocate for EM clinically and academically, and run a multimillion dollar enterprise.

For the past 20 years, I have served on the Board of Directors of EPT, helping lead our democratic practice group through the changing health care environment, demands from hospital administration, reimbursement issues, and all manner of other threats.

In 2008, I was asked to serve as the President of the Medical Staff of our 1100+ physician, two hospital system; the first emergency physician to do so. I gained invaluable experience and education in dealing closely with hospital administration, interacting with other clinical services, and overseeing the hospital transition to an electronic medical record. I now see EM through many different lenses, but always guided by the desire and passion to promote a healthy working environment for all emergency physicians.

Finally, I have served as President of two national EM organizations- the Association of Academic Chairs of Emergency Medicine and the American Board of Emergency Medicine. I have first-hand experience in serving large groups of emergency physicians- academic and community-by listening, advocating, and working hard on their behalf.

From all of my experiences, I am acutely aware of the challenges and opportunities offered by private practice and academic EM. While some make a hard distinction between the two, there is much more in common, than unique. Issues of fair reimbursement, coding and billing, appropriate staffing, LWBS, patient satisfaction, boarders, throughput metrics, and on-call availability are all important, regardless of your practice type. You have to be knowledgeable of all of these issues, and advocate for a working environment that is healthy, professionally rewarding, and satisfying for patients and emergency physicians. I have the passion and the experience to work hard on these issues on behalf of all of the ACEP membership. I hope you will support my nomination..

***Question #3:* Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

Every organization needs to take a hard look at itself and decide what is it's purpose; why do we exist ? Some organizations in Emergency Medicine have a very specialized purpose, and cannot, and should not, be placed under a large umbrella. A good example of this is the American Board of Emergency Medicine (ABEM). Their primary purpose is in setting the competency standards regarding board-certification and maintenance of certification. The Council of Residency Directors in Emergency Medicine (CORD-EM) is another example; it has a very specific and important role to play in EM residency education, and does not lend itself to being neatly folded under an umbrella

The American College of Emergency Physicians, while not as an umbrella, is never the less best suited to take the lead for our specialty, primarily due to its large and diverse membership base and its tremendous legislative advocacy work, at the national, state and local levels. I see more of a hub and spokes model, rather than an umbrella. ACEP would be at the center (hub), with other organizations working closely and collaboratively with ACEP, but also focusing on their nitch; be it research, board-certification, or EM residency training (the spokes). ACEP, and the various EM organizations should make every effort to work together on common issues, and avoid duplication of efforts at every opportunity. There is too much work that needs to be done on behalf of emergency physicians to waste time on inconsequential (in the big picture) turf issues, and strive to work together instead.

I have had the good fortune to hold leadership positions in many EM organizations- ACEP, ABEM, AACEM, and SAEM. Each has its particular strengths and focus. These organizations should continue to focus on their reason for existence. But at the same time, all organizations should work hand in hand with ACEP, ensuring a common understanding and an offer of assistance when needed. While there will certainly be differences of opinion on certain issues, it can almost always be worked out to a satisfactory conclusion when discussed and debated in a collegial atmosphere.

ACEP focuses on the practicing emergency physician- private practice, academic, employed, independent contractor, partner, locum tenens- which means just about everyone in the house of emergency medicine. If you practice our specialty, ACEP represents you, whether you are a member or not. As I have told my residents, fellow, and junior colleagues and anyone else); its not an either/or prospect when joining an EM organizations, its an "and" issue. You should belong to ACEP, and to…(you fill in the blank).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Francis L. Counselman, MD, CPE, FACEP

Contact Information

Department of Emergency Medicine, Rm 304 Raleigh Building, 600 Gresham Drive, Norfolk, Virginia 23507
Phone: 757-388-3397
E-Mail: counsefl@evms.edu

Current and Past Professional Position(s)

Founding Chairman, Department of Emergency Medicine, Eastern Virginia Medical School, 1992-present.
Program Director, Emergency Medicine residency, Eastern Virginia Medical School, 1990-2010.
Associate Program Director, Emergency Medicine residency, Eastern Virginia Medical School, 1986-1990.
Attending Physician, Emergency Physicians of Tidewater, 1986-present.
Editor-in-Chief, ***Emergency Medicine***, 2018-present.
Associate Editor-in-Chief, ***Emergency Medicine,*** 2006-2017.

Education (include internships and residency information)

Residency: Emergency Medicine, Eastern Virginia Medical School, 1984-1986.
Internship: Internal Medicine, Eastern Virginia Medical School, 1983-1984.

Medical Degree (M.D.), Eastern Virginia Medical School, 1983..

Certifications

American Board of Emergency Medicine: 2007-2020; 1997-2007;1987-1997.
Certified Physician Executive (CPE), 2010-present
Certificate in Business Management, Raymond A. Mason School of Business,
College of William and Mary, 2016

Professional Societies

American College of Emergency Physicians, 1984-present.
Virginia College of Emergency Physicians, 1984-present.
American Board of Emergency Medicine, Diplomate, 1987-present
Society for Academic Emergency Medicine, 1990-present.
Council of Emergency Medicine Residency Directors, 1990-present.
Norfolk Academy of Medicine, 1990-present.
Association of Academic Chairs of Emergency Medicine, 1993-present.
Alpha Omega Alpha (AOA) Honor Medical Society, 1994-present.
Medical Society of Virginia, 1996-present.
American Association for Physician Leadership, 2009-present.

National ACEP Activities – List your most significant accomplishments

Received ACEP Award for Outstanding Contribution in Education, Oct 2017
Faculty, ACEP Teaching Fellowship, 2004-2016 (each year)

ACEP Academic Leader/Residency Visit Program, 2005-present
Chairman, Third Emergency Medicine Workforce Study, 2007-2009.
Membership Committee, 2001-2006
-Chairman, 2004-2006
Academic Affairs, 1996-2001
-Chairman, 1999-2001

ACEP Chapter Activities – List your most significant accomplishments

Board of Directors, 1989-1997
Secretary, 1993-1994
President-elect, 1994-1995
President, 1995-9996
Immediate Past-President, 1996-1997
Received the VA ACEP Heatwole Career Achievement Award, 2001
Education Committee, 1989-2000
-Chairman,1996-2000; 1993-1995
Councilor, 1990
Alternate Councilor, 1991-1995, 1997-1998

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 **50** % Research **5** % Teaching **20** % Administration **25** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am employed by Emergency Physicians of Tidewater, a democratic private practice group of ABEM certified emergency physicians and advanced practice providers providing emergency services to five hospital EDs and two free standing EDs, with a combined patient volume of @ 360,000 annually.

I also serve as the Chairman of the Department of Emergency Medicine for Eastern Virginia Medical School, where I am fulltime, non-salaried.

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 16 Cases **Plaintiff Expert 7 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Francis L. Counselman, MD, CPE, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Emergency Physicians of Tidewater
Address: 4092 Foxwood Drive, Suite 101
Virginia Beach, Virginia 23462
Position Held: Board of Directors since 2000. Responsible for academic arm of group
Type of Organization: Private practice, democratic group of ABEM board-certified physicians (@ 65+) providing coverage for five hospital EDs and two free standing EDs.

Employer: Eastern Virginia Medical School
Address: 825 Fairfax Avenue, Norfolk ,Virginia 23507
Position Held: Chairman, Department of Emergency Medicine (since 1992. Full-time, nonsalaried)
Type of Organization: A public-private medical school

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: American Board of Emergency Medicine
Address: 3000 Coolidge Road, East Lansing, MI 48823-6319
Type of Organization: One of 24 medical specialty certification boards recognized by the American Board of Medical Specialties (ABMS).
Duration on the Board: 2008-2016

Organization: Educational Commission for Foreign Medical Graduates (ECFMG)
Address: 3624 Market Street, 4th floor, Philadelphia, PA 19104
Type of Organization: Private, nonprofit. The world leader in promoting quality healthcare.
Duration on the Board: 2017-2021

Organization: Virginia College of Emergency Physicians (VA ACEP)
Address: 2924 Emerywood Parkway, Suite 202, Richmond Virginia 23294
Type of Organization: State chapter of the American College of Emergency Physicians
Duration on the Board: 1989-1997

Organization: Eastern Virginia Medical School Alumni Association

Address: Office of Alumni Relations, 721 Fairfax Avenue, Suite 505, Norfolk, Virginia 23507

Type of Organization: Volunteer board to raise money for Eastern Virginia Medical School

Duration on the Board: Board of Trustees, 1996-2005

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: I serve as the Editor-in-Chief of ***Emergency Medicine,*** a peer-reviewed practice journal for emergency physicians.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Francis L Counselman MD, CPE, FACEP Date June 6, 2018

VIRGINIA COLLEGE OF EMERGENCY PHYSICIANS

2018 Board of Directors

Bruce Lo, MD, MBA, FACEP
President

Kenneth Scott Hickey, MD, FACEP
President-Elect

Cameron Olderog, MD, FACEP
Secretary-Treasurer

Mark R. Sochor, MD, MS, FACEP
Immediate Past President

Kirk Cumpston, DO, FACEP, FACMT
Jon D'Souza, MD, FACEP
Derrick Swartzentruber, MD
Kean Feyzeau, MD
Jason T. Garrison, MD, FACEP
Randy Geldreich, MD, FACEP
Jared Goldberg, MD, FACEP
Christopher Hogan, MD, FACEP
Scott Just, MD, MBA, FACEP
Lauren Wingfield, MD
Adam Morcom, MD
Joseph Lang, MD, FACEP
Darren S. Lisse, MD, FACEP
Todd Parker, MD, FACEP
Renee D. Reid, MD
C. Christopher Turnbull, MD
Edward G. Walsh, MD

Executive Director
Bob Ramsey, CAE
Cell: (804) 814-9350

Headquarters

2924 Emerywood Pkwy., Suite 202
Richmond, VA 23294

Tel: (804) 297-3170
Fax: (804) 747-5022
www.vacep.org

June 12, 2018

To the ACEP Nomination Committee:

The VACEP Board of Directors voted at our June 7, 2018 Board of Director meeting to endorse the nomination of Dr. Francis Counselman, MD, FACEP as a candidate for ACEP's Board of Directors.

Dr. Counselman served as VACEP's president from 1995-1996 following eight years on the Chapter's Board of Directors. He served as six years as VACEP's chair of our Education Committee.

Please let us know if you need anything else from us.

Sincerely,

Dr. Bruce Lo, MD, MBA, FACEP

VACEP President

Francis L. Counselman, MD, CPE, FACEP

I am very excited about running for the Board of Directors of the American College of Emergency Physicians (ACEP). I have been a member of ACEP since I was a resident, and would love to give back to the organization and members that have supported and encouraged me for the past three + decades.

I am a hybrid – I am both a community emergency physician (EP) and an academic EP. I am a member of a private practice, democratic group of board-certified emergency physicians; Emergency Physicians of Tidewater (EPT). I joined EPT right out of EM residency training and have been practicing with them full-time since July 1986. In addition, for the past 20+ years, I have served on EPT's Board of Directors, help leading our group forward. At the same time, I am volunteer faculty at Eastern Virginia Medical School (EVMS), where my appointment is "full-time, nonsalaried." At EVMS, I was able to lead the change from a division of the Department of Family and Community Medicine to our own academic department of Emergency Medicine. We were the first academic department of Emergency Medicine in Virginia, and only the 26th in the nation at that time (1992). I continue to serve in the role of Chairman today.

I work in the ED, seeing patients primarily and also supervising EM residents and medical students in the delivery of care. I work holidays, weekends, and evenings. In our democratic group, I work the same number of holiday and weekend shifts as the most junior partner. I know firsthand the challenges of practicing both community and academic emergency medicine.

I feel I have the experience, temperament, and leadership skills necessary to serve on the ACEP Board of Directors, and to help move the specialty forward. Over the years, I have served on committees, and in leadership positions, with ACEP, SAEM, and ABEM. I have chaired two important ACEP committees – Academic Affairs and Membership. As you well know, membership is the lifeblood of any organization, and we need to continue to meet the needs of our membership going forward. I served on the ACGME Residency Review Committee for Emergency Medicine (RRC-EM) for six years; I well understand and appreciate the policies and program requirements necessary for EM residency accreditation. I served on the Executive Committee (and eventually, President) of the Medical Staff of my hospital – Sentara Hospitals Norfolk. This includes two hospitals (Sentara Norfolk General Hospital, the areas only Level 1 Trauma Center and primary teaching hospital for EVMS, and Sentara Leigh Memorial Hospital). The medical staff includes over 1000 physicians, representing every specialty. During my year as President, I oversaw the transition to an electronic medical record and a Joint Commission visit – it was an exciting year.

I have also served on the Board of Directors of the American Board of Emergency Medicine (ABEM). I was actively involved in the negotiations with the American Board of Surgery and the American Board of Anesthesia resulting in allowing EM residency trained physicians to be eligible for critical care fellowships, and sitting for the critical care examinations. I was also very involved in the development and introduction of the eOral cases into the ABEM Oral Certifying Examination.

My various experiences have taught me the importance of listening, doing the right thing, not the easy thing, and the tremendous amount of work that a small group of dedicated individuals can accomplish. I am asking for your vote for the ACEP Board of Directors; I would like to work hard on your behalf. Thank you.

Francis L. Counselman, M.D., CPE, FACEP

Francis L. Counselman, MD, CPE, FACEP

Candidate, Board of Directors, American College of Emergency Physicians

The Virginia College of Emergency Physicians proudly endorses Dr. Francis Counselman for election to the ACEP Board of Directors. Francis has unflagging enthusiasm for our profession. His hard work and loyalty continues to contribute to the strength of emergency medicine in Virginia. Francis's expertise reflects the depth and breadth of his well-rounded experiences. His leadership and service to ABEM as well as to his home department and community demonstrate his commitment to advancing emergency medicine. We respectfully ask for your vote for Dr. Francis Counselman.

Sincerely,

Bruce Lo, MD, MBA, FACEP
President
Virginia College of Emergency Physicians

Virginia Service

- Virginia ACEP, Board of Directors, 1989-1997
- Virginia ACEP, President, 1995-1996

ACEP Service

- ACEP Award for Outstanding Contribution in Education, 2017
- ACEP Registry Review Workgroup, 2014
- ACEP Teaching Fellowship Faculty, 2004-2016
- ACEP Third Emergency Medicine Workforce Study Group, Chairman, 2007-2009
- ACEP Membership Committee, 2001-2006, Chairman, 2004-2006
- ACEP Academic Affairs Committee, 1996-2001, Chairman, 1999-2001

Other Service

- American Board of Emergency Medicine, Board of Directors, 2008-2016, President, 2014-2015
- Association of Academic Chairs of Emergency Medicine, President, 2002-2003

My promise to you is to work hard on behalf of the ACEP membership to advance our specialty. I respectfully request your support in this year's Board of Directors election.

Francis Counselman, MD, CPE, FACEP

ACEP BOARD OF DIRECTORS CANDIDATE 2018
FRANCIS L COUNSELMAN, MD, CPE, FACEP

Current Practice

- Full time EM practice (32 years)
- Board of Directors (20+ years)
  of Emergency Physicians of Tidewater
  -a 40 year old democratic practice group of board-certified EM physicians

Additional Leadership Experience

- President of Medical Staff, Sentara Hospitals Norfolk, 2008-2009 (two hospitals:1,000+ physicians)
- Program Director, EM Residency, Eastern Virginia Medical School, 1990-2010
- President, Norfolk Academy of Medicine, 1998-1999

Recognition

- Award for Outstanding Faculty Achievement, Eastern Virginia Medical School, 2016
- Mason Andrews Community Service Award, Sentara Hospitals Norfolk, 2014
- Heroes of Emergency Medicine, Virginia, American College of Emergency Physicians, 2008
- Parker J. Palmer "Courage to Teach" Award, Accreditation Council for Graduate Medical Education, 2005
- Residency Director of the Year Award, Emergency Medicine Residents' Association, 2003

DEDICATION LEADERSHIP EXPERIENCE

Endorsed by the Virginia College of Emergency Physicians (VA ACEP) and the Association of Academic Chairs of Emergency Medicine (AACEM)

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

J.T. Finnell, MD, FACEP, FACMI

***Question #1:* Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Healthcare is entering a period of rapid change. Advancement of new technologies will fundamentally change how we practice medicine. Hospitals will become smaller as more healthcare will be done at home. Precision medicine where treatments will be based on genetic, environmental and lifestyle factors. Aging will become a treatable disease. Cars that drive themselves, drastically reducing rates of traumatic injuries. When was the last time you did a saphenous vein cutdown, or diagnostic peritoneal lavage? Advances in technology have already changed and will continue to change how we practice emergency medicine.

We should be working smarter, not harder. We should be building tools to help us manage the deluge of clinical data we must consume in order to make rational treatment decisions. In Indiana, we are already working on tools to help mine "Big Data". Similar to how Amazon will present you relevant buying decisions, why can't your EHR do the same? Patient's with chest pain have their last EKG, Cardiology notes, Stress and Cath reports (regardless of health system) available for review. We've discovered this saves over 5 minutes of chart review down to just seconds.

How we use knowledge is different today than when we were younger. A quarter-century ago, when we first started going online, we took it on faith that the web would make us smarter: more information would breed sharper thinking. However, what we've seen instead is that we often sacrifice our ability to turn information into knowledge. We get the data but lose the meaning.

In a recent study, a group of volunteers read 40 brief factual statements and then typed the statements into a computer. Half the people were told that the machine would save what they typed: the other half were told that the statements would be immediately erased. The Google effect was born. The Google effect, also called digital amnesia, is the tendency to forget information that can be found readily online by using Internet search engines such as Google. This is changing how we practice, and more importantly, how we certify emergency physicians. What information should an emergency physician "know" versus have the ability to "look up"?

As a child, and before technology, I remember my father during a party game would boldly state there are five state capitals where "city" is part of their name. There are actually only four, so no one could ever come up with the fifth. My father would claim it was Indiana, and Indiana City as the capital. No one would disagree.

Psychologist and philosopher William James said in an 1892 lecture, "the art of remembering is the art of thinking." Upgrading your devices will not solve the problem. We need to give our minds more room to think.

***Question #2:* Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

How many of us recall growing up with "Emergency!" which debuted on NBC on January 15, 1972? What an awesome team. Firefighters Johnny Gage and Roy DeSoto working together with nurses (Dixie McCall) and emergency physicians Kelly Brackett, and Joe Early MD, FACS, **ACEP**. Yes, ACEP was listed in their credentials, founded only four years earlier, found its way into our hearts and living rooms.

ACEP continues to represent a family of physicians who share a commitment to improving the quality of emergency care. I've been a member of ACEP for over 30 years and have practiced in multiple settings. I've worked for both private and small groups, and currently serve as the program director of Clinical Informatics and as teaching faculty in the Indiana University

residency program. While we all wear many hats, I consider ACEP to be my home, and my informatics training to add unique value, which will truly complement the existing ACEP board.

Healthcare is entering a period of rapid change. Advancement of new technologies will fundamentally change how we practice medicine. Hospitals will become smaller as more healthcare will be done at home. Precision medicine where treatments will be based on genetic, environmental and lifestyle factors. Aging will become a treatable disease.

I'm well aware that the "promise of technology" with the advent of electronic records has presented new challenges. The burden of the electronic record has resulted in increased rates of physician burnout and spawned a new class of scribes. However, my particular set of skills helps to transform the realities of all emergency physicians. True transformation requires trusted data and sound analytics. We all work with problematic electronic records, order sets, and decision support that drive us crazy. However, I've built systems that truly reflect emergency medicine's best practices and our particular realities of care. I've led collaborative and creative teams to streamline our existing processes in order to enhance the efficiency of our department. I understand the nuances of data collection and measurement and can help our Board to insure the success of all of our practices.

As part of my extensive career I've been able to bridge the crucial gap between generations of physicians through the use of technology. We are all part of connected teams. Using tools like Slack, Trello, and Basecamp to bridge that divide. I want us to work smarter, not harder. We are currently working on tools to help mine "Big Data". When a patient presents to the ED with chest pain, why should we have to search for an old EKG, cardiology notes, or stress reports? These all should be readily available and instantly viewable.

Nomination to ACEP's board is an honor and a privilege. I would like the opportunity to bring the advances in emergency medicine that we have in Indiana to ACEP. I have the full support of my family, practice group, and state to serve you. I'm asking for your support and will bring your voice to lead our college into the future.

***Question #3:* Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

As Mark Twain once said: "The difference between the right word and the almost right word is the difference between lightning and a lightning bug." I endorse the ACEP's Mission statement.

The ACEP Mission Statement. The American College of Emergency Physicians promotes the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

John T. Finnell, MD, FACEP, FACMI

Contact Information

505 South 5th Street, Zionsville, IN 46077
Phone: 317-454-1089
E-Mail: jtfinnell@gmail.com

Current and Past Professional Position(s)

Fellowship Program Director, Clinical Informatics
President AMIA Academic Forum
Member AMIA Board of Directors
Member AMIA Education Committee
ABEM Senior Case Examiner Reviewer
ABEM Item Writer
ABEM Oral Examiner
ABEM Case Development Panel

Education (include internships and residency information)

B.S., Biology, University of Vermont	1983-1987
M.D., University of Vermont	1987-1991
Residency: Emergency Medicine, UCSF-Fresno	1991-1995
EMF/ACEP Teaching Fellowship, Dallas Tx	1997-1998
Evidence Based Medicine, McMaster University	2001
M.Sc., Clinical Research, Indiana University	2002-2004
Informatics Fellow, National Library of Medicine	2002-2005
M.D., University of Vermont	1991

Certifications

Diplomate, American Board of Emergency Medicine	1996-Present
Diplomate, American Board of Preventive Medicine in Clinical Informatics	2013-Present

Professional Societies

ACEP
Indiana ACEP
SAEM
AMA
AMIA (American Medical Informatics Association)
CCIPD (Clinical Informatics Program Directors)

National ACEP Activities – List your most significant accomplishments

Board of Directors Nominee	2016-Present
Council Steering Committee	2013-2015
Chairman Reference Committee	2014

Education Committee	2014-Present
Indiana Counselor	2010-Present
Tellers, Credentials Committee Member	2010-2013
State Leader 911 Network	2010-Present
Reference Committee Member	2010-2013
Clinical Policies Committee – Informatics Liaison	2004-2007
Academic Affairs Committee	1999-2003
Secretary Informatics Section	2002-2003

ACEP Chapter Activities – List your most significant accomplishments

Past-President INACEP	2014
President INACEP	2013-2014
Board of Directors	2009-Present

Practice Profile

Total hours devoted to emergency medicine practice per year: **1864** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **25** % Research **5** % Teaching **50** % Administration **20** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Eskenazi Health (formerly Wishard Memorial) is a county, level 1 trauma and burn center. It is one of the major teaching hospitals for central Indiana. The academic faculty are employed by Indiana Health, an affiliate of Indiana University.

Expert Witness Experience

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**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

John T. Finnell, MD, FACEP, FACMI

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Indiana University

Address: Bloomington, IN

Position Held: Emergency Medicine Attending Physician

Type of Organization: Health Care / Hospital

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: American Medical Informatics Association (AMIA)

Address: Bethesda, Maryland 20814

Type of Organization: Member Organization for Biomedical Informatics

Duration on the Board: 1 year

Organization: Outrun The Sun

Address: Indianapolis, IN

Type of Organization: Non-Profit, Melanoma Advocacy

Duration on the Board: 4 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE

☒ If YES, Please Describe: Maria, my wife, is employed by Anthem/Medicaid.

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

John T. Finnell, MD July 16, 2018

Advancing Emergency Care

INDIANA CHAPTER
American College of Emergency Physicians
630 No. Rangeline Rd. Suite D, Carmel, IN 46032
Phone: (317) 846-2977 Fax: (317) 848-8015
Email: inacep@inacep.org

January 23, 2018

John G. McManus, Jr., MD, MBA, FACEP
Chair, Nominating Committee
P.O. Box 619911
Dallas, TX 75261-9911

Dear Dr. McManus,

The Indiana ACEP Chapter highly recommends John Thomas Finnell MD, FACEP as a candidate for the national ACEP Board of Directors. As you can see from his Curriculum Vitae, Dr. Finnell has not only spent many years in leadership positions with the Indiana Chapter, but has also been very involved with numerous national ACEP committees, as well as ABEM and the national ACEP Council.

His energy and continued commitment to ACEP's interests are outstanding and his leadership skills are impeccable. He has formal training in BioMedical Informatics, is board certified in Clinical Informatics and is the program director for the first EM based Clinical Informatics program in the country. This specific skill set would help ACEP realize its informatics goals with CEDR and other data initiatives.

The Indiana ACEP Board of Directors wholeheartedly supports John Thomas Finnell MD, FACEP for candidacy to the national ACEP Board of Directors.

Sincerely,

E. Nicholas Kestner

Indiana ACEP Officers and Board of Directors 2017/2018

Gina Huhnke MD, FACEP
President

Chris Ross MD, FACEP
Vice President

Bart Brown MD, FACEP
Secretary-Treasurer

Lindsay Weaver MD, FACEP
Immediate Past President

Board Members:
Chris Cannon MD FACEP
Emily Fitz MD
Tyler Johnson DO FACEP
Andrew McCanna MD FACEP
John Rice MD FACEP
Courtney Soley MD
Lauren Stanley MD FACEP
Jonathan Steinhofer MD FACEP
Matt Sutter MD FACEP

E Nicholas Kestner III
Executive Director

John T. Finnell, MD, FACEP, FACMI

Dear Colleagues,

It is an honor and privilege to have been selected to be a candidate for your Board of Directors.

As you review the qualities of each of the exceptional candidates, I'd like for you to consider some of my core values that will give you a sense of who am I am, and the type of Board member I will be, if elected.

Service. Service is the ability to put aside your needs for the greater good of the group. For physicians specializing in Emergency Medicine - our schedules are 365/24/7. We work nights, weekends, and holidays. We work during major sporting events (Super Bowl in Indy) that we'd rather be attending. I value the commitment I've made to our specialty and I will work tirelessly for you to ensure your needs are being met in order to make the best decisions in the interest of our specialty.

Health. Wellness matters. We must do things outside of our work lives to keep us whole. For me, I'm a runner. I find the time I use running helps to clear my head and helps me to prepare for the challenges that lie in the days/weeks ahead. I'm very fortunate that my family can join me on these activities so we can spend these precious hours together.

Innovation. I like to explore new ways to do things and I think outside of the box. I have been fortunate at Indiana University to have worked with other schools on campus and have been awarded patents based upon our work together. I find that innovation comes not from one person, but from a group of individuals who wish to make something unique and better. I promise to bring these talents to your board to help make your job and our specialty better.

Informatics. Looking at the composition of the current ACEP board, I can help fill a void. We all experience the challenges related to electronic medical records and rising rates of dissatisfaction and burn out. In Indiana, we create tools to allow us to become more efficient with our time to be more productive. The simple reality of a practicing emergency physicians life includes information technology. EMR, building order sets to reflect best practices, streamlining our existing processes to enhance efficiency, and understanding data measurement are skills that I possess.

I look forward to getting to know more of you. For those that do not yet know me – here are some words that others I work with have used to describe the type of person I am.

"Calm, caring, creative, collaborative, driven, engaged, enthusiastic, experienced, fair, focused, knowledgeable, honest, insightful, open minded, personable, relaxed, thoughtful."

I ask for the honor and privilege to serve you, and for your vote for the ACEP Board of Directors.

Sincerely,

JT

JOHN T. FINNELL MD, MSc, FACEP

• ACEP Board of Directors Candidate •

Today's reality of practicing emergency medicine includes Information Technology (EMRs, Order Sets, Clinical Data).

As an informatician and data scientist, I ask for your vote to help lead ACEP into our future.

WHO I AM:

- Associate Professor of Clinical Emergency Medicine
- Associate Professor of Informatics
- Current INACEP Board Member
- Fellowship director of the first EM Clinical Informatics fellowship
- 20+ Years practicing academic physician in a Level 1 Trauma Center in an Urban Environment

PROVEN LEADERSHIP:

- Department Chair Health Informatics, Indiana University
- Fellowship Program Director, Clinical Informatics

MY GOALS AS A BOARD MEMBER:

- Physician wellness (EHRs are a major burden)
- Enhance communication around our Advocacy Issues
- Innovative on-line communities for support / mentorship

LEADERSHIP

SERVICE

DATA SCIENTIST

Endorsed by Indiana ACEP & ACEP Informatics Section

JOHN T. FINNELL MD, MSc, FACEP

• ACEP Board of Directors Candidate •

National / Chapter Service:

- ACEP Council Steering Committee 2013 - 2015
- ACEP Chairman Reference Committee 2014
- ACEP Education Committee 2014 - Present
- ACEP Indiana Councillor 2010 - Present
- ACEP Tellers, Credentials Committee 2010-2013
- ACEP State Leader 911 Network - Present
- ACEP Reference Committee 2010-2013
- ACEP Clinical Policies Committee Informatics Liaison 2004 - 2007
- ACEP Academics Affairs Committee 1999 - 2003
- INACEP Past-President 2014
- INACEP President 2013 - 2014
- INACEP Board of Directors 2009 - Present

SERVICE:

- ABEM Oral Board Examiner
- ABEM Item Writing Committee
- ABEM Case Reviewer
- American Medical Informatics Association Board of Directors

LEADERSHIP **SERVICE** **DATA SCIENTIST**

Endorsed by Indiana ACEP & ACEP Informatics Section

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Jeffrey M. Goodloe, MD, FACEP

***Question #1:* Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Emergency medicine will become more valued for its role in resuscitating, stabilizing, and navigating higher acuity, unscheduled patients. Despite a continuing multitude of attempts to simplify healthcare in the United States, largely for cost containment, with some focused upon improving the patient care experience and/or clinical outcomes, developing integrated networks of care will heavily depend upon emergency physicians throughout all hours of the day.

If history is a sage predictor of future behavior, emergency medicine will retain its "front door to the hospital" status in traditional settings. Emergency medicine is also poised to continue to find developing markets in health care as patients understandably value ease of access, efficient diagnostic capabilities, and effective treatments. Whether within a traditional emergency department or in a developing capacity (e.g. multi-national telemedicine) the emergency physician will always embody the best in patient protection and advocacy.

ACEP is widely, and appropriately, held in regard for advancing not just the science of emergency care, but doing so within the strengths of our humanity, our passions for aiding others on often the worst days of their lives. No future technology in emergency medicine can fully succeed without these strengths, fostered best within the ACEP community.

My skills include being a careful student of history to learn the lessons well from days past to enable us to move with calculated safety and effectiveness into the future. My skills also include being an optimistic futurist, with an open mind, challenging the status quo, in finding answers to the current challenges, and always remaining poised for "the next big thing" that can't yet be anticipated.

Protecting the foundations and responsibilities of the patient-emergency physician relationship, avidly incorporating the perspectives of all generations of leaders in emergency medicine, and always serving with a "What if?" and "How can we?" mindset enables me to help lead ACEP and its members effectively into and through the coming decade.

***Question #2:* Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

Speaking for emergency physicians translates specifically to advocating for emergency physicians. Effective advocacy for emergency physicians is built upon understanding and respecting us. *All* of us.

I'm celebrating 20 years since emergency medicine residency graduation. In my journey as an emergency physician, I've been taught by generalists, other specialists, non-EM residency trained/EM boarded faculty and EM residency trained/EM boarded faculty. These mentors, teachers, and colleagues are female and male, spiritual and not spiritual, and as diverse in interests as I could have ever imagined. I've found valuable medical and life lessons from them all.

I've worked at a rural/small suburban community hospital, with its 16 bed ED and with phone handsets duly worn, proving the frequency of transfers to "the big city" that most often involved more than one conversation (aka persuading, pleading, and/or praying). I've worked at an inner city tertiary referral hospital with an annual ED census soaring past 100,000 patients. I've also worked at larger suburban and even urban hospitals that many assumed were "nice little places to practice emergency medicine" while my partners and I routinely saw 4-5 patients/hour throughout 10+ hour shifts, many with acuities requiring invasive airway management, central lines pre-routine ultrasound guidance, and trauma/STEMI/stroke/sepsis teams that were all comprised of one emergency physician, 2 nurses (if we were lucky), and 1 respiratory therapist (maybe). For the past several years, I've been fortunate to share the benefits of those experiences, while still learning emergency medicine advances daily, as I teach fellows, residents, and medical students in the base hospital for an EM residency and conduct research in a historically medically underserved state.

Also, as an emergency physician, I've built upon my love for pre-hospital care that I discovered as a paramedic in college and medical school years. I've served in EMS for 30 years, 22 of those as a medical oversight physician, currently the clinical leader for over 4,000 credentialled professionals in the metropolitan Oklahoma City and Tulsa areas. I also find professional fulfillment in serving in special events medical planning and on-site coverage, including many NASCAR and IndyCar events as well as law enforcement tactical missions.

Each of these roles – bedside clinician, teacher, researcher, EMS medical oversight leader, special mission clinician - has an axis of being an emergency physician. Add in years of advocacy and service in state and national ACEP and I can't hardly believe what started as a hopeful vision has come to this fulfilling reality.

If you recognize yourself in any of the above, I can effectively help to speak for you. If you don't, I'm sincerely willing to listen so I can better understand and factor your perspectives.

Do we all have continual challenges? Yes. Can we find the answers *together*? Yes. Between our dates of birth and death, we all have a dash. Emergency physicians make positive differences with those dashes. Part of my positive difference is a sincere desire to serve you as a member of the ACEP Board of Directors, speaking for you.

***Question #3:* Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a constituency?**

Neither. ACEP must respect the democracy of medicine itself. Just as other specialty societies respected the formation and now continual advancement of ACEP itself, ACEP must acknowledge and respect the rights and abilities of emergency physicians that form other organizations centered upon our specialty. Simultaneously, ACEP must commit to advocate for all emergency physicians, avoiding unnecessary fractionation among us…all of us.

No 37,000+ member organization can ever speak in unanimity, but sincere and careful adherence to ethics, respect for differences, and responsible, responsive leaders can, and I believe will continue to position ACEP as the leading voice of emergency medicine, for its physicians, and for its patients and communities we are privileged to collectively serve.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Jeffrey M. Goodloe, MD, FACEP

Contact Information

3720 E 99th PL, Tulsa, OK 74137 (Home)
Phone: 918-704-3164 (Cell); 918-298-0502 (Home)
E-Mail: jeffrey-goodloe@ouhsc.edu (Work/Public); jgoodloemd@aol.com (Personal/ACEP staff use)

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

Medical Director, 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
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) Indianapolis, IN

The Medical School at University of Texas Health Science Center at San Antonio (1991-95)

Baylor University – Waco, TX (1987-91)

MD - 1995

Certifications

ABEM Emergency Medicine Initial Certification 1999, Recertification 2009, All MOC components met for 2019

ABEM EMS Medicine Initial Certification 2013, All MOC components current

Professional Societies

ACEP member since 1991 (medical student, resident, fellow, active, FACEP)

OCEP (Oklahoma College of Emergency Physicians – State ACEP Chapter)

NAEMSP

Prior memberships in Texas College of Emergency Physicians, Indiana ACEP Chapter, AMA, Oklahoma State Medical Association, Tulsa County Medical Society, SAEM

National ACEP Activities – List your most significant accomplishments

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, 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: **2750** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **2** % Teaching **10** % Administration **38*** %

Other: ***predominantly EMS medical oversight** ____ %

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 are multiple, including 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 currently partially staffs four emergency departments in Tulsa and Oklahoma City, employing a university academic group/private group collaborative structure. I currently am staff credentialed at Hillcrest Medical Center in Tulsa, the base hospital for the EM residency, though I have been staff credentialed in prior years at two other teaching hospitals in Tulsa. I also serve as the Medical Director for the EMS System for Metropolitan Oklahoma City and Tulsa, clinically leading over 4,000 credentialled 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, motorsports medical support (on-site track physician) for NASCAR and IndyCar events in Ft. Worth, Texas, 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 NAEMSP Annual Meeting, EMS State of the Science – A Gathering of Eagles, and Emergency Cardiovascular Care Update.

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**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE 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. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: Oklahoma College of Emergency Physicians

Address: No physical office address for OCEP – Executive Director is Gabe Graham

gabegraham11@gmail.com

Type of Organization: State Chapter of ACEP

Duration on the Board: Since 2007 continuously and currently

Organization: Emergency Medical Services Authority

Address: 1111 Classen Blvd

Oklahoma City, OK 73103

Type of Organization: Public Utility Model Ambulance Service

Duration on the Board: Ex-officio as Medical Director since 2009 continuously and currently

Organization: Emergency Medicine Residents' Association

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Professional medical association

Duration on the Board: 1995-1998

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Jeffrey M. Goodloe, MD Date July 16, 2018

August 1, 2018

Re: Endorsement for Jeffrey M. Goodloe, MD, FACEP for the ACEP Board of Directors

Dear Councillors

On behalf of the Oklahoma College of Emergency Physicians, I am writing with an enthusiastic endorsement for our current President, Dr. Jeffrey M. Goodloe, to be elected to the ACEP Board of Directors.

Dr. Goodloe is already well known nationally within ACEP, starting prior to his EMRA presidency in the late 1990s and continuing since. He is an active councillor, with past service on the Council Steering Committee and Reference Committees, including chairing a 2012 Reference Committee. He is active in advocacy activities at the federal level, regularly attending ACEP's Leadership and Advocacy Conference, and well-known among Oklahoma's US Representative and Senators. He is an active promoter of our specialty's future in supporting the Emergency Medicine Foundation, recruiting members to the Wiegenstein Legacy Society. He is a voice trusted by ACEP leaders, including multiple ACEP presidents, evidenced in part by a two-year term as Chair of the EMS Committee.

Dr. Goodloe has effectively led the Oklahoma College of Emergency Physicians as a Board Member since 2007 and as President since 2016, helping lead a resurgence in activity and interest at our local level.

Dr. Goodloe moved to Tulsa in the Summer of 2007 and immediately volunteered for service in OCEP. He was promptly elected to our Board of Directors as a councillor, given his experience and expertise representing EMRA for several years in the ACEP Council and his activity within the Texas College of Emergency Physicians. He has represented us well throughout the years, helping our councillors understand the history behind many resolutions and the intricacies often involved when contemplating the full impacts of resolutions on ACEP. He is a consummate team player and leader, encouraging involvement of any OCEP member willing to serve and mentoring younger members. OCEP membership is growing in significant part due to his dynamic vision to make OCEP more effective, more tangible, and more fun!

Dr. Goodloe leads our federal legislative action arm, yet remains very active with our state legislative priorities, testifying at the Oklahoma State House. He formed a coalition of medical specialists, including emergency physicians, internists, stroke neurologists, and EMS professionals to oppose a problematically worded stroke care bill. This coalition was able to effectively then work with the American Stroke Association and Oklahoma legislators to ultimately craft a bill that truly strengthens stroke care capabilities for Oklahomans, from first medical contact by EMTs and paramedics to

President
Jeffrey M. Goodloe, MD, FACEP

Vice-President
James Kennedye MD, MPH, FACEP

Treasurer
Timothy Hill, MD, PhD, FACEP

BOARD
Miranda Phillips, DO, FACEP
Lance Watson, MD, FACEP
Dana Larson, MD, FACEP
Cecilia Guthrie, MD, FACEP
Craig Sanford, MD, FACEP
Jeffrey Johnson, MD
Juan Nalagan, MD, FACEP
Carolyn Synovitz, MD, MPH, FACEP

Executive Director
Gabe Graham, CPA gabegraham11@gmail.com

Jeffrey M. Goodloe, MD, FACEP

Hello, fellow councillors, colleagues, and friends. I'm Jeffrey Goodloe and I'm honored and incredibly excited to be running for the ACEP Board of Directors.

Many we serve are disenchanted with government and industry leaders and/or pundits that opine about them. Truth can seemingly get defined by the holders of facts, whether real or manufactured. This is decidedly not a time to lose momentum in what we believe best advances our beloved specialty. We and our patients deserve good leaders. Energized leaders. Enthusiastic leaders. Ethical leaders. Servant leaders. Strong leaders. Vocal leaders.

Speaking for emergency physicians translates specifically to advocating for emergency physicians. Effective advocacy for emergency physicians is built upon understanding and respecting us. *All* of us.

I'm celebrating 20 years since emergency medicine residency graduation. In my journey as an emergency physician, I've been taught by generalists, other specialists, non-EM residency trained/EM boarded faculty and EM residency trained/EM boarded faculty. These mentors, teachers, and colleagues are female and male, spiritual and not spiritual, and as diverse in interests as I could have ever imagined. I've found valuable medical and life lessons from them all.

I've worked at a rural/small suburban community hospital, with its 16 bed ED and with phone handsets duly worn, proving the frequency of transfers to "the big city" that most often involved more than one conversation (aka persuading, pleading, and/or praying). I've worked at an inner-city tertiary referral hospital with an annual ED census soaring past 100,000 patients. I've also worked at larger suburban and even urban hospitals that many assumed were "nice little places to practice emergency medicine" while my partners and I routinely saw 4-5 patients/hour throughout 10+ hour shifts, many with acuities requiring invasive airway management, central lines pre-routine ultrasound guidance, and trauma/STEMI/stroke/sepsis teams that were all comprised of one emergency physician, 2 nurses (if we were lucky), and 1 respiratory therapist (maybe). For the past several years, I've been fortunate to share the benefits of those experiences, while still learning emergency medicine advances daily, as I teach fellows, residents, and medical students in the base hospital for an EM residency and conduct research in a historically medically underserved state.

Also, as an emergency physician, I've built upon my love for pre-hospital care that I discovered as a paramedic in college and medical school years. I've served in EMS for 30 years, 22 of those as a medical oversight physician, currently the clinical leader for over 4,000 credentialled professionals in the metropolitan Oklahoma City and Tulsa areas. I also find professional fulfillment in serving in special events medical planning and on-site coverage, including many NASCAR and IndyCar events as well as law enforcement tactical missions.

Each of these roles – bedside clinician, teacher, researcher, EMS medical oversight leader, special mission clinician - has an axis of being an emergency physician. Add in years of advocacy and service in state and national ACEP and I can't hardly believe what started as a hopeful vision has come to this fulfilling reality.

If you recognize yourself in any of the above, I can effectively help to speak for you. If you don't, I'm sincerely willing to listen so I can better understand and factor your perspectives.

Do we all have continual challenges? Yes. Can we find the answers *together*? Yes. Between our dates of birth and death, we all have a dash. Emergency physicians make positive differences with those dashes. Part of my positive difference is a sincere desire to serve you as a member of the ACEP Board of Directors, speaking for you.

JEFFREY M. GOODLOE, MD, FACEP

For ACEP Board of Directors

Accountable
service
Consensus
builder
Enthusiastic
commitment
Proven
leadership

Council Steering Committee Member
Council Reference Committee Chair
EMS Committee Chair
State Chapter President & Councillor
Past EMRA President & Councillor

Proudly endorsed by:

Oklahoma College of Emergency Physicians

Jeffrey M. Goodloe, MD, FACEP

1145 S. Utica Ave, Suite 600 | Tulsa, OK 74104 |918-704-3164 (Cell)

jeffrey-goodloe@ouhsc.edu

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Christopher S. Kang, MD, FACEP, FAWM

***Question #1:* Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Three years ago, I predicted that the next decade would mark a dynamic and historic time of opportunity for our College as emergency medicine transitioned from fighting for acceptance by the members of the House of Medicine, to being recognized as one of their leaders. That transition is now underway. As a newly emerged leader at a time when healthcare has become increasingly complex, subject to greater scrutiny, and factionalized, our College must undertake new challenges and responsibilities, engage its internal and external critics, and respect competing priorities with fewer resources. It is essential that the College continue to have experienced, strategic, and visionary leaders.

For 25 years, I have practiced in a variety of settings around the world, from austere environments and the back of ground and air ambulances, public health to mass casualty events, and in rural facilities and modern medical centers. As Medical Project Director for an ACEP grant, I visited and evaluated the disaster preparedness of dozens of hospitals and agencies across the country. Over the past three years, I have represented the College at state and national meetings with other professional, industry, and government organizations. Trust and respect have been earned, individual and specialty relationships developed, and the foundations for future collaboration fortified. I would like to continue to build upon these advancements.

As a military officer, I became proficient with strategic planning and management – assessing the context of a situation, setting common objectives, identifying resources, foreseeing contingencies, and adjusting plans in response to changing priorities and conditions. As research director, I objectively studied proposals, reviewed current literature, and critically evaluated data. As a result, I can rapidly interpret and effectively employ those analyses.

As President, I led the Washington Chapter as it transitioned from a small to medium chapter and its emergence as a leading resource for the College for several critical initiatives, including repudiating psychiatric boarding, curtailing opioid use and deaths, improving patient care coordination, and advocating for user-oriented clinical information sharing technologies. Also, programs for resident physician liaisons and past state leaders were started, greater engagement with state emergency nursing and medical associations fostered, and the recruitment and mentorship of future chapter leaders expanded. I have continued to seek out and serve as advisor and mentor to several generations of College members at the section, committee, chapter, and national levels. Cultivating tomorrow's emergency medicine leaders is just as important as confronting today's issues.

These skills and track record make me uniquely qualified to continue to lead the College's efforts to better serve our patients, members, and profession and to successfully sustain its role as the leader of emergency medicine and the House of Medicine.

***Question #2:* Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

My continued service on the Board of Directors would advance the College's ability to speak for all emergency physicians because of my affinity and ability to see from and appreciate diverse perspectives that stem from my personal background and professional career and which are evidenced by my College service.

I spent my childhood in Asia, North America, and Europe, where I was sometimes a member of the majority, sometimes the minority. Since medical school, I have observed and practiced a wide range of medicine in various settings across the country and around the world, including Asia, Central America, and the Middle East. I welcome and respect different values, cultures, and clinical practices.

Professionally, my career reflects the diversity of the practice models of emergency medicine. I work at a federally-operated medical center and for an independent group in a community hospital. I also serve on the faculty of an accredited emergency

medicine residency and emergency medicine physician assistant fellowship program. My responsibilities have included advisor, curriculum development, didactic and simulation instruction, research director, faculty development, and liaison to other departments and hospitals. Both jobs provide me first-hand experience with different patient populations, levels and generations of emergency medicine providers, healthcare systems, and employment and reimbursement models.

Within the College, I have solicited the counsel of past leaders and advised resident physicians, junior members, and committee and chapter leaders. I have assisted the composition, presentation, and adoption of numerous Council resolutions, some of which involved emerging and contentious issues. Over the past three years, I have visited multiple chapters and sought out and served as a liaison to numerous College sections to learn more about and foster your interests. I have also represented the College at state and national meetings with other professional, industry, and government organizations. Trust and respect have been earned, individual and specialty relationships forged, and the foundations for future collaboration cultivated. Continued appreciation for and inclusion of you will enhance patient care and rapport, fortify membership identity and contentment, and promote the growth and maturation of our specialty.

As a result of my unique background and career, I can and will continue to represent and advocate for emergency physicians and their clinical practices, interests, and priorities to advance quality emergency care and the evolution of our profession.

***Question #3:* Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

Our College should and must continue to represent, advocate for, and lead one constituency – emergency medicine.

Our College will achieve this mission by doing three things,
1. Remain devoted to advancing quality emergency patient care – patients first should always be our foremost professional responsibility;

2. Continue to have the mechanisms and resources to represent, promote, and inspire emergency physicians' interests, practices, and advocacy – they are essential to the growth, evolution, and success of our specialty; and,

3. Conduct itself and lead with fidelity, integrity, and sincerity – although sibling rivalries will occasionally arise with various emergency medicine members and organizations because of contrasting priorities, trust and respect will be earned by and successful collaboration within and outside of emergency medicine will ensue for our College and emergency medicine family.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Christopher S. Kang, MD, FACEP, FAWM

Contact Information

2184 Bob's Hollow Lane, DuPont, WA 98327
Phone: (253) 964-1445
E-Mail: Christopher.s.kang@gmail.com

Current and Past Professional Position(s)

Current Employment
1. Department of Emergency Medicine, Madigan Army Medical Center, Tacoma, WA (2001-Present)
   Faculty, Emergency Medicine Residency, Madigan Army Medical Center
2. Olympia Emergency Services, PLLC, Providence St. Peter Hospital, Olympia, WA (2007-Present)

Past Employment
1. Mt. Rainier Emergency Physicians, PLLC, Good Samaritan Hospital, Puyallup, WA (2004-2005)
2. Emergency Medical Services, 121st General Hospital, Yongsan, Seoul, Republic of Korea (2000-2001)

Academic Appointments
1. Assistant Professor, Adjunct, Uniformed Services University of the Health Sciences (2008-Present)
2. Assistant Professor, Clinical, University of Washington (2006-Present)
3. Assistant Professor, Physician Assistant Program, Baylor University (2008-Present)
4. Clinical Instructor, University of Washington (2002-2006)

Additional Emergency Medicine-Related Positions and Responsibilities
1. Peer Manuscript Reviewer, Annals of Emergency Medicine (2013-Present)
2. Disaster Clinical Advisory Council, Northwest Healthcare Response Network (2013-Present)
3. Peer Manuscript Reviewer, Journal of Wilderness and Environmental Medicine (2008-Present)
4. Peer Manuscript Reviewer/Section Co-Editor, Western Journal of Emergency Medicine (2007-Present)

Additional Professional Positions and Responsibilities
1. Institutional Review Board, Madigan Army Medical Center (2006-Present)
2. Research Director, Emergency Medicine Residency Program, Madigan Army Medical Center (2006-2015)
3. U.S. Army Safety Center Accident Investigation Board, Iraq (2004)
4. Field Surgeon, 2-3 Stryker Brigade Combat Team, Iraq (2003-2004)
5. Flight Surgeon/Emergency Treatment Physician, Joint Task Force Bravo, Honduras (2002)
6. Patient Safety Committee, Madigan Army Medical Center (2001-2003)
7. Instructor, ACLS (2001-Present)
8. Instructor, PALS (2001-Present)
9. Battalion Surgeon and Flight Surgeon, 52nd Medical Battalion, Republic of Korea (2000-2001)

Education (include internships and residency information)

Residency: Emergency Medicine, Northwestern University (1996-2000)
Medical School: Northwestern University (1992-1996)
Undergraduate: Northwestern University (1989-1992)

Doctorate of Medicine, Northwestern University (1996)

Certifications

Emergency Medicine, American Board of Emergency Medicine (2001, Recertification 2011)
Fellow, Academy of Wilderness Medicine (2009)

Professional Societies

American College of Emergency Physicians (1993-Present)
- Washington Chapter
- Government Services Chapter
- Prior Chapter – Illinois
- Sections – Disaster Medicine, EM Locum Tenens, EM Research, Pain Management, Wilderness Medicine
- Prior Sections – EM Informatics, Forensics

American Academy of Emergency Medicine (2018)
Society for Academic Emergency Medicine (2012-Present)
American Medical Association (2014-Present)
Washington State Medical Association (2007-Present)
Wilderness Medical Society (2002-Present), Fellow in Academy of Wilderness Medicine (FAWM)
U.S. Army Society of Flight Surgeons (2000-Present)

National ACEP Activities – List your most significant accomplishments

Board of Directors (2015-Present)
- Liaison - Disaster Preparedness and Response Committee (2015-Present)
- Liaison - Ethics Committee (2016-Present)
- Liaison - American College of Surgeons, Committee on Trauma (2016-Present)
- Chair, Workgroup for EM Workforce Initiative
- 50th Anniversary Task Force
- Section Liaison - Air Medical Transport, Disaster Medicine, Event Medicine, Undersea and Hyperbaric Medicine, Wilderness Medicine

Council Steering Committee (2013-2014)
Council Reference Committee (2012)
Chair, Disaster Preparedness and Response Committee (2013-2015)
National Chapter Relations Committee (2014-2015)
Secretary and Chair Elect, Disaster Medicine Section (2011-2015)
Survey Team Member and Project Medical Director, ACEP-DHS-FEMA Community Healthcare Disaster Preparedness Assessment Grant Project (2006-2012)
Advisor, Emergency Medicine Basic Research Skills Course (2009-Present)
EMF – Wiegenstein Legacy Society, 1972 Club
NEMPAC – Give a Shift Donor 5+ Years
911 Legislative Network
InnovatED Code Black (2013-2015)
Emergency Medicine Practice Research Network

ACEP Chapter Activities – List your most significant accomplishments

Washington Chapter
- Treasurer, President Elect, President (2013), Immediate Past President
- Board of Directors (2010-Present)
- Councillor (2010-2015)
- Education Committee (2008-Present), Chair (2011-2012)

Practice Profile

Total hours devoted to emergency medicine practice per year: **1948** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **10** % Teaching **35** % Administration **5** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

1. Department of Emergency Medicine, Madigan Army Medical Center, Tacoma, WA
   Federal Government Employee, Civilian
   Military Medical Center - Level II State Trauma Center, State Cardiac Center, State Stroke Center
   Direct Patient Care, Faculty for Emergency Medicine Residency and Emergency Medicine Physician Assistant Fellowship Programs
2. Providence St. Peter Hospital, Olympia, WA
   Part-Time Employee, Non-Partner of Independent Group
   Community Hospital – Level III State Trauma Center, State Cardiac Center, State Stroke Center
   Direct Patient Care

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Christopher S. Kang, MD, FACEP, FAWM

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Department of the Army, Madigan Army Medical Center

Address: 9040 Fitzsimmons Boulevard

Tacoma, WA 98431

Position Held: Attending Physician

Type of Organization: Federal Government

Employer: Olympia Emergency Services, PLLC

Address: 413 Lilly Rd NE – Providence St. Peter Hospital

Olympia, WA 98506

Position Held: Attending Physician

Type of Organization: Independent Emergency Medicine Group

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: Washington Chapter, American College of Emergency Physicians

Address: 2001 6th Avenue, Ste 2700

Seattle, WA 98121

Type of Organization: Non-Profit Professional Medical Organization, Emergency Medicine

Duration on the Board: 2010-Present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

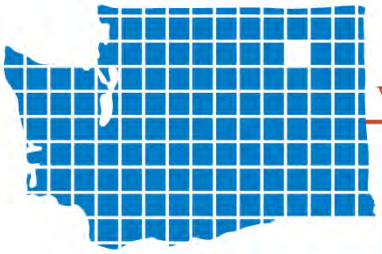
☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Christopher S. Kang, MD, FACEP, FAWM Date 9 July 2018



WASHINGTON CHAPTER American College of
ADVANCING EMERGENCY CARE Emergency Physicians

Aug. 6, 2018

Dear Members,

Please accept the Washington Chapter of the American College of Emergency Physicians' wholehearted endorsement of the candidacy of Christopher Kang, MD, FACEP for re-election to the American College of Emergency Physicians' National Board of Directors.

The state of Washington has been fortunate to have Chris as a leader for many years. Dr. Kang has made a career of serving his country in the Army for many years, including serving as residency research director at Madigan Army Medical Center, in addition to deployments all over the world. He has extensive experience in pre-hospital care, aviation medicine, disaster and emergency preparedness, wilderness medicine, and research. As member of Washington ACEP, Chris has truly done it all. Chris has lead state legislative efforts on opiate policy, psychiatric boarding, and reimbursement. While serving as chapter president, he organized the state chapter effort to host ACEP13, which was a very successful conference. He created our resident liaison program, and has mentored many Washington ACEP members to successful roles at the state and national level. Beyond his accomplishments, two qualities defined Chris Kang: he is an incredibly effective leader who gets things done, and he does it with the utmost humility, the ultimate team player who would rather promote others than get the credit himself.

Since his election to the national board of ACEP, Chris Kang has continued to be an important voice for emergency medicine. When the Ebola epidemic hit, Chris assisted with the publication of an article on Ebola in the *Annals of EM*. He is currently working on the Playbook for Social Media in the College. Because Chris is such an effective communicator, he serves in multiple liaison roles for the Board of Directors. He was also previously Chair of the Disaster Preparedness and Response Committee. Chris is an exemplary role model, who will help mold the next generation of leaders within ACEP.

The Washington Chapter is proud of the leadership that Chris Kang has brought to the Board of Directors. I hope that all ACEP members will give him the strongest consideration in re-election to the ACEP Board of Directors.

Sincerely,

Liam Yore, MD, FACEP
Washington ACEP President

Christopher S. Kang, MD, FACEP, FAWM

Dear Colleagues,

It is a privilege to have been selected to be a candidate for your Board of Directors.

As you assess each candidate, please consider the following four attributes that may attest to the type of Board member I will be if elected that may not be gleaned from the written responses, data sheets, and disclosure statements.

Awareness. Having been a history major, I incorporate lessons from past events and counsel from senior leaders. Because of my travels, I welcome and respect different values and points of view. Ingrained from my military service, I constantly seek to know and learn about what is and will be happening around me. As a result, I analyze issues from several perspectives and timelines to make decisions in the best interest of the College.

Strategic. I strive to plan ahead. However, when unfamiliar with an issue, I diligently do my homework, consult more knowledgeable peers, and organize the resources at hand. Then, I assess multiple scenarios and their impacts to determine the optimal timing and strategy for success.

Accountability. I treat everyone with respect and in the manner I want to be treated. I will not ask others to complete a task without sufficient guidance and resources, and that I have not done or would not do myself. If successful, the team members receive the credit, praise, and opportunity to grow. If not successful, it is my responsibility.

Character: For those who do not know me, please talk with anyone with whom I have worked. Ask them to describe me, how and why I did my work, and about my successes and mistakes. It is my hope that integrity, service to others, mentor, and steadfast loyalty to the College and its members are among the words mentioned.

As we celebrate our College's 50th anniversary, it is essential for us to appreciate those who have led us to this milestone and what has been achieve thus far. It is equally as important to recognize the increasingly complex issues and challenges ahead as well as those who will lead our College into the next 50 years.

If the above resonates with you and exemplifies the type of Board of Director member you want and that our College and specialty needs, please entrust me with your vote and the opportunity to serve, work with, and represent you.

Sincerely,

Christopher S. Kang, MD, FACEP, FAWM

As we celebrate our 50th anniversary and leadership within the House of Medicine, our College needs continued visionary leadership that:

- Cultivates the innovation and priorities of the next generation while also respecting the work and wisdom of our founders;
- Promotes the occupational and professional well-being of its members;
- Fosters broader member engagement and leadership at local and national levels;
- Empowers and collaborates with chapters and other organizations with the challenges we face;
- Restores the autonomy and prestige of our profession.

I will be that leader.

Christopher Kang, MD, FACEP, FAWM

Leadership: Dynamic • Veteran • Servant

For Re-election to 2018 ACEP Board of Directors

Past Service:

- Board of Directors
- Washington Chapter President
- Council Steering Commitee
- Chair, Disaster and Preparedness Committee
- National Chapter Relations Committee
- Council Reference Committee
- Liaison, Ethics Committee
- Liaison, Multiple Sections
- Wiegenstein Legacy Society
- Medical Director, ACEP/DHS Grant
- Residency Research Director
- Multiple Academic Faculty Appointments

Christopher Kang, MD, FACEP, FAWM

For Re-election to 2018 ACEP Board of Directors

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Michael J. McCrea, MD, FACEP

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

There will always be external challenges to emergency medicine: new federal and state regulations, practice care guidelines written by other specialties that affect us in the ED. Yet whenever this happens, we do what we do best: prepare as best we can for the unknown and be ready to act against whatever may come. Issues will arise for which we may be unprepared, or even could not have predicted. Sometimes those issues will be something on which I am a context expert but oftentimes not. I have learned through my time with state and national ACEP, our residency program, and in my involvement on multiple hospital committees, how important it is to ask for more information when you need it. I have demonstrated that I will put in the work to help guide action. In such times leadership and careful deliberation are of utmost importance before action.

During my second term as Ohio ACEP President, such an unforeseen and unprecedented event occurred: the contract change involving the Akron Summa EM residency. Never before had a residency program been so affected by a group contract change, ultimately resulting in the loss of ACGME accreditation and closure of the program. There were calls for Ohio ACEP to act swiftly, to do "something," but we did not know what that should be. To ensure that our Board could make an informed decision, I spent hours listening to our members from both groups, the chief residents of the Summa program, and many past leaders and mentors within the Ohio Chapter. I felt mounting pressure that we must speak out, but for whom, and what should we say?

What I learned most from the experience is that sometimes patience and restraint are more important than being heard first. Other organizations released statements before Ohio ACEP, for which I was criticized. And yet, taking an extra half-day, not rushing a response, proved the most prudent course in the end. For our Chapter statement embodied the message of who we were: a Chapter that represents all practicing emergency physicians, residents, and patients. This is the skill set I believe I have to help keep ACEP in the forefront: deliberation, thought, hard work, and never forgetting that we serve our patients and communities.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

My voice is your voice. I have worked in an eight-bed critical access ED. I have worked in a sixty-bed urban tertiary care center. I have been a community medical director of a single coverage rural ED. I am an assistant program director supervising forty-two EM residents. I have been a democratic partner, an independent contractor, and an employee of a contract medical group. Although I am core faculty for our residency, I still work in the community without residents at a single coverage ED within our health system. Currently I am a teacher and mentor to residents and medical students, but I have never forgotten my roots in the community, fresh out of residency, just trying to get through the rack. I bring this varied and shared experience to my leadership

This diverse background of practice experiences allowed me to speak and advocate for EM physicians in Ohio during my two terms as Ohio ACEP President. Having worked in nearly all practice environments provided me with first hand insight into the issues that face emergency physicians. When I met with legislators or government officials, my personal experience gave real credibility to our message as I spoke for emergency physicians in Washington, D.C. or in our state capitol. I have testified before the Ohio House of Representatives on multiple occasions and I have developed personal relationships with the state and national officials from my district. Those relationships began at ACEP's Leadership and Advocacy Conference and Ohio ACEP's Advocacy Day. I have learned and seen firsthand the value of our advocacy. Although Ohio ACEP is widely known for our education courses, it is advocacy that ranks number one in importance to our chapter members every year on the chapter member survey.

Yet we must not forget that ACEP speaks for EM residents in training and medical students as well as the practicing physician. During my tenure on the Ohio Chapter Board, we separated our resident assembly from our annual member meeting into a standalone event to emphasize the importance of resident members in our Chapter. This year I authored a bylaws amendment for our Chapter to designate one Ohio councillor seat for a resident. It passed unanimously at our annual meeting. For the past four years I have chaired a new event, the Midwest Medical Student Symposium, for medical students interested in EM. Our medical student membership has grown as a result. Working daily with residents and medical students allows me to respond to these members' needs as well.

Our members want voices that listen to their needs, speak for them, and advocate for our profession and our patients. My experiences have refined my voice and demonstrated that I can speak confidently for all current and future emergency physicians as a member of the ACEP Board of Directors.

***Question #3:* Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

This seemed like a simple question for me. I had always felt the same way going back to residency: that emergency medicine should only be practiced by residency trained, board certified emergency physicians. However perspective, maturity, and most of all, recent events in the College have caused me to re-examine exactly this question.

While struggling with this issue, I sought guidance from our College "Mission, Vision, and Values" and ACEP's definitions of "Emergency Medicine" and an "Emergency Physician." I'm pretty sure that I had read them before, but only now have I truly thought about these guiding principles for what ACEP is, who we are, and whom we represent. If you haven't read them recently or, gasp, ever, please do so. If you're feeling really adventurous, read the College Bylaws' section on membership too. One of my friends just yelled "nerd alert," but I'm on the Bylaws Committee, so I think I'm obligated to plug the Bylaws whenever I can. Joking aside, without knowing our defining principles and guiding policies, how can we possibly have an informed conversation on the topic as important as "Who does ACEP represent?"

When a non-EM boarded physician works in an ED, she or he does not introduce herself or himself as "I'm the NOT emergency physician today but I'll be taking care of you anyway." The bright red, all-capital-letter, "EMERGENCY" sign out front does not rotate to something else when a non-EM boarded physician is working. Regardless who is working: be it a residency-trained, board-certified Emergency physician; a physician boarded in something else; or in some states, a non-physician advanced practice provider, patients have the expectation and right that they will receive "the highest quality of emergency care." When we travel to Washington, D.C. each spring for ACEP's Leadership and Advocacy conference, we never couch our legislative agenda with the following caveat: "but we only want this legislation to apply to EM-boarded docs who pay ACEP dues."

Until recently, I had never thought of it this way. We advocate for everyone who works in an emergency department, whether they are members of ACEP, someone who is eligible for ACEP membership but for whatever reason has chosen not to join or renew, or a provider who is not eligible. Anyone who sees patients "dedicated to the diagnosis and treatment of unforeseen illness or injury" benefits from the tireless work and advocacy done by the College, from our clinical policies and policy statements, to committee and Board white papers that help guide all facets of emergency medicine.

I have worked with non-EM trained physicians in the community. As a community medical director, I never could have filled our schedule in our rural ED without them. They cared for patients in the same rooms with the same problems as I did. I took their sign-outs and they took mine. I came to realize how could I not see them as emergency physicians, albeit our different backgrounds and paths?

And yet, on the opposite end of the spectrum, I am an assistant residency director for forty-two residents and future board-certified emergency physicians. I unequivocally believe that dedicated training in emergency medicine following the Core Content model is important and must be valued. Residency training and board certification in emergency medicine are the ideal and highest achievement in our specialty.

So if I cannot reconcile these two conflicting issues for myself, how can ACEP? Is it quixotic to think that someday all patients seen in an ED will be cared for by an EM-boarded physician? Probably, but such a goal does not mean it should not be an ideal for which we continue to strive even if we never achieve it. However, until that day, and that may never come, I now believe that ACEP must find a way to represent all physicians who care for patients in an ED. I don't have that solution yet, but I look forward the possibility of helping ACEP accomplish this goal.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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)

Mercy Emergency Care Services, Team Health
Lucas County Emergency Physicians, Inc., Premier Physician Services
Attending Physician and Core Faculty, September 2009 - Present

Emergency Professionals of Ohio, Inc., Team Health
Staff Physician, July 2017 - Present

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

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

Certifications

American Board of Emergency Medicine
Initial certification 2008, renewed 2017

Professional Societies

American College of Emergency Physicians
Ohio ACEP
American Academy of Emergency Medicine
Council of Residency Directors
American Medical Association
Ohio State Medical Association

National ACEP Activities – List your most significant accomplishments

Council Steering Committee, 2016-17
Bylaws Committee, 2015 – current
State Legislative and Regulatory Committee, 2012 – current
Council Horizon Award recipient, 2014
Council Tellers, Election, and Credentials Committee, 2013-16
Council Reference Committee, 2012
ACEP Teaching Fellowship alumnus 2010-11 class

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 – current
Chair, Midwest Medical Student Symposium, 2016 – current
Councillor, 2011 – current
Course Co-Director, Oral Board Review Course, 2012-17
Faculty, Emergency Medicine Review Course, 2011 – current

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 **60** % Research **<1** % Teaching **40** % Administration **0** %

Other: _____ ____%

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 and assistant program director, 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 as an independent contractor

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**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Michael J. McCrea, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Mercy Emergency Care Services, Inc. Team Health

Address: 2213 Cherry St

Toledo, OH 43608

Position Held: Attending physician

Type of Organization: Employee model

Employer: Emergency Professionals of Ohio, Inc, Team Health

Address: 7123 Pearl Rd

Middleburg Heights, OH 44130

Position Held: Staff physician

Type of Organization: Independent contractor model

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: Ohio Chapter ACEP

Address: 3510 Snouffer Rd

Columbus, OH 43235

Type of Organization: Professional medical association

Duration on the Board: 2011 - current

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 graduates

Duration on the Board: 2017 – current

Organization: University of Toledo College of Medicine Alumni Affiliate

Address: 2801 W Bancroft St, MS 301

Toledo, OH 43606

Type of Organization: Alumni society for MCO/UT medical school graduates

Duration on the Board: 2014 - current

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Michael James McCrea, MD, FACEP Date 6/14/18

Ohio ACEP
American College of Emergency Physicians
Advocacy | Education | Leadership

The Board of Directors of the Ohio Chapter, American College of Emergency Physicians is proud to endorse our friend and colleague, Michael J. McCrea, MD, FACEP for election to the ACEP Board of Directors.

The Ohio Chapter has benefited immeasurably from Dr. McCrea's participation on our committees and Board of Directors (2010-present). He has served on Chapter committees, including Government Affairs and Education, and served the Chapter two terms as President (2015-2017), where his strategic focus and leadership was deeply appreciated. While extremely active with the Chapter's educational programs as a contributing faculty member, 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. 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. Dr. McCrea was awarded, by Ohio ACEP, the 2017 *Bill Hall Award for Service,* the chapter's highest honor for service with distinction.

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 Bylaws Committee 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 2014 when he received the Council Horizon Award. His commitment to Council and mentoring future leaders led him to develop for the Chapter "The First-Timers Guide to Council," a guide for encouraging ACEP service. 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 a member of the ACEP Board of Directors.

The Ohio Chapter ACEP proudly endorses Michael J. McCrea, MD, FACEP for election to the ACEP Board of Directors.

Sincerely,

John Queen, MD, FACEP
Chapter President

Ohio ACEP Executive Committee

President
John R Queen, MD, FACEP

President-Elect
Bradley D. Raetzke, MD, FACEP

Treasurer
Ryan Squier, MD, FACEP

Secretary
Nicole A. Veitinger, DO, FACEP

Immediate Past President
Purva Grover, MD, FACEP

Executive Director
Laura L. Tiberi, MA, CAE

Ohio ACEP Board of Directors

Eileen F. Baker, MD, FACEP

Dan C. Breece, DO, FACEP

B. Bryan Graham, DO

John L. Lyman, MD, FACEP

Thomas W. Lukens, MD, PhD, FACEP

Daniel R. Martin, MD, FACEP

Michael J. McCrea, MD, FACEP

Matthew J. Sanders, DO, FACEP

Ryan Squier, MD, FACEP

Thomas A. Tallman, DO, FACEP

Brooke Pabst, MD, EMRO Rep

3510 Snouffer Road, Suite 100, Columbus, Ohio 43235
Phone: (614) 792-6506 | TollFree: 1 (888) 642-2374 | Fax: (614) 792-6508
www.ohacep.org

Michael J. McCrea, MD, FACEP

Fellow Councillors:

Fifteen years ago I chose emergency medicine to be my career. As a medical student, I could not have foreseen that teaching residents and my work with ACEP advocating for our patients and our specialty would become my two professional passions. Today I am asking you to elect me to your ACEP Board of Directors.

It was through education that I became involved with Ohio ACEP but also where I first learned that I have a passion and skill for advocacy. My varied practice experience provides me insight into issues affecting all emergency physicians. During my two terms as Ohio Chapter President, I helped to defeat an out-of-network billing issue and have advocated recently for a bill that has already passed the Ohio House to extend our state's "I'm sorry" liability statute.

Through my commitment to our Chapter I have mentored future leaders. I created an insider's guide for first-timers to Council and LAC. As Chapter President I sought to better engage and address our practicing members concerns and created a membership committee. I also focused on future members by assisting in the development of a standalone Resident Assembly. I have chaired the Midwest Medical Student Symposium since it's inception.

I am unafraid to ask difficult or unpopular questions during debate. In fact, we need fresh ideas, innovation, and debate to move good solutions forward. I facilitate the conversation during meetings to ensure that differing viewpoints are heard. My leadership commitment is to moderate the conversation towards consensus for the betterment of our members.

We face real threats to the prudent layperson standard from multiple insurers across the country, non-evidence based metrics and regulations, and ever-mounting bureaucratic obstacles leading to burnout. We need to stand strong together, unified as emergency physicians celebrating our 50th anniversary as the American College of Emergency Physicians. We must always remind ourselves that we serve our members for the benefit of our specialty and our patients.

I know from my proven leadership, my passion for advocacy, and my commitment to membership, that I can help find solutions to these issues and whatever may come. I would be honored to serve you on the ACEP Board of Directors.

I look forward to seeing you in San Diego.

Michael McCrea, MD, FACEP
mmccrea2@gmail.com
614-975-5370

MICHAEL McCREA, MD, FACEP

FOR ACEP BOARD OF DIRECTORS

SERVICE TO ACEP

ACEP & COUNCIL

- Steering Committee
- Bylaws Committee
- Recipient, Council Horizon Award
- State Legislative and Regulatory Committee
- Tellers, Election, and Credentials Committee
- Reference Committee
- Alumnus, ACEP Teaching Fellowship

OHIO CHAPTER ACEP

- Two-term Chapter President
- Board of Directors
- Recipient, Bill Hall Award for Service to Ohio ACEP
- Medical Education Advisory Committee
- Government Affairs Committee
- Course Faculty
  - Co-Director and Examiner, Oral Board Review Course
  - Instructor, Written Board Review Courses
  - Instructor, LLSA Review Course
- Chapter Editor
  - *Dr. Carol Rivers' Written Board Review Materials*
  - *Dr. Carol Rivers' Oral Board Review Materials*
- Graduate, Leadership Development Academy
- ACEP Councillor

PROFESSIONAL

- Assistant Program Director and Simulation Education Director, Mercy St. Vincent Medical Center EM Residency
- Rural ED Medical Director
- Community Trauma Center ED Assistant Medical Director

PROUDLY ENDORSED BY:

Ohio ACEP
American College of Emergency Physicians
Advocacy | Education | Leadership

PROVEN LEADERSHIP. EFFECTIVE ADVOCACY. COMMITMENT TO MEMBERSHIP.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Mark S. Rosenberg, DO, MBA, FACEP

***Question #1:* Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Emergency medicine is not going away. Not during my lifetime and not during yours. One thing for sure, there will be changes. During the years ahead, the impact of legislators, insurers, lobbyists, and changing demographics will continue as well as the paradigm shift from a medical model to a population health model of medicine. Emergency medicine will continue to expand diverse delivery options such as mobile care units, telemedicine, free standing mental health emergency centers, and urgent care centers to name a few. Some changes may be based on new diseases, viruses, or epidemics. New inventions such as self-driving cars may increase the number of car accidents or decrease them. New medications may change the infectious disease landscape. New treatments for addiction, cardiovascular disease, stroke, and cancer may change delivery systems. Value-based payment models and bundled payment strategies are already changing reimbursements. Recent numbers show that Emergency Department (ED) visits are decreasing nationwide and the use of advanced practice providers is on the rise. In the future, it is possible that we will have all of the emergency physicians necessary to fill all of ED slots. A workforce analysis is critical as it may affect how our residency programs function, possibly necessitating changes in emergency medicine curriculums. It is impossible to know all of the changes that will happen.

So, the question is how will my skill set place ACEP successfully in the forefront over the next decade. My career has been a lifelong process of learning. It has been a process of learning to negotiate with different departments within a hospital, expanding to community partners and government leaders. Emergency medicine has been my first and only love from my first rotation years ago. Throughout my career, I have worked in a variety of different environments including academics, private emergency department practice, inner city, and suburban settings. I have been president and CEO of a large, national emergency medicine practice management company as well as the sole owner of a small emergency department group. I am currently an employed physician at St Joseph's Health where I am Chairman of Emergency Medicine and Chief Innovations Officer.

I understand the national landscape from being on the ACEP board for the past three years. I understand the state landscape from being active in New Jersey ACEP for more than a decade. This can be an exciting time for us as we need innovation, and that's what I do. Over the past decade I have started several programs in the ED including palliative care, Geriatric Emergency Departments and the Alternative to Opioids (ALTO) program which is on its way to becoming national legislation and was already passed by the House of Representatives. All of these programs provide necessary resources for emergency physicians to help provide better patient care and better outcomes. Creating these programs helps to address the evolving needs of our populations but also requires collaboration with community leaders, senators, congressmen, and other government representatives. This type of collaboration keeps ACEP at the legislative table as a leading voice for emergency care.

***Question #2:* Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

In the very beginning, my mentor told me to join ACEP for life and that is exactly what I did. I have been a member ever since 1979. I have served on the council, committees, and task forces and was elected to the ACEP Board in 2015.

During my career I have had the opportunity to work in small community hospitals as well as large medical centers. I have experience working with large, national companies as well as small groups. I have had the privilege of owning my emergency medicine practice management company as well. Currently, I am employed as Chairman of Emergency Medicine and Chief Innovations Officer in a teaching hospital with an emergency medicine residency program. Emergency medicine residents are mirrors of our profession. They question the status quo, verbalize obstacles and barriers, and communicate opportunities to improve our practice. We have the opportunity to listen, discuss, collaborate, and innovate throughout our department, hospital, and community. We learn from each other.

Through my work with ACEP as well as my work within my hospital community, I have found myself collaborating with senators and congressman on issues of importance to emergency physicians such as out of network billing, access to care and population health issues. I have found that I am not shy and have a love affair with the microphone. I have learned not to talk for the sake of talking but to have a goal and know what needs to be said. I have been successful most recently with legislation for an alternative to opioid (ALTO) program in my home state of New Jersey and is now on its way to becoming national legislation. The ALTO program is an example of our discipline adapting to the needs of our communities. We remain that safety net across the country.

I remember where I started. I remember staying up all night wondering what I could have done differently when I have lost a patient. At this point in my career, I am up all night wondering what I can do for our college and how best can I serve. I believe I enhance ACEP's ability to speak for all emergency physicians because of my diverse practice experiences, my activities with ACEP, and my genuine love and respect for our profession. Thank you.
.

***Question #3:* Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

The question of whether ACEP should be an umbrella organization or to represent a particular constituency requires serious discussion. However, time is of the essence. Over the years Emergency Medicine has become divided and that is just the nature of our specialty as it matures and grows. I think we all realize that as emergency physicians we have more in common than not. Our specialty started with us as a unified college and ACEP has become the largest EM professional organization with more than 37,000 members, even as a many of our members belong to multiple EM organizations.

I believe the House of EM is stronger as one unified voice on issues of vital importance. To that end, I recommend that an EM Council be created to include representatives from each emergency medicine organization and foundation. This council's mission would be to find the common ground and identify areas that divide EM. This forum would allow for the leadership, and collaboration necessary to debate concerns of today such as protecting EM as an essential health care benefit or the prudent layperson standard. Ultimately, the EM Council would be the sounding platform for the house of EM in which we need to survive the harsh practice environment and allow us to speak with one voice and one message.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Mark S. Rosenberg, DO, MBA, FACEP

Contact Information

38 North Ridge Road Denville, NJ 07834
Phone: 9732240570
E-Mail: mrosenberg@acep.org

Current and Past Professional Position(s)

CURRENT POSITIONS

Chairman, Emergency Medicine – 2008-Currently
Chief Innovation Officer (CINO) – 2017-Currently
Associate Professor Emergency Medicine
St Joseph's Health, Paterson NJ

Board of Directors - American College of Emergency Physicians (**ACEP**)
Board of Directors - Emergency Medicine Foundation (**EMF**)
Pain Management Task Force - U.S Department of Health & Human Services (**HHS**)
Pain Task Force - Institute of Healthcare Improvement (**IHI**)

PAST POSITIONS

Chief Population Health - – St Joseph's Health Paterson NJ
Chief, Geriatric Emergency Medicine 2009 to 2015 – St Joseph's Health Paterson NJ
Chief, Palliative Medicine 2010 to 2015 – St Joseph's Health Paterson NJ
President and CEO, Evergreen Emergency Solutions, Contract Management Group, FL and NJ – 2004 - 2008
President PhyAmerica Physician Services, Contract Management Group, Ft Lauderdale, FL – 1997 - 2004
Vice President of Medical Affairs, Coastal Physician Services – 1995 – 1997
Chief, Emergency Services, The Germantown Hospital and Medical Center, Philadelphia, PA – 1993 - 1997
Director of Emergency Services, Roxborough Memorial Hospital, Philadelphia, PA – 1987 - 1993
Director of Emergency Services, Metropolitan Hospital - Parkview Division, Philadelphia PA – 1982 – 1986

Education (include internships and residency information)

Masters, Business Administration in Medical Management
St. Joseph's University
Philadelphia, Pennsylvania 19131
1990 to 1995

Internship and Residency, Emergency Medicine
Metropolitan Hospital
201 8th Street
Philadelphia, PA
1978-1980

Doctor of Osteopathic Medicine
Philadelphia College of Osteopathic Medicine
Philadelphia, PA 19131
1974 to 1978

Certifications

Board Certified Emergency Medicine (AOBEM-AOA)
Certificate No. 161, Feb. 29, 1988

Board Certified Emergency Medicine (ABEM-ABMS)
December 6, 1995; September 2004, October 2013

Board Certified Hospice and Palliative Medicine (ABIM)
December 31, 2010

Professional Societies

American Academy of Hospice and Palliative Medicine
American College Emergency Physicians
American Geriatric Society
American Osteopathic Association
American Medical Association
American College Osteopathic Emergency Physicians
New Jersey Chapter of the American College Emergency Physicians
Society of Academic Emergency Medicine

National ACEP Activities – List your most significant accomplishments

ACEP Board of Directors - Current
Multiple activities as BOD Member
Emergency Medicine Foundation Board of Directors – Current
HHS Pain Management Task Force – Representing ACEP
IHI Opioid Task Force – Representing ACEP
Past Chairman, ACEP Section of Geriatric Emergency Medicine 10/2011-2013
Past Chairman and Founder, ACEP Section of Palliative Medicine 10/2012-10/2014
ACEP Councilor 2011-2017
ACEP Disaster Committee 2013-2015
ACEP Ethics Committee 2014-2016
ACEP NOW – Editorial and Advisory Board 2014-Present
ACEP Practice Management Committee 2014-2016
ACEP Steering Committee 2013-2015

ACEP Chapter Activities – List your most significant accomplishments

NJ-ACEP President 7/2015-6/2016

Practice Profile

Total hours devoted to emergency medicine practice per year: **>2080** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **5** % Research **5** % Teaching **20** % Administration **70** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am Chairman of Emergency Medicine as a hospital employee and Manage two emergency departments. The larger is a bust inner city teaching hospital that sees 170,000 visits per year. The second is a community hospital Emergency Department seeing 30,000 visits/year

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 **Cases** **Plaintiff Expert** **Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Mark S. Rosenberg, DO, MBA, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: St Joseph's Health

Address: 703 Main Street

Paterson NJ 07503

Position Held: Chairman, Emergency Medicine and Chief Innovations Officer

Type of Organization: Healthcare

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: ACEP

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Emergency Medicine Membership Organization

Duration on the Board: 3 Years

Organization: D2i formally EMBI

Address: 110 Cornelia Street

Boonton, NJ 07005

Type of Organization: Data Analytics

Duration on the Board: 4 Years

Organization: EMF, Emergency Medicine Foundation

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Research Foundation

Duration on the Board: 1 year

Organization: New Jersey Hospital Association Health Research Educational Trust

Address: 760 Alexander Road

Princeton NJ

Type of Organization: Education and Research Funding

Duration on the Board: 9/2014- Currently

Organization: American College of Osteopathic Emergency Medicine

Address: 142 E Ontario Street Suite 1500

Chicago IL 60611

Type of Organization: Professional Membership Organization

Duration on the Board: 2012-2014

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

X NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

X NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

X NONE

☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

X NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

X NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Mark Rosenberg Date 7/1/18

NEW JERSEY CHAPTER
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

August 7, 2018

John G. McManus, Jr., MD, MBA, FACEP
Chair, Nominating Committee
4950 W. Royal Ln
Irving, TX 75063

Dear Dr. McManus:

The New Jersey Chapter of the American College of Emergency Physicians (NJ-ACEP) would like to provide our support once again to Mark Rosenberg, DO, MBA, FACEP, FAAHPM for the national ACEP Board of Directors. Our Chapter wholeheartedly endorses Mark's candidacy because we know that his continued presence on the Board will immeasurably benefit our college for years to come. He has created a significant impact in emergency medicine with his vision in the areas of pain management, geriatrics, palliative medicine, and most importantly the role of the emergency department as a major hub in future healthcare systems.

Mark's career spans 39+ years ranging from bedside ED physician to administrator to business owner. His intuition has served him well in terms of understanding the need to constantly evaluate and test new processes in the delivery of emergency care. Mark's vast experience has allowed him to forge ahead with pilot programs, innovations, and creative solutions utilizing existing resources as well as identifying new solutions and strategies. Currently, Mark is the Chairman of Emergency Medicine at St. Joseph's University Medical Center in Paterson, NJ. This large teaching hospital is home to one of the busiest emergency departments in the country with over 170,000 visits. At St. Joe's, Mark started one of the nation's first comprehensive Geriatric Emergency Departments and also developed an ED based Palliative Medicine program called 'Life Sustaining Management and Alternatives'. He serves as faculty for their EM residency and was instrumental in three new fellowship offerings: EM Neuro Stroke Fellowship, Acute Pain Fellowship and a Mental Health and Addiction Fellowship. In 2016, he helped develop The Alternatives to Opioids (ALTO) program at St. Joe's, to address the issue of variation and over-prescribing. In 2018 the ALTO program was written in to House and Senate legislative bill. He testified in congress supporting this bill and it has passed the House. It is anticipated this will be signed into law this summer or fall.

Mark has a sophisticated, broad based and profound understanding of the complex nature of our specialty and its relationship to all of medicine. He is a nationally

recognized leader and has authored many articles and textbook chapters. In addition, he has lectured internationally in Geriatric Emergency Medicine, Palliative Medicine, and Opioid reduction strategies.

Mark has been an ACEP member since 1979 and has embraced service to ACEP with gusto and determination over the last few years. He is Past-President of the Geriatrics and Palliative Medicine Sections, both of which he founded. Through those sections he has helped guide not only ACEP's positions on these important matters but also many members with similar interests.

He is active in our state chapter, serving as President from 2015-2016. He continues to provide guidance by attending quarterly Board meetings as a Past President in a non-voting capacity. He is an effective communicator at both the state and national levels, testifying before the New Jersey state legislature on Out-of-Network legislation in 2016, to most recently testifying before Congress in March regarding the need to combat the nation's opioid crisis.

His strongest qualities are his innovative management style (highly collaborative), a desire and willingness to innovate to improve care, and a passion for our specialty. I have been happy to see him expand into the areas of national leadership and academics and look forward to seeing what the future holds for him.

I welcome the opportunity to talk with you at any time to discuss our enthusiastic support of Dr. Mark Rosenberg to serve a second term on the ACEP Board of Directors. Our proud chapter stands behind him as he seeks to advance the advocacy of emergency medicine through our vital organization.

Sincerely,

Marjory Langer

Marjory Langer, MD, FACEP
President, New Jersey Chapter

Mark S. Rosenberg, DO, MBA, FACEP

To my fellow Councillors:

The purpose of this letter to the council is to give you a brief glimpse of who I am as a person and board member. To let you know what my successes have been on the ACEP board these past three years and what my thoughts are for the future. I have learned a tremendous amount about the board, the college, and the challenges of chapters and practices across the country. I have worked tirelessly on advocacy efforts at the local, state, and national level. As an EMF Board member, I work to promote the mission and support the research that improves our patients' care.

I have been a member of ACEP for over 39 years. I have acquired a unique set of skills throughout my career that offers leadership, advocacy, innovation, financial/business, and graduate medical education expertise. Currently, I serve as Chairman of Emergency Medicine and Chief Innovations Officer of one of the largest EDs in the country seeing over 170,000 visits annually. In that role I have developed a dual accredited AOA and ACGME program, which now has 24 residents and includes several fellowship programs: Acute Pain management, Administration, Mental Health and Addiction, and ED Neuro-Stroke.

As a board member, besides being liaison to many committees, sections and task forces, I have also had the great opportunity to develop several programs and projects.

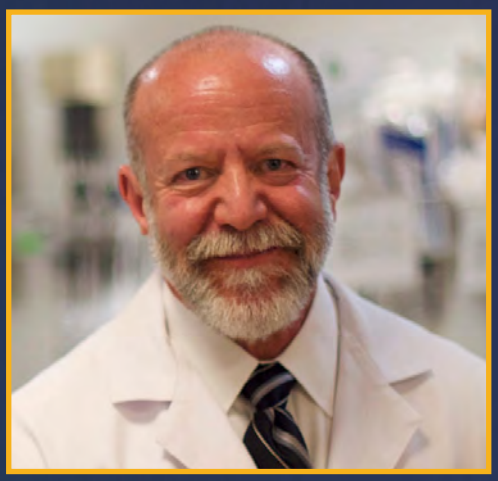
- **Palliative Medicine in the ED**: After successfully starting the Palliative Medicine section, this palliative initiative was chosen as part of ACEP's Choosing Wisely Campaign. The pilot program, Life Sustaining Management and Alternatives (LSMA), went on to achieve nation recognition.
- **Geriatric Emergency Department (GED) and Accreditation Development**: I had the opportunity to open our nations first *ED run* GED in 2009 and was instrumental in the development of the GED Guidelines in 2012. As a board member, I worked with ACEP to develop the GED Accreditation Program in 2017. Several healthcare systems and hospitals have been accredited and many are in the accreditation process. This is a great initiative for our patients, their families, and for emergency physicians as more resources are brought to the ED to better care for this group of patients.
- **Alternatives to Opioids Program (ALTO)**: I started the first ED Acute Pain Fellowship. The following year, 2016, I developed the national acclaimed ALTO program. Partnering with ACEP accelerated the success of this program. ALTO is now the leading prevention strategy for the opioid epidemic. The program not only provides evidenced-based opioid reduction strategies but also provides Medical Assisted Treatment and a warm handoff to hospital and community resources. Together with ACEP, ALTO was introduced into congressional bills that have passed the house and hopefully will become law before the end of the year.
- **Mental Health and Addiction Fellowship**: In 2018, in conjunction with ACEP, I developed a mental health and addiction fellowship. The goal of the program is to develop simple evidence-based protocols for managing this challenging set of patients that present to our EDs across the country. These protocols will assist emergency physicians in providing exceptional evidence-based care, make it easier to manage patients, and decrease psych holding.

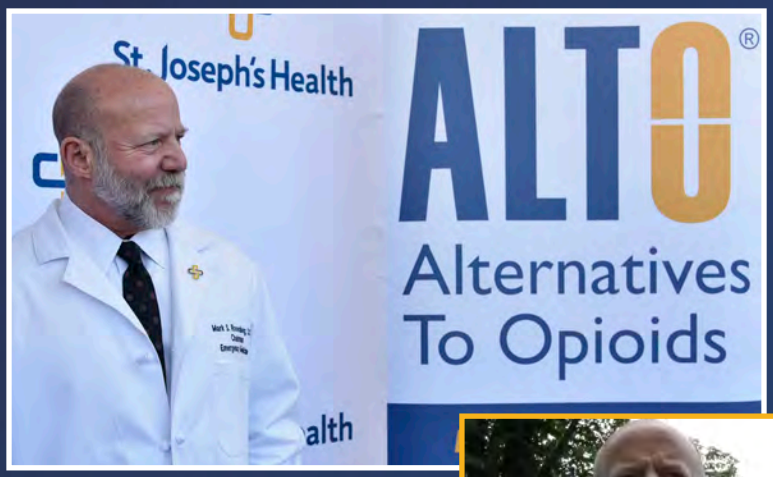
I believe I possess the necessary qualifications and work experience to be re-elected to the ACEP Board of Directors. I ask you for your vote to the ACEP Board of Directors, so that I may continue to advocate for our membership as well as identify innovations for Ease of Best Practice as well as our future success as a college.

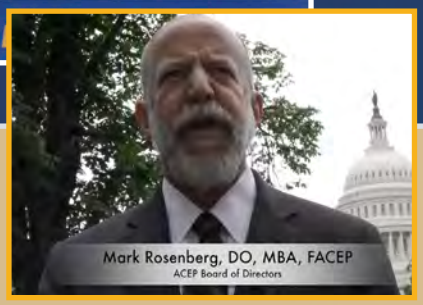
Sincerely
Mark Rosenberg
mrosenberg@acep.org

Mark Rosenberg, DO, MBA, FACEP, FAAHPM

Candidate, Board of Directors (Incumbent)







ACEP Leadership

- Board of Directors, ACEP
- Board of Directors, EMF
- Board of Governors, Geriatric Emergency Department Accredita ogram
- ACEP Governance Task Force
- Tr e Task Force

Clinical Leadership

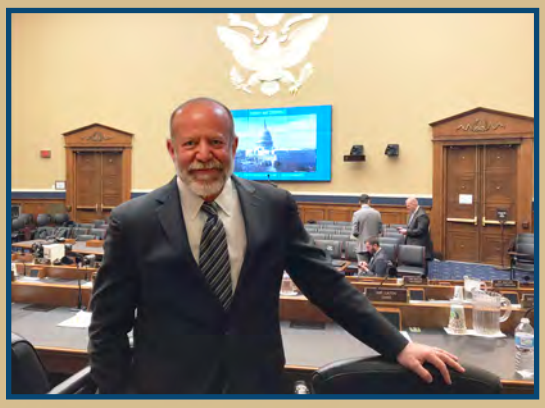
- Chairman, Emergency Medicine, St. Joseph's Health
  - o The na s third busiest Emergency Department 170,000 visits/year
- Chief Innova
- Associate Professor Emergency Medicine
- Fellowship Program Development
  - o Acute Pain Management
  - o Ment

Innovator

- Founded and developed the Alterna es to Opioids Program (ALT y acute pain management program and provides treatment for T and Peer Counselors.
- Developed the Geriatric Emergency Department at St. Joseph's University Medical Center st departments in the country – and the only one in New Jersey to achieve accredita om the American College of Emergency Physicians - ACEP.
- Developed Emergency Department Pallia e Care Program called, Life Sustaining Management and Alterna es (LSMA)

National App ointment s

- U.S. Department of Health & Human Services (**HHS**) - Pain Management Task Force
- Ins e for Healthcare Improvement (**IHI**) – Opioid Best Pr Task Force
- Center of Disease Control (**CDC**) – Opioid Prescribing Es te Project
- Board of Directors - Emergency Medicine Founda on (**EMF**)
- Board of Directors American College of Emergency Physicians (**ACEP**)



American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Thomas J. Sugarman, MD, FACEP

***Question #1:* Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

I believe EM will continue to flourish because we meet so many different needs of our communities. The question is how will the health care system value emergency care? It is clear that payers – and our patients – will continue to push to reduce the overall cost of health care in the US. In order to ensure our patients and our communities have affordable access to high quality care, true physician leadership will be paramount. EPs are expert at making decisions to save lives. As a College we must use our skills collaboratively to save the health care system. ACEP is the perfect organization to bring together the diverse interests and stakeholders in emergency medicine to fulfill this vision.

ACEP members working collaboratively in the section and committee structure have produced great improvements in care delivery. Through these efforts, ACEP supports high quality care with clinical policies, non-clinical policies, education, and physician wellness. I have been an active member of the Emergency Practice Committee and the State Legislative/Regulatory Committee. In addition, I was appointed to serve on four ACEP task forces: sedation, mobile integrated healthcare/community paramedicine, contract transitions and the ACEP/EDPMA joint task force on reimbursement issues. When I was president of California ACEP, we initiated a public health improvement program, which continues today. During my presidential year, the first 2 initiatives, statewide dissemination of safe prescribing guidelines and a toolkit to facilitate implementation of the PECARN pediatric head CT guidelines, were rolled out. As a BOD member, I will continue to work to facilitate and shorten the time needed for every practice to adopt best practices that will improve both patients' lives and EPs' practices. Providing better more coordinated care is key to increasing and proving the value of EM.

Over the next decade, I expect there will be more and more pressure to control the cost of medical care with attempts to control costs by simply cutting. For profit driven insurance companies, the easy solution seems to be to just pay less. However, physicians know that without adequate reimbursement, access to care will suffer. EPs can lead the way towards developing a more rational health care system. In the era of cost containment, EPs should be adequately reimbursed for providing services that reduce avoidable healthcare costs.

The battles over surprise bills, out of network coverage and denying coverage for retrospectively determined "non-emergencies" will continue. California had a particularly absurd bill this year, AB 3087, which literally fixed prices for commercially insured patients at a multiple of Medicare for physicians and hospitals. Of course the bill did nothing to ensure Medicaid (Medi-Cal) or non-funded patients' care would be adequately reimbursed. Fortunately, California ACEP, the California Medical Association, the California Hospital Association and other stakeholders killed the bill, but not before it passed out of committee. This episode should be a wake up call to others across the country. Just as HMO implementation and balance billing bans in California portended these problems in other states, I believe price fixing and cost cutting efforts will occur again – not just in California, but also in many other states.

ACEP, as the voice of EPs, must continue to be at the forefront of political advocacy. I believe our best strategy will be to work with our patients, their employers, like-minded medical specialties, and healthcare innovators. In the current environment, it's not just politics that will be local – so will the best solutions for our practices. I believe we need grassroots effort in every community, every state chapter, with our national organization helping us promote best practices and tactics more widely with policy makers. My skills developed during my time on the BOD and as president of California ACEP, president of my county medical association and BOD member for both EMAF and NEMPAC, and alternate director for PFC will allow me to bring valuable perspectives to the ACEP BOD as we navigate these challenges.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

ACEP is the preeminent organization advocating on behalf of emergency physicians and our patients. Since completing my EM residency in 1992, I have averaged at least 10 shifts a month as a pit doctor, practicing in 3 states and in multiple practice settings. I primarily practice at small, but busy, suburban hospital (60,000 visits/year). My group, Vituity, (formerly CEP America) is a democratic partnership and 100% physician owned with no investor ownership. We share best practices and solutions across our multiple sites, spanning the breadth of EM. Vituity exists to offer doctors the opportunity for a fulfilling medical practice, delivering care the way we want our families to receive care. My personal practice experiences include rural hospitals, urban hospitals, teaching hospitals, for profit, non-profit and government owned hospitals. As an actively practicing pit doc, I understand the challenges facing EPs and our patients.

During my years in California ACEP and ACEP leadership, I learned that listening and understanding various perspectives is key to influencing positive change. ACEP BOD members must not only understand the needs and goals of all EPs, but also the views of patients, other specialties, government officials, payers, hospitals and other stakeholders in the medical system. We must educate and innovate for our patients and communities to enjoy high quality emergency care that is both available and affordable. Patients deserve to feel secure when seeking care for perceived emergencies without fear of dire economic consequences. They also deserve better tools to access the right care at the right time, with the right follow-up for post-stabilization care. Without stabilizing reimbursement, improving practice enjoyment and increasing resources for EM training, there will not be enough high-qualified EPs to deliver emergency care. ACEP, on behalf of EPs, must thread the needle by improving the value of the care EPs provide and ensuring that EM practices are sustainable. As an example, working with the EMS committee, California ACEP and the mobile integrated healthcare/community paramedicine task force, we were able to modernize ACEP's policy on community paramedicine. The new policy allows for care to be delivered in appropriate settings without undermining access to emergency care and EMTALA.

I will represent you and make decisions on the board from a paradigm of improving patient care and ensuring access to quality care. ACEP must mitigate EP practice hurdles such as administrative hassles, excessive time documenting in EHRs and unreasonable MOC requirements so EPs can focus on clinical care. I remain convinced that the best paradigm to advocate for improvements to our EM practices is to view the situation from the patients' perspectives. What is good for our patients and the community will be good for emergency medicine and emergency physicians.

I humbly ask for your vote so that I may represent you on the BOD. Thank you.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

The American College of Emergency Physicians is an organization representing emergency physicians. I believe that ABEM or AOBEM certification is the gold standard for EPs. I agree with our current membership policies that require EM residency or fellowship completion to join ACEP. However the reality is that there are many providers caring for emergency patients that are not board certified EPs. Our education interests, practice challenges and, most importantly, our patients are the same. Since the best way to advocate for EPs, is to advocate for emergency patients, ACEP should strive to provide services including education, practice support and advocacy (where there is alignment) for the broader community of physicians (and advanced providers) caring for emergency patients. That said, ACEP must be very careful to never undermine the concept that residency/fellowship training and board certification is the gold standard. ACEP will be more effective if we appreciate the perceptions of our patients, legislators and all emergency providers.

The more inclusive the EM house that ACEP represents, educates and supports, the more effective ACEP will be representing the best interests of EPs. ACEP should improve collaboration with other organizations representing EPs such as AAEM, ACOEP and SAEM. If I am elected to the ACEP BOD I will continue to work towards reconciliation with AAEM (of which I am a member). AAEM represents an important constituency of ACEP members, but the vast majority of goals and aspirations of both organizations are shared by all EPs.

The challenges facing us are great. EM practice is growing more complex. Reimbursement pressures are increasing. Too many of us are losing the sense of joy and fulfillment in our personal and professional lives. Rather than fighting within the house of EM or between specialties, we must work collegially to improve our practices and the care we deliver. As a united voice we will be more effective at convincing policy makers to make patient centered decisions that target high quality, high value care rather than sticker price. EP job satisfaction and fulfillment will improve when our practices allow us to focus on providing high quality care. The most effective way to improve emergency medicine is to unite to achieve our common goals.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Thomas J. Sugarman, MD, FACEP

Contact Information

1569 Solano Avenue, #463, Berkeley, CA 94707
Phone: 510-219-7261
E-Mail: tjsugarman@gmail.com

Current and Past Professional Position(s)

Current:

Emergency Physician (2001) and Chair of Emergency Services (2013), Sutter Delta Medical Center (FT)

Senior Director Government Affairs, Vituity (formerly CEP America) (2016) (PT)

Urgent Care Physician, East Bay Physicians Medical Group (2014) (PT)

Past:

Emergency Physician, Alameda Hospital (2003-2015) (PT)

Fire Brigade Emergency Physician for Vituity, California and Illinois hospitals (FT)

Emergency Physician, Illinois, Kentucky and California hospitals for Team Health (and precursors) (1992-3 and 1995-2001) (FT and PT)

Emergency Physician St Mary Medical Center and San Pedro Peninsula Hospital (1993-1994) (FT)

Clinical Faculty, Harbor UCLA Department of Emergency Medicine (1993-5) (PT)

Education (include internships and residency information)

Harbor UCLA Emergency Medicine Residency and Internship, 1989-1992

MD with Honors, University of Illinois at Chicago, 1989

Certifications

ABEM certified 1994, recertified 2004 and 2014

Professional Societies

ACEP

California ACEP

AAEM

CalAAEM

AMA

CMA (California Medical Association)—member Council on Legislation, 2010-current

ACCMA (Alameda Contra Costa Medical Association)—President, Nov 2017-Nov 2018, BOT, 2014-current.

National ACEP Activities – List your most significant accomplishments

ACEP Councillor, 2007-current, Alternate, 2006

Emergency Practice Committee member, 2010-current

State Legislative/Regulatory Committee, 2016-current

ACEP Sedation Task Force, 2013-2016

Mobile Integrated Healthcare/Paramedicine Task Force, 2016-2017

Contract Transitions Task Force, 2017

Joint ACEP/EDPMA Task Force on Reimbursement, 2017-current

NEMPAC BOD member, 2017-current

Emergency Medicine Action Fund BOD member, 2018-current

Invited speaker at ACEP Leadership and Advocacy Conference: "Taking the Lead: Essential Skills to Becoming a Highly Effective Chapter Leader," 2014

ACEP Chapter Activities – List your most significant accomplishments

California ACEP:

President, 2013-2014, BOD, 2006-2015

Chair Government Affairs Committee, 2013

Walter T. Edwards Meritorious Service Award, 2015

Chapter Service Award, 2012

Practice Profile

Total hours devoted to emergency medicine practice per year: **2400** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **55** % Research **0** % Teaching **0** % Administration **10** %

Other: **Advocacy** **35** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

My clinical practice is at suburban non-profit community hospital. Our ED sees 60,000 pt/year and the hospital has 145 beds. My group, Vituity, is a multi-state, multi specialty, but predominantly emergency medicine physician partnership. All physicians (working the required hours) become full partners with equal ownership after 4 years. We own our billing company and practice management company and we have no outside investors.

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 **1** **Cases** **Plaintiff Expert** **0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT
Thomas J. Sugarman, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Vituity

Address: 2100 Powell St #900, Emeryville, CA 94608

Position Held: Emergency Physician and Senior Director of Government Affairs

Type of Organization: Physician partnership

Employer: East Bay Physicians Medical Group

Address: 3687 Mt Diablo Blvd, Lafayette, CA 94549

Position Held: Urgent Care Physician

Type of Organization: Physician group contracting with Sutter East Bay Medical Foundation

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: California ACEP

Address: 1121 L St #407, Sacramento, CA 95814

Type of Organization: State Chapter of ACEP

Duration on the Board: 2006-2015

Organization: Alameda Contra Costa County Medical Association

Address: 6230 Claremont Ave, Oakland, CA 94618

Type of Organization: County component society of California Medical Association

Duration on the Board: 2014-current

Organization: NEMPAC

Address: 2121 K Street, NW, Suite 325, Washington, DC 20037

Type of Organization: Political action committee

Duration on the Board: 2017-current

Organization: EMAF

Address: 2121 K Street, NW, Suite 325, Washington, DC 20037

Type of Organization: Advocacy fund promoting emergency medicine

Duration on the Board: 2018-current

Organization: Physicians for Fair Coverage

Address: 8400 Westpark Drive, 2nd Floor McLean, VA 22102

Type of Organization: Advocacy organization focusing on surprise insurance gaps/billing

Duration on the Board: Alternate BOD member 2018-current

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE
☒ If YES, Please Describe:

I am a physician partner with < 1% equity interest with Vituity. Vituity's legal name is CEP America. I am the Senior Director of Government Affairs. Vituity has a quality clinical data registry and offers physician (and other providers) CME.

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:

I am a physician partner with < 1% equity interest with Vituity. I am the Senior Director of Government Affairs. Vituity has a quality clinical data registry and offers physician (and other providers) CME. Vituity owns a billing company and a practice management company. Vituity physicians, including me, are members of The Mutual Risk Retention Group which provides professional liability insurance to both Vituity and non-Vituity physicians.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☐ NONE
☒ If YES, Please Describe:

I am a member of AAEM, California Medical Association and AMA. I am President of Alameda Contra Costa Medical Association (term ends November 2018).

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Thomas J. Sugarman Date July 15, 2018

CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

1121 L Street, Ste 407
Sacramento, CA 95814

PH 916.325.5455
FX 916.325.5459
TF 800.735.2237
E-Mail info@californiaacep.org

www.californiaacep.org

August 15, 2018

Dear Colleagues:

The California Chapter is pleased to give its enthusiastic endorsement to Thomas J. Sugarman, MD, FACEP for ACEP Board of Directors and strongly urges your support of his candidacy.

Dr. Sugarman's career demonstrates his steadfast commitment to emergency medicine and his relentless pursuit to make a difference in the lives of his fellow pit doctors and the patients they care for.

Dr. Sugarman is a Past President of the Chapter, and has served our Chapter with incredible enthusiasm and dedication in a variety of leadership roles for more than a decade. His numerous accomplishments, many years of service, and diversity of clinical experience ranging from Base Station EMS Medical Director, to International Medical Corps volunteer physician, to Sepsis Champion at his community ED, will bring a broad and knowledgeable perspective to the Board. He truly understands the challenges emergency physicians face in all practice settings and has dedicated his career to removing those practice barriers.

Dr. Sugarman is a tireless and enthusiastic advocate for emergency physicians, with several decades of commitment at every level of organized medicine. In addition to being a Past President of the Chapter, Dr. Sugarman is currently serving as President of his local medical society and as a delegate to the California Medical Association House of Delegates. For nearly a decade he has served as a representative to the Medical Association's Council on Legislation, where he has ensured that the positions taken adequately represent the uniqueness of our specialty. He is also the Co-Chair of the East Bay Safe Prescribing Coalition and has testified before the California Medical Board on behalf of the Chapter, helping ensure safe prescribing efforts are tailored toward the unique needs of the ED.

Dr. Sugarman's advocacy leadership is always focused on improving the practice of emergency physicians. For example, his work includes regulatory efforts on procedural sedation and legislation relating to psychiatric holds. He also initiated and led efforts to create PECARN and safe prescribing tools for emergency physician use at the bedside.

At the Chapter, group, and national level, Dr. Sugarman has been involved in fair payment issues for many years. During and after his service on the Chapter's Board, he testified before legislators in support of fair payment for emergency physicians. He also serves on ACEP's State Legislation and Regulatory Committee and is currently the Senior Director of Government Affairs for Vituity.

Dr. Sugarman's dedication to emergency medicine and unique skill set embodies precisely the kind of person we need leading and serving us on the ACEP Board of Directors. Our Chapter has been witness to his ability to inform and influence legislators, lobbyists, and regulators one day and turn around the following day to treat and care for patients. Dr. Sugarman has received numerous awards acknowledging his contributions to emergency medicine, including the Chapter's highest award, the Walter T. Edwards Meritorious Service Award, for a career's worth of exceptional contributions to the Chapter.

Dr. Sugarman is a tireless and enthusiastic advocate for emergency physicians. His expertise, experience, and desire to serve the College will prove invaluable to the Board of Directors. The California Chapter is extremely proud to endorse and respectfully request your support of Dr. Tom Sugarman for the Board of Directors.

Respectfully,

AIMEE MOULIN, MD, FACEP

President

Thomas J. Sugarman, MD, FACEP

Fellow Councillors:

I am honored to be nominated for the ACEP board, the preeminent organization representing EP's. I spend the majority of my professional time practicing clinically, and I love it. I am acutely aware of the increasing pressures we all face at the bedside. My passions to deliver excellent care and improve our specialty drive my advocacy and leadership endeavors. **As a board member, my main goal for the College will be enabling EPs to focus on patient care**. **By reducing on-shift hassles and ensuring EPs are fairly compensated, EM will be more fulfilling and sustainable. My vision is that collaboration, innovation and redesign— facilitated and supported by ACEP—will make our system of care healthier for everyone.**

Advocacy

At LAC, Surgeon General Jerome Adams told us that "advocacy is looking beyond the problem in front of you...it's figuring out how to prevent the problem. It's more than clinical excellence." ACEP allows EPs to harness the collective power of a united voice to benefit our patients. As an example, I led California ACEP's effort to improve the ability of EPs to place mental health holds resulting in decreased ED boarding and less EP frustration.

Clinical Practice Support

ACEP should strive to shorten the time and expense needed to adopt clinical enhancements that increase the value of EM. During my presidency, California ACEP developed safe opioid prescribing and PECARN pediatric head trauma CT toolkits. Tools included sample letters to medical staff, scripting for patient/parent discussions, and clinician pocket cards. Facilitating best practice implementation and mitigating burdensome regulations reduce burnout risks and improve care.

Reimbursement

We all know that EPs provide efficient, timely, life-saving care. But we must do a better job *communicating* the value of EM. Given the higher cost of care in America, financial pressure on the acute care system will increase. Accountable physicians must guard against cost containment efforts that threaten quality or access and member wellness. Emergency care must be a covered benefit without unaffordable patient financial risk. ACEP needs to promote price transparency by facilities and outcomes research that demonstrate our true value to both public and private insurers.

Workforce

ACEP members comprise less than two thirds of the ED workforce. Many physicians practicing in underserved EDs do not qualify for College membership. Many rural and metropolitan ED's utilize advanced providers to meet local demand for emergency care. ACEP should formally review and consider the differences between physician and advanced provider skills, experience, and roles in healthcare.

MOC guarantees the public that ABEM Diplomates are expert EPs, but we need ongoing efforts to ensure MOC is not overly burdensome.

Medical students, residents and newer graduates deserve relief from debt burdens hindering their ability to practice in the community of their choosing.

As an organization representing member EPs, ACEP must ensure its programs and policies serve members in multiple settings (rural, suburban, urban, academic, non-academic) and group structures (partners, employed, independent contracting). The College should play a leading role

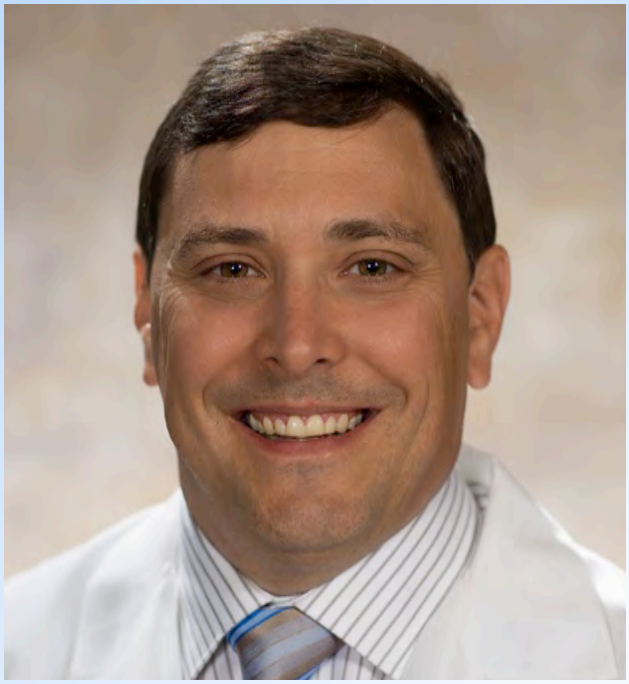
in developing telemedicine and other care delivery modalities, such as mobile integrated healthcare, to close the performance gaps in many communities. Multiple challenges face the ACEP board to fulfill our primary mission.

Councillors:

My College service on committees and task forces, presidency of California ACEP and my county medical association demonstrate my long-term passion and ability to collaborate, innovate and co-develop practical solutions to real-world problems. As a BOD member, I will continue advocating to empower EPs to focus on patient care. I humbly ask for your vote to represent current and future ACEP members.

Sincerely,

Thomas J. Sugarman, MD, FACEP
Thomas.Sugarman@Vituity.com 510-219-7261



- Active Clinician
- Advocacy expertise
- Reduce on-shift hassles
- Ensure sustainable and fulfilling EM practices
- California ACEP endorsed

Thomas J. Sugarman, MD, FACEP
for
ACEP Board of Directors

My vision is that collaboration, innovation and redesign—facilitated and supported by ACEP—will make our system of care healthier for everyone. As a clinician, I understand the pressures on the practicing emergency physician. As a board member, my main goal for the College will be enabling emergency physicians to focus on providing patient care. By reducing on-shift hassles and ensuring EPs are fairly compensated, EM will be more fulfilling and sustainable.

- Actively practicing in California, past practices in Illinois and Kentucky
- Practice experiences range from tertiary care to rural hospitals, both academic and non academic
- I have worked as a partner, independent contractor and employee in various group structures. Currently practicing as a partner in Vituity (formerly CEP America), a democratic, 100% physician owned partnership
- Chairman of Emergency Services at Sutter Delta Medical Center
- Senior Director of Government Affairs, Vituity (formerly CEP America)

Selected Experience and Service

ACEP

- Councillor, 2007-current, Alternate, 2006
- Emergency Practice Committee member, 2010-current, Contractual Relationships Subcommittee Chair
- State Legislative/Regulatory Committee, 2016-current, Advocacy Objective Subcommittee Chair
- ACEP Sedation Task Force, 2013-2016
- Mobile Integrated Healthcare/Paramedicine Task Force, 2016-2017
- Contract Transitions Task Force, 2017
- Joint ACEP/EDPMA Task Force on Reimbursement, 2017-current
- NEMPAC BOD member, 2017-current
- Emergency Medicine Action Fund BOD member, 2018-current
- **Invited speaker, ACEP 2014 Leadership and Advocacy Conference: "Taking the Lead: Essential Skills to Becoming a Highly Effective Chapter Leader"**

California ACEP

- Lobbied successfully for expansion of 'temporary mental health hold" in CA resulting in less EP frustration and decreased mental health boarding
- **During Presidency (2013-2014)—led California ACEP's development of implementation toolkits for Safe Prescribing and for PECARN CT guidelines for minor pediatric head injuries**
- Advocated successfully to improve PDMP use and availability without onerous requirements for EPs
- **Awarded Walter T. Edwards Meritorious Service Award, 2015**

Physicians for Fair Coverage

- Alternate BOD member, 2018-current

California Medical Association

- Council on Legislation and House of Delegates—active member
- **Collaborated with multiple specialties to modernize CMA policy to support a fair payment standard with arbitration for out of network services**

Alameda Contra Costa County Medical Association

- President, 2017-2018
- Co-chair East Bay Safe Prescribing Coalition—physician, hospital, pharmacist, community and government coalition –**achieved 50% decrease in Alameda County opioid related mortality, significantly fewer high MME prescriptions and co-prescribing, increased MAT use**

I am the right candidate to serve ACEP members on the BOD because I am a clinician with an in depth understanding of the impact of healthcare policy on our practices. I have frontline experience protecting patient and physician interests. I always keep in mind that Emergency Medicine's value is created by the individual physician providing bedside care. I humbly ask for your vote to represent current and future ACEP members.

ACEP HONORS 2019 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

The 2019 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

Sandra M. Schneider, MD, FACEP

Presented to a current or past national ACEP leader for outstanding contribution to the College. The award honors the late John G. Wiegenstein, MD, a founding member and the first president of ACEP.

James D. Mills Outstanding Contribution to Emergency Medicine Award

Ramon W. Johnson, 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

Peter J. Jacoby, MD, 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

---

Judith E. Tintinalli Award for Outstanding Contribution in Education

William Ken Milne, MD

Recognizes a member who has made a significant contribution to the educational aspects of emergency medicine.

ACEP HONORS 2019 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Award for Outstanding Contribution in Research

Rebecca Cunningham, MD, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.

Award for Outstanding Contribution in Research

Gail D'Onofrio, MD, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.

Award for Outstanding Contribution in EMS

Robert E. O'Connor, MD, MPH, 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

Richard C. Hunt, MD, FACEP

The Disaster Medical Sciences Award recognizes individuals who have made outstanding contributions of national/international significance or impact to the field of disaster medicine.

Council Meritorious Service Award

John H. Proctor, MD, MBA, FACEP

Recognizes consistent contributions to the growth and maturation of the ACEP Council.

ACEP HONORS 2019 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

John A. Rupke Legacy Award

Juan A. Gonzalez-Sanchez, 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.

Pamela P. Bensen Trailblazer Award

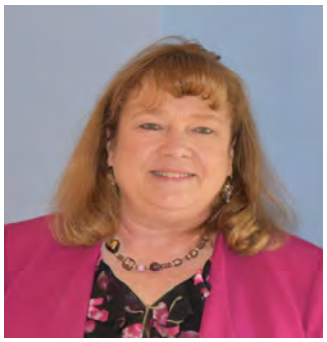
Andrew I. Bern, MD, FACEP

The Pamela P. Bensen Trailblazer Award is 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).

Honorary Membership Award

Lowell W. Gerson, PhD

Presented to individuals who have rendered outstanding service to the College or the medical profession.



Honorary Membership Award

Laura Gore

Presented to individuals who have rendered outstanding service to the College or the medical profession.

Policy Pioneer Award - Presented at Leadership and Advocacy Conference

Megan L. Ranney, MD, MPH, FACEP

Recognizes early and mid-career members who have made outstanding contributions to the College's health policy and advocacy initiatives.

ACEP HONORS 2019 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Diane K. Bollman Chapter Advocate Award

Elena Lopez-Gusman

The Diane K. Bollman Chapter Advocate Award is 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.

Community Emergency Medicine Excellence Award

Andrew G. Southard, MD, FACEP

Recognizes individuals who have made a significant contribution in advancing emergency care and/or health care within the community in which they practice.

Innovative Change in Practice Management Award

Edward N. Barthell, MD, FACEP

This annual award is given 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.

2019 ACEP COUNCIL AWARDS

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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 briefly recognized at the Council luncheon.

Council Meritorious Service Award

John H. Proctor, 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. he nominee's contributions to the Council should include, but are not limited to, one or more of the following: Steering Committee membership; reference committee participation; participation on other Council committees; resolution development and debate; longevity as a councillor; or service as a Council officer.

Council Horizon Award

Zachary J. Jarou, 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

Bradford L. Walters, 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..

2019 ACEP COUNCIL AWARDS

Council Champion in Diversity & Inclusion Award

Bruce MD, MBA, RDMS, FACEP

Purpose: The award celebrates and promotes diversity of experience and thought, the merit of inclusivity, and the value of equity. It is presented to a councillor, group of councillors, or component body that has demonstrated a sustained commitment to fostering a diversity of contributions and an environment of inclusivity that directly enhances the work of the Council and provides excellence to ACEP.

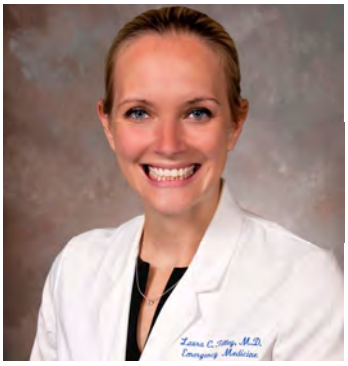
Criteria: The nominee should exemplify service to the College through the promotion of diversity and inclusion. The nominee must demonstrate evidence of having a commitment to the promotion of a diverse leadership and/or membership and/or initiatives related to diversity and inclusion through mentorship, programmatic activities, professional development, and other contributions specifically purposed to promote the mission, support the policies, and enhance the work of the Council and the specialty of emergency medicine.

Council Teamwork Award

Anne Zink, MD, FACEP

Laura Tilley, MD, FACEP

Brad Gruehn



Shields Act Team

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.

This report will be provided when available.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019-20 Committee Structure

COMMITTEE	CHAIR	STAFF LIAISON
Academic Affairs Committee (Dr. Finnell)	Bruce Lo, MD, FACEP	Loren Rives, MNA
Audit Committee (Dr. Rosenberg)	Omar Hammad, MD, FACEP	Layla Powers, MBA
Awards Committee (Dr. Jaquis – President-Elect)	President-Elect	Sonja Montgomery, CAE
Bylaws Committee (Dr. Hirshon – Vice President)	Larisa M. Traill, MD, FACEP	Leslie Moore, JD
Bylaws Interpretation Committee (Dr. Hirshon – Vice President)	TBD (if needed)	Leslie Moore, JD
Clinical Emergency Data Registry Committee (Dr. Augustine)	Abhi Mehrotra, MD, FACEP	Pawan Goyal, MD
Clinical Policies Committee (Dr. Hirshon)	Stephen J. Wolf, MD, FACEP	Rhonda Whitson, RHIA Travis Schulz, MLS, AHIP
Clinical Resources Review Committee (Dr. Hirshon)	Michael Turturro, MD, FACEP	Sam Shahid, MBBS, MPH
Coding & Nomenclature Advisory Committee (Dr. Cirillo)	David G. Friedenson, MD, FACEP	David McKenzie, CAE
Communications Committee (Dr. Anderson)	Jennifer L. Stankus, MD, JD, FACEP	Maggie McGillick Nancy Calaway, CAE
Compensation Committee (None)	Marco Coppola, DO, FACEP	Layla Powers, MBA
Disaster Preparedness & Response Committee (Dr. Kang)	Marc S. Rosenthal, DO, FACEP	Pat Elmes, EMT-P
Education Committee (Dr. Klauer)	Ernest E. Wang, MD, FACEP	Michele Byers, CAE, CMP
Emergency Medicine Practice Committee (Dr. Haddock)	Daniel Freess, MD, FACEP	Margaret Montgomery, RN, MSN
EMS Committee (Dr. Perina)	Julio R. Lairet, DO, FACEP	Rick Murray, EMT-P
Ethics Committee (Dr. Kang)	Raquel M. Schears, MD, FACEP	Leslie Moore, JD

COMMITTEE	CHAIR	STAFF LIAISON
Federal Government Affairs Committee (Dr. Jaquis – President-Elect)	Carlton E. Heine, MD, FACEP	Laura Wooster, MPH
Finance Committee (Dr. Rosenberg – Secretary-Treasurer)	Gary C. Starr, MD, FACEP Vice Chair Joshua Moskovitz, MD, FACEP	Layla Powers, MBA
Health Information Technology Committee (Dr. Finnell)	Nicholas E. Genes, MD, FACEP	Pawan Goyal, MD
International Emergency Medicine Committee (Dr. Kivela – Immediate Past President)	Christian Arbelaez, MD, MPH, FACEP	Faeeza Faruq
Medical-Legal Committee (Dr. Klauer)	Rade Vukmir, MD, JD, FACEP	Craig Price, CAE
Membership Committee (Dr. Schmitz)	Achyut B. Kamat, MD, FACEP	Jana Nelson
National/Chapter Relations Committee (Dr. Schmitz)	Mark Notash, MD, FACEP	Maude Hancock
Pediatric Emergency Medicine Committee (Dr. Perina)	Anne Dietrich, MD, FACEP	Sam Shahid, MBBS, MPH
Public Health & Injury Prevention Committee (Dr. Augustine)	Alan Heins, MD, FACEP	Margaret Montgomery, RN, MSN
Quality & Patient Safety Committee (Dr. Liferidge)	Richard Griffey, MD, MPH, FACEP	Pawan Goyal, MD
Reimbursement Committee (Dr. Cirillo)	Heather A. Marshall, MD, FACEP	David McKenzie, CAE
Research Committee (Dr. Finnell)	Manish Shah, MD, FACEP	Loren Rives, MNA
State Legislative/Regulatory Committee (Dr. Haddock)	Danyelle Redden, MD, FACEP	Harry Monroe
Well-Being Committee (Dr. Perina)	Arlene Chung, MD	Kelly Peasley

2019-20
Final Committee Objectives

Academic Affairs Committee

Chair: Bruce Lo, MD, FACEP
Board Liaison: John T. Finnell, MD, MSc, FACEP
Staff Liaison: Loren Rives, MNA

1. Solicit nominations and recommend recipients for the:
   a. National Faculty and Junior Faculty Teaching Awards (nominations are approved by the Board)
   b. Excellence in Bedside Teaching Award (nominations are approved by the Board)
   c. National Outstanding Medical Student Award (nominations approved by the Board)
   d. Local Medical Student Awards

2. Review and recommend journal articles, texts, practice guidelines, and important advances relating to ABEM's Lifelong Learning Self-Assessment (LLSA) and emergency medicine practice.

3. Review the following policies per the Policy Sunset Review Process:
   - ACEP Recognized Certifying Bodies in Emergency Medicine

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

4. Continue collaboration with EMRA to:
   a. Complete the development of a leadership/business curriculum for medical students and residents.
   b. Complete the development of a personal financial literacy curriculum for medical students and residents.

5. Provide input to the Well-Being Committee and EMRA to identify and/or develop resources for residents and medical students to address resiliency and coping mechanisms. (Well-Being is the lead committee.)

6. Provide input to the Well-Being Committee (resident perspective) and the Wellness Section to study the unique, specialty-specific factors leading to depression and suicide in emergency physicians and formulate an action plan to address the contributory factors unique to emergency medicine and provide a report of the findings to the 2019 Council as directed in Resolution 16(18) No More Emergency Physician Suicides. (Well-Being is the lead committee.)

7. Develop and provide resources that highlight the benefits of residency programs to the institution, including information on how EM programs are funded and alternative methodologies for funding.

8. Identify aspects of an academic practice that lead to low burnout rates and greater career satisfaction.

9. Develop a guide for writing letters of recommendation for academic promotion. Address how best to encourage diversity and inclusion in emergency medicine in terms of academic promotion.

10. Identify resources and opportunities for returning physicians for focused practice improvement.

11. Explore ways to encourage support of protected time for faculty in residency programs. (Academic Affairs is the lead committee.) See also Amended Resolution 19(18) Reduction of Scholarly Activity Requirements by the ACGME.

12. Develop a list of speakers willing to give Grand Rounds lectures and their lecture topics.

13. Complete development of an information paper that describes the benefits of the academic partnership between the VA and a residency program.

2019-20
Final Committee Objectives

Audit Committee

Chair: Omar Hammad, MD, FACEP
Board Liaison: Mark S. Rosenberg, DO, MBA, FACEP, Secretary Treasurer
Staff Liaison: Layla Powers, MBA

1. Complete the audit functions of the College.
   - review the audited financial statements with the auditors
   - review the IRS form 990

2. Create a multi-year plan and timeline for monitoring and testing the Cyber Security System.

3. Review the annual 401k audit.

2019-20
Final Committee Objectives

Awards Committee

Chair: William P. Jaquis, MD, FACEP
Board Liaison: William P. Jaquis, MD, FACEP, President-Elect
Staff Liaison: Sonja Montgomery, CAE

1. Review award nominations and recommend award recipients to the Board of Directors.

2019-20
Final Committee Objectives

Bylaws Committee

Chair: Larisa M. Traill, MD, FACEP
Board Liaison: Jon Mark Hirshon, MD, MPH, PhD, FACEP, Vice President
Staff Liaison: Leslie Moore, JD

1. Review the national ACEP Bylaws and identify any areas where revision may be appropriate and submit recommendations to the Board of Directors.

2. Review chapter bylaws per the Chapter Bylaws Review Plan. Contact chapter representatives to discuss any suggested changes to the chapter's bylaws.

3. Review and revise as needed the chapter bylaws review and approval process to ensure effectiveness and efficiency. Reassess communications with chapters and educate committee members on best practices to accomplish assigned tasks.

4. Review proposed 2020 Bylaws resolutions to determine if there are conflicts with other portions of the Bylaws. Review proposed 2020 Council Standing Rules and proposed 2020 College Manual resolutions to determine if there are implications for the Bylaws if these resolutions are adopted. Provide comments to the resolution authors as needed.

5. Review 2019 Bylaws amendments adopted by the Council and the Board for potential Bylaws Committee action.

6. Develop best practices for communication with smaller chapters.

7. Identify potential new committee members and increase diversity in the membership of the committee.

2019-20
Final Committee Objectives

Bylaws Interpretation Committee

Chair: Elected by Committee Members
Board Liaison: Vice President
Staff Liaison: Leslie Moore, JD

Note: The committee is assigned as needed for definitive interpretation of Articles VIII – Council, IX – Board of Directors, X – Officers/Executive Director, XI – Committees, and XIII – Amendments, of the ACEP Bylaws.

2019-20
Final Committee Objectives

Clinical Emergency Data Registry Committee

Chair: Abhi Mehrotra, MD, FACEP
Board Liaison: James J. Augustine, MD, FACEP
Staff Liaison: Pawan Goyal, MD

Steering

1. Develop short and long range plans for the registry.

2. Participate in the understanding of existing and future government rules and regulations driving the registry and measures process, related to MACRA, MIPS, and APMs and the impact they have to CEDR and Emergency Medicine.

Measure and Data Validation

3. Develop data acquisition and analytics capabilities to meet the following goals:
   - Design efficient data refinement, process, validation and reliability testing
   - Produce annual reports which summarize statistics and best practices
   - Develop processes that result in cleaned, and deidentified data for research
   - Provide ad hoc responses to government requests

4. Support the quality measure development lifecycle by providing feedback on existing quality measures and supporting testing efforts for new quality measures.

5. Provide feedback on quality measure concepts developed by the Quality & Patient Safety Committee.

6. Support the quality measure requirement in relation to alternative payment models (AACM and AUCM models).

7. Respond to CMS requests and engage with other EM group / registries on specific measures / requests other specialty registries on overlapping measures (ex. Radiology)

Research and Publication

8. Leverage the Clinical Emergency Data Registry (CEDR) data for clinical research by:
   - Developing and implementing a data validation process for CEDR dataset, potentially using an outside vendor. (Data validation process must be established prior to completion of remaining objectives.)
   - Deploying an RFP for research proposals utilizing the CEDR dataset and establishing norms for CEDR dataset use for research.

Education

9. Create educational materials for ACEP members regarding CEDR and federal programs.

Marketing and Member Outreach

10. Provide oversight and update short and long-term CEDR marketing plans.

11. Drive and expand engagement of participant and interested groups through:
    i. Monitoring and increasing the use of the engagED CEDR user community
    ii. Publishing a newsletter on a quarterly basis
    iii. Initiating an annual participant experience survey and user interview to identify areas of strength and weakness in the customer experience.

12. Develop and implement a participant experience improvement plan informed by the survey and interviews to improve the CEDR customer experience.

2019-20
Final Committee Objectives

Clinical Policies Committee

Chair: Stephen J. Wolf, MD, FACEP
Board Liaison: Jon Mark Hirshon, MD, PhD, MPH, FACEP
Staff Liaisons: Rhonda Whitson, RHIA, Travis Schulz, MLS, AHIP

1. Monitor clinical policies developed by other organizations, abstract information pertinent to emergency medicine, post the abstraction on the ACEP website, and communicate the information to members through ACEP communications.

2. Review and comment on other organizations' guidelines under development or for which endorsement has been requested, post the endorsement information on the ACEP website, and communicate the information to members through ACEP communications.

3. Provide recommendations for appointments to outside entities requesting member representation on guideline development panels.

4. Continue updating or modification of current clinical policies as necessary:
   a. Opioids: (Include elements of Amended Resolution 35-15: Create clinical practice guidelines for treatment of patients presenting to the ED in opioid or benzodiazepine withdrawal; and create a practice resource to educate emergency providers about the science of opioid and benzodiazepine addiction.)
   b. Acute heart failure syndromes
   c. Mild traumatic brain injury
   d. Community-acquired pneumonia
   e. Appendicitis
   f. Acute blunt trauma
   g. Asymptomatic elevated blood pressure
   h. Procedural sedation
   i. Seizures
   j. Thoracic aortic dissection
   k. tPA for acute ischemic stroke
   l. Pediatric fever
   m. Transient ischemic attack

5. Develop a new clinical policy on airway management.

6. Serve as a resource to the Quality & Patient Safety Committee to identify performance measures in new and revised clinical policies.

7. Review current clinical policy development in combination with consensus guideline development (e.g., unscheduled sedation consensus guideline).

8. Review the following policies per the Policy Sunset Review Process:
   - Clinical Guidelines Affecting Emergency Medicine Practice

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

2019-20
Final Committee Objectives

Clinical Resources Review Committee

Chair: Michael Turturro, MD, FACEP
Board Liaison: Jon Mark Hirshon, MD, PhD, MPH, FACEP
Staff Liaison: Sam Shahid, MBBS, MPH

1. Develop the process and criteria for review and approval of externally funded ACEP products (excluding federal grants), including but not limited to bedside point-of-care tools, toolkits, etc.

2. Develop a process for the Clinical Resources Review Committee operations, including potential consulting groups, such as ACEP expert panels, coalitions, and sections.

3. Review and comment on draft ACEP information papers on clinical topics as needed.

4. Review products developed by other organizations and requesting ACEP's comments.

2019-20
Final Committee Objectives

Coding & Nomenclature Advisory Committee

Chair: David Friedenson, MD, FACEP
Board Liaison: L. Anthony Cirillo, MD, FACEP
Staff Liaison: David McKenzie, CAE

1. Identify and analyze Medicare, Medicaid, and private payer claims processing policies that deviate from CPT principles and/or documentation guidelines and recommend strategic solutions. Track payer issues such as denials, rates, appeals, and pay for performance. Monitor the Recovery Audit Contractor (RAC), and other audit activities, and react appropriately to issues affecting emergency medicine.

2. Track ICD-10 implementation and continue to provide educational material on ICD-10 for members to aid in their reimbursement. Collaborate with content experts from the Quality & Performance Committee to ensure ACEP measures use appropriate ICD-10-CM/PCS mapping assignments. Continue to monitor the impact of ICD-10 implementation, evaluate the effect on reimbursement, and modify educational materials as needed.

3. Continue to advocate nationally for emergency medicine issues through the AMA CPT process and through possible CMS development of physician or facility documentation guidelines. Monitor efforts for transparency and claims processing edits. Explore development of an ED-specific code, such as using alternative payment models (APMs), for care coordination or transition to the post-acute setting.

4. Identify and develop educational materials such as articles, webinars, and Frequently Asked Questions (FAQs) to provide members with up-to-date information that will facilitate an effective balance between optimal coding and compliance.

5. Explore the development of CPT codes for community paramedicine and mobile integrated health care. Seek input with the EMS Committee and other committees as appropriate. (Coding & Nomenclature Advisory is the lead committee.)

6. Provide input to the Reimbursement Committee to develop a resident guide to billing and coding. Seek input from the Reimbursement Committee and EMRA. (Reimbursement is the lead committee)

2019-20
Final Committee Objectives

Communications Committee
(formerly the Public Relations Committee)

Chair: Jennifer L. Stankus, MD, JD, FACEP
Board Liaison: Stephen H. Anderson, MD, FACEP
Staff Liaison: Maggie McGillick and Nancy Calaway, CAE

1. Provide subject matter guidance to public relations staff on promoting the specialty of emergency medicine to external audiences, including health care consumers and policymakers, via the media on priority issues including, but not limited to:
   - Surprising billing and related issues such as balance billing, bundling payments and out-of-network payment, etc.;
   - Opioids and acute pain management;
   - Violence in the emergency department;
   - Correcting mischaracterizations around the high cost of emergency care;
   - Mental Health and reducing ED boarding; and
   - Other relevant emergency care issues as they arise.

2. Provide subject matter guidance to communications and marketing staff on promoting the specialty of emergency medicine to internal audiences, including ACEP members and leaders in the emergency medicine field on priority issues including, but not limited to:
   - Workforce issues, including scope of practice of NPs and PAs;
   - Ways to reduce the burden of Electronic Health Records systems and administrative regulations/paperwork;
   - Physician well-being – through both personal and systemic adjustments;
   - ACEP's benefit to all practice settings and models; and
   - Other relevant emergency physician issues as they arise.

3. Provide technical review and consultation for promoting *Annals of Emergency Medicine*.

4. Unify and amplify the ACEP's Spokesperson Network to deliver effective messages at the local level.

5. Increase ACEP's social media presence through platforms including Twitter, Facebook, You Tube, podcasts, etc.

6. Provide input into the implementation of the comprehensive communications and public relations plan, including internal and external messaging.

2019-20
Final Committee Objectives

Compensation Committee

Chair: Marco Coppola, DO, FACEP
Board Liaison: None
Staff Liaison: Layla Powers, MBA

1. Establish stipends for Board members, Board officers, and Council officers.

2. Monitor compensation trends (stipend and expense reimbursement) for the Board of Directors and officers of other medical specialties to ensure ACEP members are compensated appropriately.

2019-20
Final Committee Objectives

Disaster Preparedness & Response Committee

Chair: Marc Rosenthal, DO, FACEP
Board Liaison: Christopher S. Kang, MD, FACEP
Staff Liaison: Pat Elmes, EMT-P

1. Utilize identified national and international organizations active in disaster medical preparedness and response to assure appropriate liaisons and channels of communication with ACEP to seek opportunities to increase collaboration and development of in-time resources available to working ED doctors for when events happen.

2. Explore incorporating an advanced level within the existing Mass Casualty Medical Operations Course, or a separate course using the current course as a prerequisite, to include a pediatric component. Seek input from the Disaster Medicine Section and the Pediatric Emergency Medicine Committee. (Disaster Preparedness & Response Committee is the lead committee).

3. Solicit nominations for the Disaster Medical Sciences Award and recommend the recipient to the Board of Directors.

4. Review and disseminate online disaster and other related training for emergency physicians including a repository for tabletops and an assessment of the use of virtual reality technology in disaster response training.

5. Collaborate with fellowship directors to update the list/database of all disaster fellowships and the similarities or differences. Explore development of a Disaster Medicine board certification.

6. Identify existing groups, such as the National Center for Disaster Public Health (NCDPH), to explore ways to collaborate to collect disaster data and engage members to share data and reports about disaster events.

7. Develop a policy statement that defines the role of physicians who provide management, planning, and care during disasters. Include language that supports physician compensation for EM/EMS physicians with disaster training/experience that participate in efforts to support preparedness for the healthcare system.

8. Explore methods to advocate a greater role of emergency physicians in jurisdictional emergency management at the local level for hospital/community disaster preparedness, planning and operations.

9. Research existing deployment checklists and develop a specific version for emergency physicians who plan to respond to a disaster. Include information such as items to pack, references, research, and actions to take before, during, and after a response mission. Develop a list of recommended courses to consider before participating on a response mission.

10. Provide input to the Education Committee to explore online and other EMS, disaster, and other related training for emergency physicians. (Education is the lead committee.)

2019-20
Final Committee Objectives

Education Committee

Chair: Ernest E. Wang, MD, FACEP
Board Liaison: Kevin M. Klauer, DO, EJD, FACEP
Staff Liaison: Michelle Byers, CMP, CAE

1. Identify member educational needs based on assessments from a variety of sources, including state and facility CME requirements, board certification requirements, quality measures, test results, activity evaluations, member surveys, ACEP.org search terms and ACGME Milestones.

2. Design, implement, evaluate, and revise educational activities that meet identified needs and enhance ACEP's position as the primary source for state-of-the-art emergency medicine education, including:
   a. Live and enduring CME activities on the emergency medicine core content designed to reinforce cognitive expertise.
   b. Alternative educational opportunities such as simulation courses for procedural competencies and skills.
   c. Mobile and online CME courses and other activities that incorporate new learning technologies.
   d. Podcasts, social media, FOAMed.
   e. Performance Improvement-CME activities approved for the ABEM Improvement in Medical Practice requirements; Explore MOC on Mental Health in the ED (Adults and Children); Low Risk Chest Pain; and Charting and Documentation.
   f. Digital editions of ACEP titles published for a variety of reading devices.
   g. EMS subspecialty certification prep resources.
   h. Activities designed to help students, residents, and young physicians during early years of practice.
   i. Activities specific to the issue of litigation stress.
   j. Educational products related to the Clinical Emergency Data Registry Learning Collaborative.
   k. Educational products related to Geriatric Emergency Department Accreditation (GEDA) Learning Collaborative.
   l. Develop educational products for preventing prescription opioid misuse and addiction

3. Submit a nomination for the 2020 ACEP Award for Outstanding Contribution in Education.

4. Pursue strategic partnerships with publishers and other organizations that contribute to the College's CME mission, goals, and objectives.

5. Develop CME activities for physicians and providers practicing emergency medicine in resource-limited settings.

6. Explore cost-efficient ways to provide education to international emergency physicians. Enhance ACEP's expertise internationally in marketing publications and meetings. Design and implement ACEP International Global Leadership program. Create ACEP Live channel for International members and audience to have access to educational online products. Seek input from the International Emergency Medicine Committee. (Education is lead committee.)

7. Explore online and other EMS, disaster, and other related training for emergency physicians. Seek input from the EMS Committee and the Disaster Preparedness & Response Committees. (Education is the lead committee.)

8. Maximize the delivery platform for educational products to improve discoverability and access.

9. Increase diversity in the faculty for ACEP educational meetings and education programs. Ensure educational products to include diversity and inclusion throughout offerings and include topics such as unconscious bias in clinical care and practice management.

10. Provide input to the Well-Being Committee to complete development of interactive tutorials on resiliency strategies for members as part of Wellness Week activities and explore the possibility of providing CME. (Well-Being is the lead committee.)

2019-20
Final Committee Objectives

11. Provide input to the Pediatric Emergency Medicine Committee to develop a simulation-based consensus curriculum for pediatric emergency medicine, in collaboration with other organizations and for open access. (Pediatric Emergency Medicine is the lead committee.)

12. Provide input to the National/Chapter Relations Committee to develop resources to address the needs of small and medium sized chapters that were identified by the 2019 chapter services survey. (National/Chapter Relations is the lead committee.)

13. Implement and evaluate a research plenary session during *ACEP19*. Seek input from the Research Committee to (Education is the lead committee.)

14. Prioritize educational needs of members with the changing ABEM recertification exam. Re-position PEER products to fulfill board review requirements for those taking the initial qualifying exam and those seeking continuing certification through the new MyEMCert model and to maintain market share in an increasingly competitive Board prep market.

15. Publish Strauss and Mayer 2nd edition of Management of the ED.

16. Develop new podcast strategies, featuring Young Physicians Section-developed content.

17. Implement SimCourse in FY19-20.

2019-20
Final Committee Objectives
Emergency Medicine Practice Committee

Chair: Daniel Freess, MD, FACEP
Board Liaison: Alison J. Haddock, MD, FACEP
Staff Liaison: Margaret Montgomery, RN, MSN

1. Review the following policies per the Policy Sunset Review Process:
   a. Cultural Awareness and Emergency Care
   b. Deferral of Care After Medical Screening of Emergency Department Patients
   c. Emergency Department Patient Advocate Role and Training
   d. Emergency Department Planning and Resource Guidelines
   e. Emergency Medicine Telemedicine
   f. Freestanding Emergency Departments
   g. Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the ED
   h. Management of the Patient with the Complaint of Sexual Assault
   i. Recognition of Subspecialty Boards in Emergency Medicine
   j. Retail-Based Clinics
   k. Third-Party Payers and Emergency Medical Care
   l. Use of Patient Restraints
   m. Use of the Title "Doctor" in the Clinical Setting

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

2. Develop a policy statement addressing the responsibility of the medical director in the development of clinical provider staffing models that reflect the role of the physician as the medical team leader.

3. Develop a policy statement on the availability of food and beverage for clinical providers while working in the ED.

4. Review the results of The Joint Commission survey on onerous standards and develop resources and a communication plan to share the results with members.

5. Develop an "ED Boarding Toolkit," a step-by-step guide to ways directors dealing with boarding can work practically with other concerned parties in their hospital system to improve operational flow.

6. Solicit nominations for the 2020 Community Emergency Medicine Award and Innovation in Practice Award and recommend recipients to the Board of Directors.

7. Provide input to the Well-Being Committee and determine if ACEP's "Physician Impairment" should be revised to incorporate Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care or if a new policy statement is needed to address physician mental health and to aid in reducing physician barriers to mental health care. (Well-Being is the lead committee.)

8. Compile resources to support examples effective family leave practices, policies and procedures and provide input to the Well-Being Committee to develop an information paper on best practices regarding paid parental leave for emergency physicians as directed in Amended Resolution 36(17) Maternity and Paternity Leave. (Well-Being is the lead committee.)

9. Develop a policy statement on the role of the emergency physician in acute trauma management.

10. Identify additional resources or educational materials for emergency physicians on the care of patients with Autism Spectrum Disorder who present to the ED. (Resolution 40-18 Care of Individuals with Autism Spectrum Disorder in the ED).

11. Develop a psychiatric boarding toolkit to address care of the boarded behavioral health patient as directed in Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient. Seek input from the Coalition on Psychiatric Emergencies. (EM Practice is the lead committee.)

2019-20
Final Committee Objectives

EMS Committee

Chair: Julio R. Lairet, DO, FACEP
Board Liaison: Debra G. Perina, MD, FACEP
Staff Liaison: Rick Murray, EMT-P

1. Develop resources and guidelines for EMS medical directors on topics such as Mobile Integrated Healthcare (MIH) and Community Paramedicine (CP) programs and collaborate with NAEMSP and related stakeholders as needed.

2. Collaborate with stakeholders involved in changes to current controlled substances regulations (e.g., DEA regulations) and develop educational resources related to any new DEA regulations for EMS medical directors.

3. Develop resources for EMS medical directors regarding the new CMS Triage, Treat, and Transport (ET3) demonstration project.

4. Develop resources to promote and support the subspecialty of EMS medicine and the roles of the EMS medical director, such as EMS medical director reimbursement and the need for specific EMS training and experience. Collaborate with NAEMSP and related stakeholders as needed.

5. Develop EMS resources for assessing and treating pediatric patients. Collaborate with AAP, NAEMSP, ENA, the Pediatric Emergency Medicine Committee, and other stakeholders. (EMS is the lead committee.)

6. Develop a repository of documents for EMS medical directors to share, such as protocols, medical direction agreements, etc. Collaborate with the EMS Section. (EMS Committee is the lead)

7. Provide input to the Education Committee to explore online and other EMS, disaster, and other related training for emergency physicians. (Education is the lead committee.)

8. Submit a nomination for the 2020 ACEP Outstanding Contribution in EMS Award. Coordinate with the EMS Section and the Air Medical Transport Section.

9. Develop EMS and related course proposals and submit to the Educational Meetings Subcommittee for consideration by August 1, 2020 (for ACEP2021).

10. Develop resources for EMS medical directors for use in the oversight of EMS personnel such as Clinical Managers and QI/QA Managers.

11. Review the following policies per the Policy Sunset Review Process:
    - A Culture of Safety in EMS Systems

    Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

12. Continue the work of the High Threat Casualty Care Task Force (HTCCTF):
    - create a high-threat incident database, standardized data-gathering tool, and support the creation of data-gathering rapid response to enable rapid dissemination of lessons-learned
    - develop and disseminate best practices for translation of military lessons learned, consistent with Mission Zero.
    - develop and disseminate resources related to recovery from high-threat incidents.

13. Provide input to the Coding and Nomenclature Advisory Committee (CNAC) to explore the development of and use of CPT codes for EMS medical director reimbursement for community paramedicine and mobile integrated healthcare programs as well as on-line and off-line EMS medical direction. (Coding & Nomenclature is the lead committee).

2019-20
Final Committee Objectives

Ethics Committee

Chair: Raquel Schears, MD, FACEP
Board Liaison: Christopher S. Kang, MD, FACEP
Staff Liaison: Leslie Moore, JD

1. Identify and develop educational opportunities and materials on ethics issues, including at least three articles for ACEP publications including:
   - Ethical issues of inter-professional relationships in the ED.
   - Ethical issues in social media and protecting the privacy and security of Emergency Physicians in the ED.
   - Ethical role of Emergency Physicians in the training of Physician Assistants and Nurse Practitioners.
   - Hospital ethics committee and their relationship in Emergency Medicine (due to urgent need of intervention).
   - Ethical implications of expanding EM residency programs and spots.
   - Ethical obligations to provide maternal and parental leave benefits.

2. Review the *Policy Compendium of the Code of Ethics for Emergency Physicians* and recommend needed revisions to the Board of Directors.

3. Review ethics complaints and provide recommendations to the Board of Directors.

4. Develop the following information papers:
   - ethical issues stemming from medicine/healthcare becoming more business-centric and consumer oriented, and the impact on the dynamics and integrity of the patient-physician relationship
   - ethics of using Artificial Intelligence (AI) in emergency medicine
   - ethics concerning 100% RVU compensation
   - ethical issues in access to emergency care for undocumented immigrants

5. Review the following policies per the Policy Sunset Review Process:
   - ACEP Business Arrangements
   - Animal Use in Research
   - Collective Bargaining, Work Stoppages, and Slowdowns
   - Ethical Issues at the End of Life
   - Fictitious Patients
   - Reporting of Medical Errors

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

6. Review and revise the policy statement "Use of Social Media by Emergency Physicians" to include the practice of "doxxing."

7. Develop a policy statement regarding ethical and practical guidance for emergency physician care of family members, friends, colleagues, and self.

8. Provide input to the Federal Government Affairs committee to develop draft legislation for the 116th Congress to address ED-specific end-of-life issues. (Federal Government Affairs is the lead committee.)

9. Survey members to identify PTSD and stress-related disorders among emergency physicians. Develop resources to assist members with PTSD and stress-related disorders. Seek input from the Well-Being Committee. (Ethics is the lead committee.)

10. Review the "Expert Witness Guidelines for the Specialty of Emergency Medicine" policy statement and determine if revisions are needed or develop a new policy statement to explicitly oppose cross-specialty testimony for the standard of care. Seek input from the Medical-Legal Committee. (Ethics is the lead Committee.)

2019-20
Final Committee Objectives

Federal Government Affairs Committee

Chair: Carlton Heine, MD, FACEP
Board Liaison: William P. Jaquis, MD, FACEP, President-Elect
Staff Liaison: Laura Wooster, MPH

1. Analyze and recommend legislative and regulatory priorities for the Second Session of the 116th Congress.

2. Develop strategies to expand the 9-1-1 Advocacy Network. Encourage committee members to meet with their congressional representatives either locally or on Capitol Hill.

3. Develop a legislative and/or regulator strategy to address the growing drug shortage issue at the federal level.

4. Develop draft legislation for the 116th Congress to address ED-specific end-of-life issues. Collaborate with content experts from the Ethics Committee and State Legislative/Regulatory Committee. (Federal Government Affairs is the lead committee.)

5. Develop a legislative and/or regulatory strategy to facilitate and require Indian Health Service data-sharing with prescription drug monitoring programs.

6. Identify new opportunities to work with federal agencies, including the Veterans Administration, Department of Defense, Indian Health Services, etc.

7. Develop and assess potential innovative approaches to improving the way care is delivered and reimbursed in rural areas, with the goal of improving patient access to emergency department services in these areas. Collaborate with content experts from other committees and task forces as needed.

8. Develop and assess potential legislative ideas to address firearm safety and injury prevention.

9. Develop recommendations for federal legislative and/or regulatory strategies to ensure telemedicine can advance emergency medicine and protect the practice environment for emergency physicians and quality of care for patients.

10. Develop an annual report to all ACEP members regarding advocacy work done on behalf of emergency medicine.

11. Monitor and respond to federal legislative action related to out of network billing. Collaborate with content experts from the ACEP-EDPMA Joint Task Force, Reimbursement Committee, and State Legislative/Regulatory Committee. (Federal Government Affairs is the lead committee.)

12. Review the following policy per the Policy Sunset Review Process:
    - Worldwide Nuclear Disarmament
    - Health Care Cost Assignment by Taxes

    Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

13. Review Resolution 34(18) Violence is a Health Issue, determine whether model legislation should be developed, and provide a recommendation to the Board of Directors.

14. Support advocacy efforts on rescheduling of cannabis to facilitate well-controlled studies of cannabis and related cannabinoids for medical use in patients as directed in Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis.

2019-20
Final Committee Objectives

Finance Committee

Chair: Gary Starr, MD, MBA, FACEP
Vice Chair: Josh Moskovitz, MD, MBA, MPH, FACEP
Board Liaison: Mark S. Rosenberg, DO, MBA, FACEP, Secretary-Treasurer
Staff Liaison: Layla Powers, MBA

1. Perform duties as delineated in the *Compendium of Financial Policies and Operational Guidelines*, including:
   - Cash flow analysis
   - Review the annual college budget and three year financial projections and make recommendations to the Board.
   - Review the financial status of the College monthly.
   - Consider budget modifications and make recommendations to the Board.
   - Review and monitor expenses for the Clinical Emergency Data Registry
   - Review strategic intiative project requests for funding and provide recommendations to the Board. Monitor financial performance of projects that have been initiated.

2. Review the *Compendium of Financial Policies and Operational Guidelines* and provide recommendation to the Board for any necessary revisions.

3. Conduct an annual review of contributions made by ACEP to affiliated organizations.

4. Review and report on return on investment and/or performance for all projects in Strategic Projects Initiatives (SPI) and evaluate new projects that meet the criteria for the SPI.

2019-20
Final Committee Objectives

Health Information Technology Committee

Chair: Nicholas Genes, MD, FACEP
Board Liaison: J.T. Finnell, MD, FACEP
Staff Liaison: Pawan Goyal, MD

1. Develop work products related to HIT policies, standards, implementation specifications, certification criteria, and similar issues, as well as the adoption, usability, and safety of health information technology solutions, that advances the electronic access, exchange, and use of health information.

Participate in national committees and leadership organizations that direct the application of health care information technology and direct healthcare information technology policy.
Develop a process for continuous migration and updating of communication within the College.
Evaluate and propagate interactive technologies for all aspects of IT management and education.
Prepare and maintain policies necessary to coordinate and assure compatibility of information technology within the College.
Develop and disseminate information for knowledge of the ACEP Fellowship in Informatics.
Make recommendations related to the implementation of communication platforms to serve the College and its members, from conventional methods to methods utilizing the latest mainstream technology.

Suggested First Year Priorities:
Increase the awareness on Health IT issues and challenges leading to physician burden and burn-out, as well as, drive adoption of solutions to improve the usability of electronic health records (EHRs) and physician documentation practices at the point of care.
Provide leadership for a Health IT Summit to drive the vision for the transformation of Emergency Care through Information Technology integration and data-driven quality.

Define goals, scope, and approach to Data Analytics and Research platform development.
Invite major IS vendors to participate in the Committee, as appropriate.
Continue and complete the work of the ED Health Information Systems Taskforce, as appropriate.

Example Objectives:
- Collaboration with the Well-Being Committee to identify and develop resources to address EHR Burnout. (Well-Being is the lead committee).
- Provide resources for members regarding best practices for decision support and clinical documentation.
- Develop a resource for medical students and residents about subspecialty certification and opportunities after EM residency. Collaborate with EMRA .
- Assist CEDR with Quality Reporting and Measurement (CEDR is the lead).
- Assist Coding and Nomenclature Committee with tracking ICD-10 implementation and continue to provide educational material on ICD-10 for members to aid in their reimbursement. Collaborate with content experts from the Quality & Performance Committee to ensure ACEP measures use appropriate ICD-10-CM/PCS mapping assignments. Continue to monitor the impact of ICD-10 implementation, evaluate the effect on reimbursement, and modify educational materials as needed. (Coding is lead).
- Assist Disaster and Preparedness Committee with monitor the national disaster medicine environment for federal regulations, new guidelines, standards, and technologies that potentially significantly impact disaster medicine and provide recommendations to the Board as needed. (Disaster is lead).
- Review and identify gaps in current beside tools for clinicians.

2019-20
Final Committee Objectives

International Emergency Medicine

Chair: Christian Arbelaez, MD, FACEP
Board Liaison: Paul Kivela, MD, FACEP, Immediate Past President
Staff Liaison: Faeeza Faruq

1. Review ACEP's policies on violence in the ED, determine if a new or revised policy statement is needed to address violence in the ED internationally, and provide a recommendation to the Board of Directors.

2. Identify ways to increase membership and attendance at Scientific Assembly

3. Identify ways to make ACEP products and resources more readily available to international members.

4. Identify and address the educational needs of international emergency physicians.

5. Identify and cultivate relationships with other national and international emergency medicine organizations, societies, NGOs, and governmental entities.

6. Oversee and direct the ACEP International Ambassador Program and Ambassador Conference to better understand emergency care, models, and activities in each country.

7. Work with the International Emergency Medicine Section Leadership to implement priority tactics and programming.

2019-20
Final Committee Objectives

Medical-Legal Committee

Chair: Rade Vukmir, MD, FACEP
Board Liaison: Kevin M. Klauer, DO, EJD, FACEP
Staff Liaison: Craig Price, CAE

1. Review, update, and provide information to members on medical legal matters that impact the administrative and clinical practice of emergency medicine.

2. Participate in the review of new clinical policies and provide information on potential medical-legal issues.

3. Explore new opportunities to deter inaccurate expert witness testimony and promote awareness and utilization of ACEP resources designed to curtail egregious testimony.

4. Develop recommendations to protect digital communications between physicians and advance practice providers so that constructive feedback given by physicians when signing charts completed by advance practice providers is not discoverable.

5. Explore opportunities and strategies to enhance the protection of electronic health records data from discovery.

6. Develop a policy statement, or revise existing ACEP policy, to address patients or family members recording or live-streaming care without consent in the emergency department.

7. Review the medical-legal resources on the ACEP website and update as needed.

8. Develop curricula for emergency medicine residents on medical-legal issues.

9. Review the following policies per the Policy Sunset Review Process:
   - Responsibility for Admitted Patients

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

10. Develop an information paper that explains the standards members should expect from expert witnesses, including that expert witnesses should adhere to ACEP's "Expert Witness Guidelines for the Specialty of Emergency Medicine" policy statement and sign the reaffirmation statement.

11. Review and update the Standard of Care Review Process.

2019-20
Final Committee Objectives

Membership Committee

Chair: Aychut Kamat, MD, FACEP
Board Liaison: Gillian R. Schmitz, MD, FACEP
Staff Liaison: Jana Nelson

1. Work with staff to review potential membership models and recommend viable options and a timeline for consideration by the Board of Directors.

2. Identify ways to improve relationships with residents, particularly those transitioning to full ACEP membership.

3. Explore ways to engage younger physicians, with particular emphasis on first six years, including more efficient, targeted communication and educational offerings.

4. Make recommendations for enhancing social media and online presence. Provide input for content development of the membership recruitment, renewal, and benefit sections of ACEP.org.

5. Analyze membership retention among growing population of semi-retired, retired and Life members and make recommendations for enhancing status and benefits.

6. Develop recommendations for acquisition efforts towards ABEM-certified non-members.

7. Recommend avenues to promote engagED to special interest groups and sections that are topic specific.

8. Section Governance
   a. Oversee the annual section grant process and recommend grant recipients to the Board of Directors.
   b. Select recipients of the annual section awards for recommendation to the Board of Directors.
   c. Review requests for formation of new sections and provide recommendations to the Board of Directors.
   d. Review rules for section membership compliance and make recommendations for changes as needed.
   e. Revise the Section Grant Criteria, as needed, to reflect current priorities of the college as recommended by the Board of Directors.

9. Serve as a resource in the development of a group and residency portal to facilitate administrative efficiency for group enrollment of multiple members.

10. Explore ways to retain emergency physicians who are transitioning to non-traditional work settings engaged in the College.

11. Provide input to the National/Chapter Relations Committee to develop resources to address the needs of small and medium sized chapters that were identified by the 2019 chapter services survey. (National/Chapter Relations is the lead committee.)

2019-20
Final Committee Objectives

National/Chapter Relations Committee

Chair:-Mark Notash, MD, FACEP
Board Liaison: Gillian R. Schmitz, MD, FACEP
Staff Liaison: Maude Hancock

1. Solicit nominations for the Diane K. Bollman Chapter Advocate Award and recommend recipient(s) to the Board of Directors.

2. Analyze the results of the 2019 annual chapter survey. Develop and promote chapter resources and best practices in cultivating current and future leaders.

3. Develop resources to address the needs of small and medium sized chapters. Seek input from the Education Committee and Membership Committee. (National/Chapter Relations is the lead committee.)

4. Explore mentoring and collaboration opportunities between regionally paired/grouped large, medium, and small chapters.

2019-20
Final Committee Objectives

Pediatric Emergency Medicine Committee

Chair: Ann Dietrich, MD, FACEP
Board Liaison: Debra G. Perina, MD, FACEP
Staff Liaison: Sam Shahid, MBBS, MPH

1. Develop a policy statement on the role and responsibilities of emergency medicine providers in the initial management of acute pediatric mental health emergencies.

2. Develop the following information papers:
   - role of telemedicine in pediatric emergency care and in support of community emergency departments. Seek input from the Emergency Telehealth Section. (Pediatric Emergency Medicine is the lead committee)

3. Support the Pediatric Readiness Project and assist in developing resources to promote ED preparedness.

4. Work with the EMSC Innovation & Improvement Center (EIIC) to:
   - Ensure ACEP is recognized as a full partner of the EIIC.
   - Create its leadership and policy infrastructure and to develop strategies to optimize resource utilization between general emergency medicine and pediatric emergency medicine.
   - Ensure ongoing collaboration with the committee and the ACEP grant-funded staff from EIIC.

5. Collaborate with the American College of Radiology to provide pediatric content expertise in generating recommendations for radiographic tests in the emergency management of children.

6. Collaborate with the American Academy of Pediatrics and the Emergency Nurses Association (ENA) to develop a policy statement to optimize pediatric safety in the emergency care setting.

7. Work with the American Academy of Pediatrics to develop new and review current technical report papers and policy statements as needed.

8. Review the following policies per the Policy Sunset Review Process:
   - Patient and Family Centered Care of Children in the Emergency Department

   Determine by December 15 if the policy should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

9. Develop an open access simulation-based consensus curriculum for pediatric emergency medicine, in collaboration with other organizations and stakeholders. Seek input from the Education Committee, Simulation Subcommittee, and the Pediatric Emergency Medicine Section. (Pediatric Emergency Medicine is the lead committee.)

10. Provide input to the Disaster Preparedness & Response Committee to refine the Mass Casualty Medical Operations Management Course to include pediatric disaster education. (Disaster Preparedness & Response is the lead committee.*)*

11. Provide input to the EMS Committee, in collaboration with AAP, NAEMSP, ENA, and other stakeholders, to develop resources for assessing pediatric readiness of EMS systems and pediatric medication dosing. (EMS is the lead committee.*)*

12. Develop resources to encourage emergency medicine residents to enter pediatric emergency medicine.

13. Complete development of a joint policy statement with the American Academy of Pediatrics and the Pediatric Surgery Society on trauma imaging in the pediatric patient population according to existing guidelines and decreasing unnecessary radiation in pediatric trauma patients.

14. Complete development of a policy statement on the use of antitussive medications, specifically opiate-containing antitussives, and their utility in the treatment of pediatric patients.

2019-20
Final Committee Objectives

15. Develop a policy statement on the importance of scheduled vaccinations. Seek input from the Public Health & Injury Prevention Committee. (Pediatric Emergency Medicine is the lead committee.)

16. Provide input to the Public Health & Injury Prevention Committee to develop a policy statement on antimicrobial stewardship. (Public Health & Injury Prevention is the lead committee.)

2019-20
Final Committee Objectives

Public Health & Injury Prevention Committee

Chair: Alan Heins, MD, FACEP
Board Liaison: James J. Augustine, MD, FACEP
Staff Liaison: Margaret Montgomery, RN, MSN

1. Review the following policies per the Policy Sunset Review Process:
   - 911 Caller Good Samaritan Laws
   - Emergency Care Electronic Data Collection and Exchange
   - HIV Testing and Screening in the Emergency Department
   - Role of the Emergency Physician in Injury Prevention and Control for Adult and Pediatric Patients

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

2. Develop a policy statement on Adult Mental Health Emergencies.

3. Review smoking cessation materials on the ACEP website and consider the development of a policy statement, PREP, and/or resources on smoking cessation.

4. Review the "Human Trafficking" policy statement and revise to include reference to children.

5. Provide input to the Quality & Patient Safety Committee to develop an antimicrobial stewardship toolkit as directed in Amended Resolution 38(18) Antimicrobial Stewardship. (Quality & Patient Safety is the lead committee.)

6. Develop an information paper on the stigma associated with substance use and mental health disorders.

7. Develop talking points or "smart phrases" for discharge summaries and/or educational resources on public health and injury prevention issues.

8. Collaborate with the Epidemic Expert Panel to explore development of best practices for treating patients with flu or flu-like illness that meet sepsis guidelines during the flu season.

9. Provide input to the Pediatric Emergency Medicine Committee to develop a policy statement on the importance of scheduled vaccinations. (Pediatric Emergency Medicine is the lead committee.)

10. Develop a policy statement on antimicrobial stewardship. Seek input from the Pediatric Emergency Medicine Committee. (Public Health & Injury Prevention is the lead committee.)

2019-20
Final Committee Objectives

Quality & Patient Safety Committee

Chair: Richard Griffey, MD, FACEP
Vice Chair: Keith Kocher, MD, FACEP
Board Liaison: Aisha T. Liferidge, MD, MPH, FACEP
Staff Liaison: Pawan Goyal, MD

Measure Lifecycle Management

1. Create and initiate a workflow with the Clinical Emergency Data Registry Committee for future quality measure development efforts.
2. Manage the quality measure lifecycle at ACEP by:
   a. Creating, prioritizing, and suggesting quality measure concepts that align with the CMS Meaningful Measures Initiative to the CEDR Data Validation Sub-Committee for development, testing, and implementation of new quality measures.
   b. Performing maintenance on current ACEP measures and working with staff and vendors and make improvements or recommending measures for retirement.
3. Educate members in quality measurement to develop new leaders for the quality measure development program.
4. Assist with the quality measure lifecycle on behalf of external organizations by monitoring quality initiatives and commenting on behalf of ACEP on the appropriateness of quality measures that impact the practice of emergency medicine, the emergency department, and the reimbursement of emergency physicians.

Nominations

5. Nominate emergency physicians to represent ACEP to internal and external bodies that are developing quality measures that have relevance to the practice of emergency care.

Clinical Policies and Federal Review

6. Comment on the quality provisions of the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), the Physician Fee Schedule (PFS), Medicare Access and CHIP Reauthorization Act (MACRA)
7. Educate members regarding implementation and best practices for quality measures and federal quality measurement programs.

Patient Safety

8. Complete development of a behavioral health toolkit as directed in Amended Resolution 14(16) Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in the ED.
9. Collect candidate quality improvement projects and develop improvement tools. Develop emergency medicine-specific improvement activities for the QPP program.
10. Develop an antimicrobial stewardship toolkit as directed in Amended Resolution 38(18) Antimicrobial Stewardship. Seek input from the Public Health Committee. (Quality & Patient Safety is the lead committee.)

Choosing Wisely

11. Conduct periodic evidence-based literature reviews to existing Choosing Wisely recommendations.
12. Promote ACEP within the Choosing Wisely Champion program.

Measures Technical Expert Panel (TEP)

13. Utilize the Technical Expert Panel to provide oversight and feedback on new quality measures recommended for development.
14. Provide feedback on quality measures submitted from the Clinical Emergency Data Registry Measure and Data Validation Subcommittee and identify quality measures to recommend to the Board.

2019-20
Final Committee Objectives

Reimbursement Committee

Chair: Heather Marshall, MD, FACEP
Board Liaison: L. Anthony Cirillo, MD, FACEP
Staff Liaison: David McKenzie, CAE

1. Identify and analyze the governmental reimbursement environment as it pertains to emergency medicine and assist in positioning the College appropriately on issues of importance. Concentrate on audit activity and payment policies throughout the Medicare system.

2. Continue to identify and analyze reimbursement challenges that impact emergency medicine and recommend strategic solutions. Continue to monitor private payer practices such as balance billing and fair payment, and challenge health plan claim bundling practices. Track out of network payments and payer mix shifts based on the ACA and databases such as FAIR Health.

3. Continue to support the efforts of the liaisons to the AMA RBRVS process, and advocate for improvement of work, practice expense, and malpractice relative values. Participate in any episode of care development activity in that venue.

4. Identify and develop educational materials such as articles, webinars, and Frequently Asked Questions (FAQs) to provide members with practical information on developing reimbursement trends. Develop specific content for residents and young physicians. Create tools to assist medical students with documentation that facilitate the integration of the medical student's documentation in the medical record with the supervision of the attending physician.

5. Develop a strategy for emergency medicine to be represented in alternate payment models, including episodes and population health, to prepare for the transition from fee-for-service reimbursement to value-based reimbursement. Provide analysis of new payment models for emergency physician services that may replace or supplement the predominant fee for service model and offer advice on how ACEP members should prepare for these new models (ACOs, bundled payment, value-based reimbursement, etc.) Seek input from the Alternative Payment Models Task Force. Expand the AUCM analysis to other payers.

6. Monitor Medicaid reforms at the state level and provide resources as appropriate. Explore developing a model to implement the AUCM framework at the state level for Medicaid payors. Seek input from the State Legislative/ Regulatory Committee to coordinate with state chapter stakeholders in drafting the implementation process. (Reimbursement is the lead committee).

7. Provide input to the Federal Government Affairs Committee to develop a regulatory and/or legislative strategy to encourage the use of appropriate alternatives to Emergency Department copays in State Medicaid waiver applications that embrace the prudent layperson concept. (Federal Government Affairs is the lead committee.)

8. Provide input to the Federal Government Affairs Committee in developing a proactive federal-level strategy on out-of-network/balance billing, including consideration of introducing federal legislation. (Federal Government Affairs is the lead committee.)

9. Provide input to the State Legislative/Regulatory Committee and the out-of-network/balance billing "strike team" leaders to provide expertise and resources to states addressing balance billing/out-of-network legislation. (State Legislative/Regulatory is the lead committee.

10. Develop a resident guide to billing and coding. Obtain input from the Coding & Nomenclature Committee and EMRA. (Reimbursement is the lead committee).

2019-20
Final Committee Objectives

Research Committee

Chair: Manish Shah, MD, FACEP
Board Liaison: John T. Finnell, MD, MSc, FACEP
Staff Liaison: Loren Rives, MNA

General Research Committee Objectives

1. Submit a nomination for the 2020 ACEP Award for Outstanding Contribution in Research.
2. Collaborate with the American College of Osteopathic Emergency Physicians (ACOEP) to identify strategies and resources to assist emergency medicine residency programs in meeting scholarly activity requirements for faculty and residents.
3. In collaboration with SAEM's Research Committee, review and submit responses to the NIH's requests for information (RFIs).
4. Support the development of community-based research and researchers.
5. Explore ways to develop and strengthen the emergency medicine EM research network for multicenter clinical studies.
6. Identify priority topics for a focal EMF grant.
7. Develop a consensus process that includes the opinions of Research Committee members, EMF and research leaders, and membership more broadly, to identify strategies for future research support and development.

Research Forum Subcommittee

8. Implement, advance and improve the 2020 *Research Forum* meeting
9. Select recipients for medical students, residents, young investigators, and best paper awards.
10. Highlight basic science and senior researchers during Research Forum.
11. Identify emergency medicine research that results in innovative practice changes and promote the research at ACEP's annual meeting.

Scientific Review Subcommittee

12. Assist EMF with funding opportunities.
13. Explore potential collaborations with other specialty groups for grants.
14. Review grant proposals for EMF and recommend applicant funding and provide on-going monitoring of funded grant progress reports.
15. Expand the pool of EMF grant reviewers through development of a junior faculty mentorship program and establishment of a list of pre-approved ad hoc reviewers.
16. Initiate a standardized process for EMF grant reviewer development.
17. Identify potential areas of further targeted research that are of interest to members.
18. Review the EMF grant portfolio with a specific focus on pipeline (i.e., training and development) awards and revise as needed.
19. Engage new reviewers and develop a mentoring plan for new reviewers.

2019-20
Final Committee Objectives

State Legislative/Regulatory Committee

Chair: Danyelle Redden, MD, MPH, FACEP
Board Liaison: Alison J. Haddock, MD, FACEP
Staff Liaison: Harry Monroe

1. Monitor Medicaid payment reforms at the state level and provide resources as appropriate. Seek input from the Reimbursement Committee to explore opportunities to advocate for alternative payment models for Medicaid. (State Legislative/Regulatory is the lead committee.)

2. Draft model state legislation that can be used by chapters to advocate for the prudent layperson standard in light of recent practices by commercial and government payers that deny or reduce payment based retrospectively on diagnosis. Collaborate with the Emergency Department Practice Management Association.

3. Provide input to the Reimbursement Committee and the out-of-network/balance billing "strike team" leaders to provide expertise and resources to states addressing balance billing/out of network legislation. (State Legislative/Regulatory is the lead committee.)

4. Develop a regulatory and/or legislative strategy to encourage the use of appropriate alternatives to Emergency Department copays in State Medicaid waiver applications that embrace the prudent layperson concept.

5. Research and summarize best practices by states working to overcome barriers to the provision of new treatments and modalities that reduce, when appropriate, the use of opioid medications.

6. Research and provide at least two case studies of states and/or regions that have developed and implemented successful programs for addressing the boarding of psychiatric patients.

7. Develop model state legislation for chapters to use to access funding related to the Preventing Overdoses While in the Emergency Rooms (POWER) Act and to address Amended Resolution 25(18) Funding for Medication Assisted Treatment Programs, Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs, and Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder.

8. Develop a toolkit and other resources to assist chapters in the passage of state legislation to enact extreme risk protection orders as directed in Amended Resolution 45(18) Support for Extreme Risk Protection Order to Minimize Harm.

9. 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.

10. Review and update resources related to qualifications of expert witnesses in medical liability cases. Create a toolkit of resources for chapter to use in advocating for reforms.

11. Promote and administer the state public policy grant program.

12. Submit a nomination for the 2020 Rorrie Health Policy Award.

13. Submit a nomination for the 2020 Policy Pioneer Award.

14. Monitor Medicaid reforms at the state level and provide resources as appropriate. Explore developing a model to implement the AUCM framework at the state level for Medicaid payors. Provide input to the Reimbursement Committee to coordinate with state chapter stakeholders in drafting the implementation process. (Reimbursement is the lead committee).

15. Develop resources for chapters on fundraising for advocacy initiatives.

16. Provide input to the Federal Government Affairs committee to develop draft legislation for the 116th Congress to address ED-specific end-of-life issues. (Federal Government Affairs is the lead committee.)

17. Monitor and respond to federal legislative action related to out of network billing. Collaborate with content experts from the ACEP-EDPMA Joint Task Force, Reimbursement Committee, and State Legislative/Regulatory Committee. (Federal Government Affairs is the lead committee.)

2019-20
Final Committee Objectives

Well-Being Committee

Chair: Arlene Chung, MD, FACEP
Board Liaison: Debra G. Perina, MD, FACEP
Staff Liaison: Kelly Peasley

1. Implement the Wellness Week program for emergency physicians and providers to encourage personal and professional wellness strategies. Explore wellness training tactics for residents and young physicians. Strive for a 30% participation rate of all ACEP members.

2. Complete development of interactive tutorials on resiliency strategies for members as part of Wellness Week activities and explore the possibility of providing CME. Seek input from the Education Committee. (Well-Being is the lead committee.)

3. Compile and disseminate information on the "joys" (professional and personal satisfaction) of practicing emergency medicine. Incorporate ideas of well-being and wellness into a sustainable platform beyond wellness week. Refine campaigns for a culture change for emergency physicians to focus on the positive accomplishments in the ED.

4. Update the "Being Well in Emergency Medicine: ACEP's Guide to Investing in Yourself**."**

5. Analyze emergency departments with higher and lower physician and nurse turnover and examine characteristics of the department and individuals that may have a positive or negative effect on wellness.

6. Develop a series of articles for submission to *ACEP Now*, including how to improve being well in emergency medicine and bringing "joy" to practice.

7. Enhance activities in the Wellness Center based on learnings and recommendations from 2019.

8. Identify exemplary practices that promote wellness. Seek input from the Emergency Nurses Association, the Society for Emergency Medicine Physician Assistants, and the American Academy of Nurse Practitioners to.

9. Conduct outreach with international emergency medicine organizations to share ideas and opportunities for collaboration. Investigate the potential for working with the International Federation of Emergency Medicine to develop international working groups focused on well-being in emergency medicine. Seek input from the International Emergency Medicine Committee. (Well-Being is the lead committee.)

10. Discover exemplary practices that contribute to wellness in emergency medicine and disseminate the information to all EDs in the U.S.

11. Continue collaboration with EMRA and the Academic Affairs Committee to identify and/or develop resources for residents and medical students to address resiliency and coping mechanisms. (Well-Being is the lead committee.)

12. Complete an information paper on best practices regarding paid parental leave for emergency physicians as directed in Amended Resolution 36(17) Maternity and Paternity Leave. Work with the Emergency Medicine Practice Committee. (Well-Being is the lead committee.)

13. Review ACEP's current resources and develop additional resources as needed to address interruption of clinical emergency medicine practice as directed in Resolution 51(17) Retirement or Interruption of Clinical Emergency Medicine Practice.

14. Review the following policies per the Policy Sunset Review Process:
    - Physician Impairment (Obtain input from the Emergency Medicine Practice Committee. Review Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care and determine if a new policy statement is needed to address physician mental health and to aid in reducing physician barriers to mental health care.)
    - Support for Nursing Mothers

Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

15. Study the unique, specialty-specific factors leading to depression and suicide in emergency physicians and formulate an action plan to address the contributory factors unique to emergency medicine and provide a report of the findings as directed in Resolution 16(18) No More Emergency Physician Suicides. Seek input from the Academic Affairs Committee (resident perspective) and the Wellness Section. (Well-Being is the lead committee.)

16. Identify other organizations engaged in wellness and evaluate for potential collaborative efforts.

17. Provide input to the Ethics Committee on a survey members to identify PTSD and stress-related disorders among emergency physicians and develop resources to assist members with PTSD and stress-related disorders. (Ethics is the lead committee.)

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEP Strategic Plan for 2019-2022

Goal 1 –Improve the Delivery System for Acute Care

Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Objective G – Pursue meaningful medical liability reform and other initiatives at the state and federal levels.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

Objective A – Improve the practice environment and member well-being.

Objective B – Increase total membership and retain graduating residents.

Objective C – Provide robust communications and educational offerings, including novel delivery methods.

Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner

Objective E – Ensure optimal organizational infrastructure and governance to support membership.

Objective F – Provide and promote leadership development among emergency medicine organizations and strengthen liaison relationships.

Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

Objective H – Promote job security and opportunity for individual members at all stages of their career.

EMERGENCY MEDICINE FOUNDATION REPORT TO THE COUNCIL

- EMF funded 23 research grants for $805,319 in 2019-2020 and continues to lead the way as the largest foundation funder of EM research. See attached.

- EMF has announced its new slate of 24 grant opportunities for 2020/2021 – see attached listed of grant opportunities or visit www.emfoundation.org for grant opportunities. EMF also has three new directed research grants available.

- EMF is requesting your continued generosity and support so that we can fund even more emergency medicine research grants.

- Dave Wilcox, MD, FACEP will serve as the new EMF Chair in 2020

- NEW this year: EMF and ACEP approved ***The Brooks F. Bock Lecture Series***

Here are some easy ways to participate in supporting EMF during ACEP19:

- **Make your Council Pledge today.** Goal: Raise $150,000 this year! With a contribution of $600 or above, receive access to the EMF Major Donor Lounge throughout the ACEP19 National Conference, providing a comfortable lounge area and complimentary refreshments.

- **EMF In-booth vendor promotions on Exhibit Floor benefitting EMF: Go by the Vapotherm Booth 1333 and Brault booth 1014 on the exhibit floor** to participate in their fun in-booth activities to benefit EMF. Bring a friend with you because it all adds up to more money for research!

- **EMF Silent Auction: Sunday October 27-Tuesday, October 29, 9-4 p.m. in the Grand Concourse of the Colorado Convention Center:** Go by and bid on an item at the silent auction to benefit EMF, including jewelry, sports, music, and celebrity memorabilia, art, and more. Don't forget to bring a colleague with you!

- **EMF Wiegenstein Legacy Society:** Don't forget the Wiegenstein Legacy Society (WLS) by adding EMF to your Will or Estate Plan. Over 100 ACEP members have joined WLS accounting for $2.5 million in future receipts for EMF. If you are a WLS member and attending the Reception Monday night, be sure to bring a friend who may be interested in WLS.

- **Round Up for Research at the EMF VIP Reception:** If you are not already attending as a major donor, be sure to purchase a ticket to attend the EMF VIP Reception, on Sunday, October 27 from 7:00 to 8:30 p.m., at the ACEP19 Registration Counter or come to the EMF Major Donor Lounge in Room 502 of the Colorado Convention Center.

EMF 2020-2021 Grant Categories

- Mid-Career Research Development
  - 1 grant; $250,000 total
- Resident to Faculty Research Development
  - 1 grant; $150,000 total
- Pilot Research
  - 1 grant; $50,000 total
- EMBRS
  - 1 grant; $5,000 total
- EMF/SAEM Medical Student
  - 4 grants at $5,000/each; $20,000 total
- EMF/SAEM/GEMSSTAR
  - 1 grant; $25,000
- EMF/Medical Toxicology Foundation
  - 1 grant; $10,000
- EMF/EMRA Resident
  - 5 grants at $10,000/each; $50,000 total
- EMF/CORD Education Research
  - 2 grants at $25,000/each; $50,000
- EMF/CORD Education Research Starter
  - 2 grants at $10,000/each; $20,000
- EMF/ENAF/AFFIRM Research
  - 1 grant; $75,000
- EMF/EMRA/AFFIRM Resident
  - 1 grant; $12,000
- EMF/NAEMSP EMS Research
  - 3 grants at $5,000 each; $15,000 total

EMF Emergency Medicine Foundation®

research → education → patient care

Help us meet the $200,000 goal!

Donate at emfoundation.org/council

23rd Annual Council Challenge

The ACEP Council is the largest and longest sustaining supporter of EMF. Because of your generosity, EMF is funding innovative research to improve the practice of emergency medicine.

2019–2020 EMF GRANTEES

Mid-Career Research Development

Ryan McCormack, MD, MS
NYU Langone Health
Rapid Induction of Buprenorphine in the Emergency Department
$248,799

VA Fellow to Faculty Career

Matthew Augustine, MD, MS
Icahn School of Medicine at Mount Sinai, James J Peter VA Medical Center
Using Regional Information Exchanges to Understand VHA and Non-VHA ED Utilization
$200,000

EMF/AFFIRM Early Career Research Development

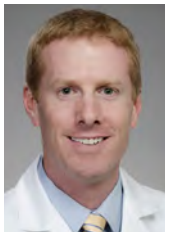
Kristen Mueller, MD
Washington University in St. Louis
Firearm Injuries and Recidivism at St. Louis Level I Trauma Hospitals
$150,000

Pilot Research

Dowin Boatright, MD, MBA, MHS
Yale University
Racial/Ethnic Differences in Emergency Medicine Residency Milestone Evaluation
$50,000

EMF/CORD Emergency Medicine Education Research

Jeffrey Riddell, MD
Keck School of Medicine of the University of Southern California
A Qualitative Exploration of Trust and Credibility Judgments in Educational Podcasts
$25,000



EMF/CORD Emergency Medicine Education Starter

Cynthia Peng, MD
Stanford University
Use of an Online Simulation Platform for Assessing Entrustable Professional Activities During Transition into Residency
$10,000

Michael Gottlieb, MD
Rush University Medical Center
The Impact of Driving on Podcast Knowledge Acquisition and Retention Among Emergency Medicine Resident Physicians
$10,000

EMF/Medical Toxicology Foundation

Daniel Nogee, MD
Yale New Haven Hospital
Machine Learning Enhanced Diagnosis of Toxic Exposures
$10,000

EMF/AFFIRM Medical Student Research

Henry Schwimmer, BA
Emory University School of Medicine
Rural Emergency Department Firearm Assessment, Screening, and Treatment (FAST) Trial
$5,000

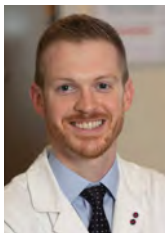
Thank You For Your Contribution!

Leadership Circle: $5,000
1972 Club: $1,972
Friend of EMF: $1,200
Wilcox Challenge Level: $600

EMF/EMRA Resident Research

Dana Im, MD, MPP, MPhil
Massachusetts General Hospital
and Brigham and Women's Hospital
Quality Measurement Framework for Emergency Department Care of Psychiatric Emergencies
$7,770

Patrick Tyler, MD
Beth Israel Deaconess Medical Center
Thromboelastography to Assess Coagulopathy and Glycocalyx Degradation in Sepsis
$10,000



Nicklaus Ashburn, MD
Wake Forest School of Medicine
Integrating Cutting-Edge Biomarkers into the Emergency Chest Pain Evaluation (ICE-CP)
$10,000

Avi Baehr, MD
University of Colorado, Denver
Adverse Events After ED Discharge for Conditions with High Variability in Discharges
$10,000

Jesse Wrenn, MD, PhD
Vanderbilt University
The Scanned Document Problem: Using Paper Records in Emergency Care
$10,000

EMF/SAEMF Medical Student Research

Kirstin Woody Scott, MPhil, PhD
University of Washington
Assessing Financial Risk Among Uninsured Patients Seeking Emergency Medical Care
$5,000

Tejeshwar Bawa, BS
Wayne State University
Effective Nutritional Analyses as a Predictive Utility for 30-Day Cardiac Recovery
$5,000

Matthew Lippi, BS
University of Colorado School of Medicine
National Trends and Outcomes of Sepsis Readmission
$5,000

Austin Jones, BA, BS
Tulane University
Evaluating Hepatitis C Linkage to Care: Emergency Department Versus Community Clinics
$5,000

Alexandra Flessel, BS
Wayne State University
Investigating Psychosocial Factors, Health Behaviors, and Diabetic Control in Emergency Department Patients
$5,000

EMF/NAEMSP EMS Research

David Hostler, PhD, EMT-P and **Brian Clemency, DO, MBA, FACEP**
University at Buffalo
Understanding the Nutrition Practices of Dayshift and Nightshift EMS Workers
$5,000

Jason McMullan, MD, MS, FAEMS and **Joshua Borkosky, NRP**
University of Cincinnati
Paramedic Attitudes to Obtaining Informed Consent for Prehospital Research Trials
$5,000

Gregory Faris, MD; David Rayburn, MD, MPH; and **Leon Bell, EMT-P, MS**
Indiana University School of Medicine, Indianapolis Emergency Medical Service
Utilizing Simulation to Improve Pediatric Prehospital Medical Care
$3,750

Please contact Tanya L. Downing at tdowning@acep.org or call 469-499-0296 if you have any questions about the Council Challenge.

HEY Y'ALL!

JOIN EMF AND ROUND-UP FOR RESEARCH

ACTIVITIES AT ACEP19

EMF COUNCIL CHALLENGE

Thursday, October 24 ★ 3:00pm–6:00pm
Friday, October 25–Saturday, October 26
8:00am–6:00pm

Hyatt Regency

ACEP Councilors have contributed more than $2.3 million since the challenge inception, demonstrating their commitment to fund research, education and support investigators.

EMF VIP RECEPTION

Sunday, October 27 ★ 7:00pm–8:30pm

National Western Complex

Complimentary tickets for EMF's $1,200+ donors and Wiegenstein Legacy Society members. Join loyal major donors, EMF and ACEP Leaders, dedicated physicians groups and committed companies invested in emergency medicine at this exclusive annual invitation only event.

EMF WIEGENSTEIN LEGACY SOCIETY RECEPTION

Monday, October 28 ★ 6:00pm–8:00pm

Embassy Suites, Crystal B, 3rd Floor

This private reception is to recognize the WLS members who have made the extraordinary commitment to include EMF in their estate plans.

EMF MAJOR DONOR LOUNGE

Sunday, October 27–Tuesday, October 29
7:00am–4:00pm

Colorado Convention Center, Room 502

EMF Donors who have given $600+ in 2019 can relax in this private room with complimentary breakfast, lunch, snacks and business center amenities.

EMF SILENT AUCTION

Sunday, October 27–Tuesday, October 29
9:00am–4:00pm

Colorado Convention Center, Grand Concourse

One-of-a-kind experiences, sports, music and celebrity memorabilia, art, jewelry and much more. Bid, buy and support EMF to make a lasting impact on emergency medicine.

EMF EXHIBITS WITH A CAUSE

Colorado Convention Center, Exhibit Hall A

Be sure to stop by the Vapotherm booth 1333 and Brault booth 1014 for a fun game break! All funds raised at these exhibit booths will directly benefit EMF.

EMF Emergency Medicine Foundation®
research → education → patient care

SEE Y'ALL THERE!

Report to the ACEP Council

The National Emergency Medicine Political Action Committee (NEMPAC)

and

The ACEP 911 Legislative Network

Denver, CO
October 2019

NEMPAC

A small, forward thinking group of ACEP members founded NEMPAC back in 1980 to help ACEP promote our legislative goals and express the concerns of emergency medicine to Members of Congress. Back then, the founders determined they would need to raise $10,000 to make a difference on the issue of independent contractor status for emergency physicians. Today, due to the increased costs of running for office and the many issues that ACEP can influence in Congress, our goal is to raise more than $1 million annually.

Just like our Board 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 the 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 nearly 40 years. Issues like out-of-network billing, physician payment reform, medical liability reform, solutions to the opioid and mental health crisis, gun violence and injury prevention, protecting the prudent layperson standard, and funding for EM research and graduate medical education, to name a few.

Today, by combining and carefully allocating donations from thousands of individual emergency physicians, NEMPAC has grown to be one of most recognized and credible health care PACs in the nation and is THE VOICE of emergency medicine in the political process.

The Council Challenge has been in place for more than 25 years. Councilors now contribute more than $300,000 annually to NEMPAC, which is more than one-quarter of our total raised annually.

Currently, NEMPAC is the 4th largest physician specialty PAC and the 5th largest health care professional PAC in the nation.

2018 Election Cycle Highlights

NEMPAC raised $2,145,070 over the 2018 two-year election cycle. We had 5,514 donors with a 20% participant rate of eligible donors. The average donation to NEMPAC is $263.

In the 1988 elections, NEMPAC contributed just under $100,000 to 13 Senate and 73 Congressional candidates. 30 years later, NEMPAC contributed more than $2.2 million to 27 Senate candidates, 150 House candidates, and other national party committees. Our giving was split 58% Republican/42% Democratic.

NEMPAC raised $605,000 as of September 26 toward our goal of $2 million for the 2020 election cycle.

The number of "Give-A-Shift" ($1,200 and above) donors continues to grow exponentially. In 2004, 70 ACEP members contributed at the "Give-a-Shift" level. As of September 25, 591 ACEP members are donating at the "Give-a-Shift" level.

In 2009, we instituted the ***"Five Year Give-a-Shift"*** level which recognized 71 ACEP members. Today, we have 125 ACEP members at this level.

In 2014, we began to recognize ***"10 Year Give-a-Shift"*** donors. Currently, there are 77 ACEP members at this level.

In 2019, for the first time, we will recognize 30 ACEP members who donate at the ***"15 Year Give-a-Shift"*** level.

21 ACEP members donate at the $2500 "Platinum" level.

Two ACEP members donate at the $5,000 "Chairman's Club" level.

NEMPAC Guidelines for contributions to candidates in the 2020 Election Cycle

At the beginning of each two-year election cycle, the NEMPAC Board of Trustees develops a NEMPAC Contribution Guidelines/Strategic Plan and Budget. The 2020 Cycle Plan and Budget was approved by the NEMPAC Board of Trustees on May 5, 2019. This document is available by request to the NEMPAC Board of Trustees.

Federal candidates are evaluated using multiple criteria including but not limited to votes and co-sponsorship of ACEP priority legislation. 2020 criteria follow past NEMPAC practice of focusing on a candidate's support and co-sponsorship of ACEP's key legislative and regulatory initiatives, committee assignments, leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions. Incumbents and new candidates seeking NEMPAC support that meet criteria in several categories are eligible for more support. In addition, a list of NEMPAC Champions was identified by the NEMPAC Board and staff. The champions receive maximum financial support and additional resources that NEMPAC is able to provide.

Although a candidate may be budgeted a certain contribution amount, the candidate will not necessarily receive the full amount for which he or she is budgeted. A significant change in the legislative/political climate may dictate that we reach as many candidates as possible (rather than a targeted focus on candidates on a committee). Ongoing assessments by the NEMPAC Board of Trustees determine which overall approach is most compatible with ACEP's legislative and regulatory agenda.

An internal spreadsheet is maintained by NEMPAC staff which tracks criteria for every seated member of Congress and includes recommended budget amounts for each member. This document is reviewed and modified throughout the election cycle to reflect movement on legislative considered by congress, campaign activity and election ratings and ACEP staff and member interactions with legislators. The internal document includes voting/sponsorship records of key ACEP legislation for that Congress and votes and sponsorships of key legislation in prior Congressional sessions if applicable. The decision to track specific votes and co-sponsorships is based on the legislative priorities established by the ACEP Federal Government Affairs committee at the beginning of each Congress. Although ACEP may track multiple issues and bills in any given congressional session, only those that are determined by the ACEP FGA Committee and ACEP Board of Directors to be key issues for emergency medicine that are moving through the congressional process either by accumulating co-sponsors, consideration by congressional committees, or inclusion in House or Senate floor votes, for example, are tracked.

NEMPAC Honor Roll

The Board of Trustees of the National Emergency Medicine Political Action Committee (NEMPAC) would like to thank the following ACEP members for their generous support.
*List is as of September 25, 2019 and will be updated post ACEP19.

Chairman's Club ($5000 annually)
Matthew Richard, MD, FACEP
Darin Gregory Wiggins, MD, FACEP

Platinum Donors ($2500 or more annually)
Neal Finley Aulick, II, MD, FACEP
Brien Alfred Barnewolt, MD, FACEP
A Compton Broders, MD, FACEP
Carrie de Moor, MD, FACEP
Irv Edwards, MD, FACEP
William Basil Felegi, DO, FACEP
Michael W Fill, DO, FACEP
Clifford Findeiss, MD
Kelly Foley, MD, FACEP
William E Franklin, DO, FACEP
Vidor E Friedman, MD, FACEP
Angela Gardner, MD, FACEP
Russell H Harris, MD, FACEP
Peter J Jacoby, MD, FACEP
Joseph Kuchinski, DO, FACEP
Michael Lozano, MD, FACEP
Howard K Mell, MD, MPH, CPE, FACEP
Nathan Phillip Peimann, MD, FACEP
Thomas B Pinson, MD, FACEP
Jeremy David Tucker, DO, FACEP
Mark E Winther, MD, FACEP

15 Year "Give-a-Shift" Donor
Bruce S Auerbach, MD, FACEP
Rashid J Baddoura, MD, FACEP
Dominic Joseph Bagnoli, Jr., MD, FACEP
John D Bibb, MD, FACEP
Michael D Bishop, MD, FACEP
Brooks F Bock, MD, FACEP
Kate Burke, MD, FACEP
Joseph J Calabro, DO, FACEP
Michael L Carius, MD, FACEP
Kathleen Cowling, DO, FACEP
William Basil Felegi, DO, FACEP
Vidor E Friedman, MD, FACEP
Angela F Gardner, MD, FACEP
Peter J Jacoby, MD, FACEP
Ramon W Johnson, MD, FACEP
Nicholas John Jouriles, MD, FACEP

Linda L Lawrence, MD, FACEP
Sharon E Mace, MD, FACEP
Robert T Malinowski, MD, FACEP
James C Mitchiner, MD, MPH, FACEP
John C Moorhead, MD, FACEP
David C Packo, MD, FACEP
Ernest Page, II, MD, FACEP
Steven Joseph Stack, MD, FACEP
Robert Eduard Suter, DO, MHA, FACEP
Mary Jo Wagner, MD, FACEP
Deborah E Weber, MD, FACEP
Arlo F Weltge, MD, MPH, FACEP
David E Wilcox, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

Ten Year "Give-a-Shift" Donors

Jim V Antinori, MD, FACEP
Brahim Ardolic, MD, FACEP
Andrew Luke Aswegan, MD, FACEP
Neal Finley Aulick, II, MD, FACEP
Brien Alfred Barnewolt, MD, FACEP
Andrew I Bern, MD, FACEP
Frederick C Blum, MD, FACEP
Samuel Francis Bosco, MD, FACEP
A Compton Broders, MD, FACEP
L Anthony Cirillo, MD, FACEP
Marco Coppola, DO, FACEP
James Michael Cusick, MD, FACEP
Carrie de Moor, MD, FACEP
Marc M Dreier, MD, FACEP
Irv E Edwards, MD, FACEP
Angelo L Falcone, MD, FACEP
Clifford Findeiss, MD
Diana L Fite, MD, FACEP
Juan Francisco Fitz, MD, FACEP
Kelly Foley, MD, FACEP
Scott H Freedman, MD, FACEP
Daniel Freess, MD, FACEP
Michael Joseph Gerardi, MD, FACEP
Jeffrey Michael Goodloe, MD, FACEP
Kelly Gray-Eurom, MD, MMM, FACEP
Andrea L Green, MD, FACEP
Robert D Greenberg, MD, FACEP
Rachelle Ann Greenman, MD, FACEP
Carlton E Heine, MD, PhD, FACEP
William C Haselow, MD, FACEP
Douglas M Hill, DO, FACEP
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Larry Allen Hobbs, MD, FACEP

Kenneth L Holbert, MD, FACEP
Hans Roberts House, MD, FACEP
Lisa Dianne Hrutkay, DO, FACEP
Marc P Hyde, MD
Jay A Kaplan, MD, FACEP
Paul Daniel Kivela, MD, MBA, FACEP
Kevin Michael Klauer, DO, FACEP
Michael Lozano, MD, FACEP
Thomas W Lukens, MD, PhD, FACEP
Catherine Anna Marco, MD, FACEP
Nathan Raymond MacDonald, MD, FACEP
David S McClellan, MD, FACEP
Dennis Lucas McGill, MD, FACEP
David A Milbrandt, MD, FACEP
John S Milne, MD, MBA, FACEP
Ira R Nemeth, MD, FACEP
Orlee Israeli Panitch, MD, FACEP
Rebecca B Parker, MD, FACEP
Charles F Pattavina, MD, FACEP
Lee E Payne, MD, FACEP
Daniel Eugene Peckenpaugh, MD, FACEP
Ericka Powell, MD, FACEP
John H Proctor, MD, MBA, FACEP
Richard Dean Robinson, MD, FACEP
John J Rogers, MD, FACEP
Alexander Max Rosenau, DO, FACEP
Luke Chris Saski, MD, FACEP
Nathaniel R Schlicher, MD, JD, FACEP
Sandra M Schneider, MD, FACEP
Regan Andre Schwartz, MD, FACEP
David Charles Seaberg, MD, CPE, FACEP
Gregory L Shangold, MD, FACEP
David P Sklar, MD, FACEP
Mark Slabinski, MD, FACEP
Todd Slesinger, MD, FACEP
Virgil W Smaltz, MD, MPA, FACEP
Robert C Solomon, MD, FACEP
Peter Erik Sokolove, MD, FACEP
Richard L Stennes, MD, MBA, FACEP
Thomas Jerome Sugarman, MD, FACEP
Jeremy David Tucker, DO, FACEP
Matthew J Watson, MD, FACEP
Mildred J Willy, MD, FACEP

Five Year "Give-a-Shift" Donors

James B Aiken, MD, MHA, FACEP
Stephen H Anderson, MD, FACEP
James Augustine, MD, FACEP
Michael J Baker, MD, FACEP

Leigh Anderson Barrow, DO, FACEP
Randal Dale Bensen, MD, FACEP
Jessica Ann Best, MD
Brenna M Born, MD, FACEP
Thomas Patrick Boyer, DO, FACEP
Sabina A Braithwaite, MD, FACEP
Jennifer H Bradstreet, MD, FACEP
David Wesley Brewer, MD, FACEP
Stephen W Bretz, MD, FACEP
Joel E Buzy, MD, FACEP
Jesse Caron, MD, FACEP
John Casey, DO, MA
Jordan GR Celeste, MD
Michael Cetta, MD, FACEP
Lawrence Chu, MD, FACEP
Justin D Coomes, MD
Christopher Corbit, MD, FACEP
Randal L Dabbs, MD, FACEP
Brian C Dawson, MD, FACEP
Wendy DeMartino, MD, FACEP
Ryan M Dowden, MD, FACEP
Reginald D Duling, MD, FACEP
David N Ferrand, MD
John T Finnell, II, MD, FACEP
William Stephen Gallea, MD, FACEP
Gregory Paul Garcia, MD
Michael David Garfinkel, MD, FACEP
Daniel C Geary, MD, FACEP
Thomas E Gutwein, MD, FACEP
Alison Haddock, MD, FACEP
Timothy James Hall, MD, FACEP
Christopher J Heberer, MD, FACEP
Jonathan Heidt, MD, FACEP
Justin P Hensley, MD
William Paul Jaquis, MD, FACEP
Zachary Joseph Jarou, MD
Andrew David Jenis, MD, FACEP
Amit S Kalaria, MD
Achyut B Kamat, MD, FACEP
Christopher S Kang, MD, FACEP
Giao N Kaplan, MD
Gary R Katz, MD, MBA, FACEP
Brian F Keaton, MD, FACEP
Rami R Khoury, MD, FACEP
Heidi C Knowles, MD, FACEP
Scott Jason Korvek, MD, FACEP
Terry Kowalenko, MD, FACEP
Paul Andrew Kozak, MD, FACEP
Joseph J Kuchinski, DO
Richard Kwun, MD

David Lancaster, MD
Philip Luke LeBas, MD, FACEP
Christopher M Lloyd, DO, FACEP
Donald Lombino, MD, FACEP
Seth A Lotterman, MD, FACEP
Donald Lum, MD
Merci G Madar, MD, FACEP
Kevin D Markowski, MD
H Lynn Massingale, MD, FACEP
Angela F Mattke, MD, FACEP
John McCourt, MD, FACEP
Michael McCrea, MD, FACEP
Edward McCutcheon, MD, MHA, FACEP
John Gerard McManus, Jr, MD, FACEP
Howard K Mell, MD, MPH, FACEP
Thomas R Mitchell, MD, FACEP
Craig B Mittleman, MD, FACEP
George W Molzen, MD, FACEP
Kevin Monfette, MD, FACEP
Jeffrey Alan Moore, MD, FACEP
Joshua B Moskovitz, MD, MPH, FACEP
Matthew B Mostofi, DO, FACEP
James B Mullen, III, MD, FACEP
Carla Elizabeth Murphy, DO, FACEP
Hemant Nayak, MD, FACEP
Charles Niziol, MD, FACEP
Jason T Nomura, MD, FACEP
Ashley Booth Norse, MD, FACEP
Andrew Sean Nugent, MD, FACEP
Robert E O'Connor, MD, MPH, FACEP
Jon Pierre Pazevic, DO, FACEP
Nathan Phillip Peimann, MD, FACEP
Deb G Perina, MD, FACEP
Mark Rice, MD, FACEP
Julio E Rios, MD, FACEP
Jeffrey P Roger, MD
J Michael Roseberry, MD
Mark S Rosenberg, DO, MBA, FACEP
Matthew Rudy, MD
Tony B Salazar, MD, FACEP
Tracy G Sanson, MD, FACEP
Lawrence J Satkowiak, MD
Gillian Schmitz, MD, FACEP
David L Scott, MD, FACEP
Suzy Shukovsky, MD
Sullivan K Smith, MD, FACEP
Susanne J. Spano, MD, FACEP
Ryan Stanton, MD, FACEP
Lawrence M Stock, MD, FACEP
Brian Sutton, MD

Abel Tewodros, MD
Travis Ulmer, MD, FACEP
Bradley J Uren, MD, FACEP
Hemant H Vankawala, MD, FACEP
Nicole Ann Veitinger, DO, FACEP
Nicole Harris von Suhr, DO
Bradford L Walters, MD, FACEP
Roger Wang, MD, FACEP
Joel Wassermann, MD
Bradley Alan Watling, MD, FACEP
Daniel R Wehner, MD, MBA, FACEP
Richard Preston Wendell, MD, FACEP
James M Williams, DO, FACEP
David Wirtz, MD, FACEP
Nathanael Wood, MD
Thomas E Wyatt, MD, FACEP
Andrew R Zinkel, MD, FACEP
Michael D Zwank, MD, FACEP

Outstanding EM Group Contributors

The ACEP Board of Directors and the NEMPAC Board of Trustees recognizes the following EM physician groups for their efforts to encourage their ACEP member physicians to contribute to NEMPAC to unify and strengthen the voice of emergency medicine in the political process.

Cascade Emergency Physicians
Eastside Emergency Physicians
Emergency Physicians of Central Florida
EPIC
Henry Ford
Northeast Emergency Medicine Specialists (NEMS)
Northside Emergency Associates (NEA)
TeamHealth
UMASS Memorial University Health Associates
(WV) University of Virginia
US Acute Care Solutions (USACS)
Vituity
Wake Emergency Physicians Washington University

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. More than 4,000 ACEP members currently participate in the 911 Network.

Hosting an ED Visit or Participating in a District Meeting with Your Legislator

An important component of the 911 Network is coordinating meetings back home between ACEP members and their federal legislators. These meetings help to educate legislators on emergency medicine issues and the challenges faced in providing emergency care today. Over the past year, we met all of the 90 new members of the House of Representatives either in meetings during LAC, fundraising events coordinated by NEMPAC or ED Visits and District Meetings with ACEP members. 55 meetings were held back home with ACEP 911 Members. Over the recent six-week congressional recess, ACEP members met back home with 42 legislators and/or their district staff to discuss surprise billing.

The program is ongoing and we urge you to contact the ACEP Washington DC office if you would like to host a visit for your federal legislator.

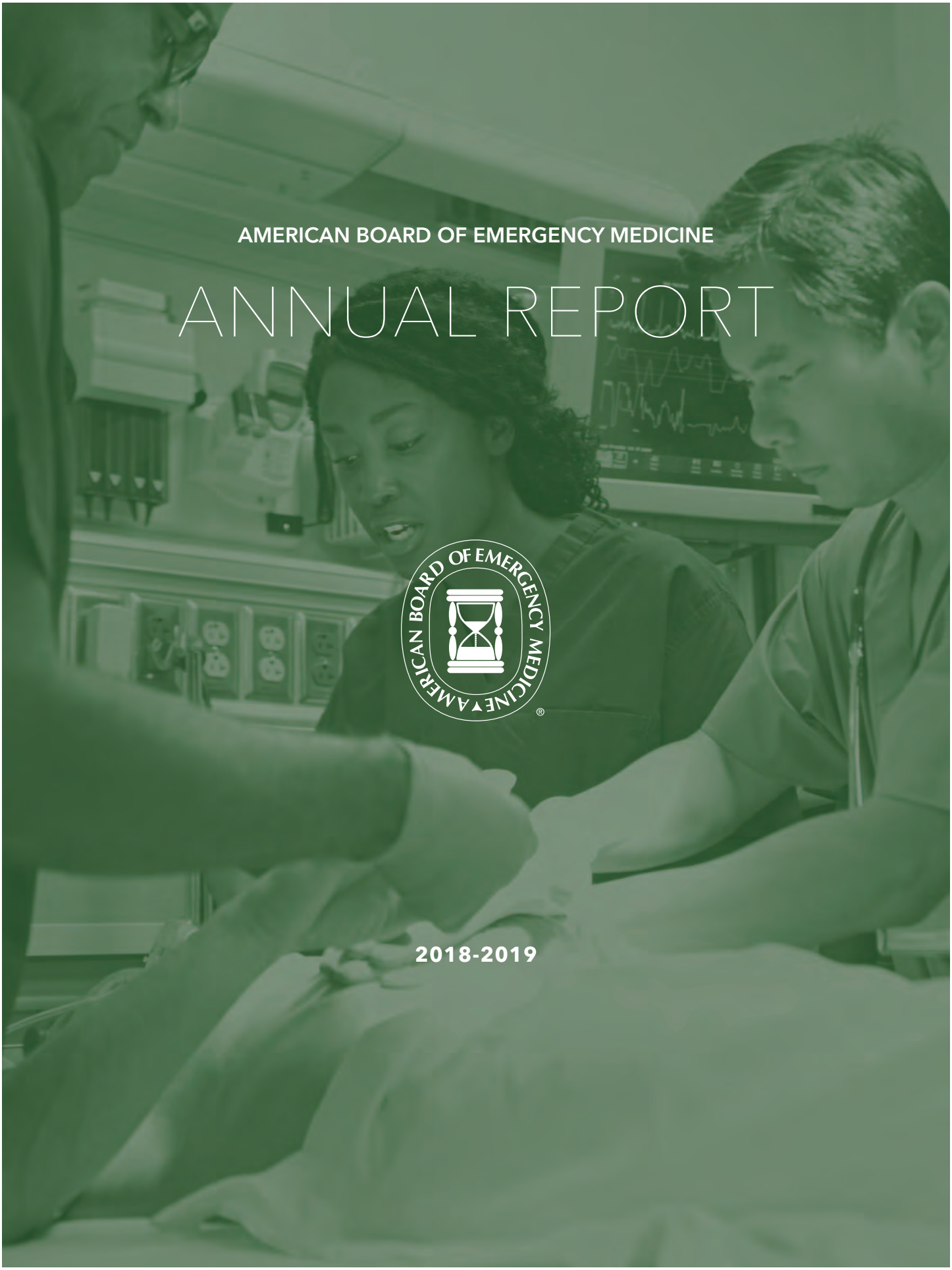
911 Network Member of the Year
Each year, a "911 Network Member of the Year" is selected from among the most active advocates in the Network based on an accrued point system which includes attending events, hosting ED visits, responding to action alerts and recruiting new members to the Network. **The 2019 winner was Dr. Don Stader from Colorado.**

As leaders of ACEP, it is important that members of the Council participate in the 911 Legislative Network. Councillors are well informed about the issues facing emergency medicine and ACEP's efforts to promote the specialty. This makes members of the Council the perfect spokes persons to carry ACEP's message to their legislators. **ACEP's goal is to achieve 100% Councillor participation in the ACEP 911 Network.**

NEMPAC and the 911 Legislative Network help promote the specialty of emergency medicine. We thank the Councillors for their past support and encourage all members of the Council to contribute to NEMPAC and sign up for the 911 Legislative Network. Your participation will help ensure the future of our specialty and our patients.

AMERICAN BOARD OF EMERGENCY MEDICINE

ANNUAL REPORT



2018-2019

ABEM'S MISSION

TO ENSURE THE HIGHEST STANDARDS IN THE SPECIALTY OF EMERGENCY MEDICINE.

ABEM'S PURPOSES[1]

To improve the quality of emergency medical care

To establish and maintain high standards of excellence in Emergency Medicine and its subspecialties

To enhance medical education in the specialty of Emergency Medicine and related subspecialties

To evaluate physicians and promote professional development through initial and continuous certification in Emergency Medicine and its subspecialties

To certify physicians who have demonstrated special knowledge and skills in Emergency Medicine and its subspecialties

To enhance the value of certification for ABEM diplomates

To serve the public and medical profession by reporting the certification status of the diplomates of the American Board of Emergency Medicine

[1]ABEM holds the interests of patients and their families in the highest standing, particularly with regard to the provision of the safest and highest-quality emergency care. ABEM addresses its commitment to patients by supporting the physicians who provide care to the acutely ill and injured, and by working to transform the specialty of Emergency Medicine.

TABLE OF CONTENTS

President's Message 2
Leadership 4
ABEM-certified Physicians 5
Examination Activity 7
Staying Certified 8
Subspecialty Certification 10
Volunteers 11
2018-2019 Highlights 13
Finances 15
Senior Directors 17
Examination Statistics 18

PRESIDENT'S MESSAGE

Be stubborn about your goals, and flexible about your methods.

~ Author Unknown

Robert L. Muelleman, M.D.

Evolution

Making certification and recertification more relevant has always been a focus of ABEM's efforts to maintain the highest standards in Emergency Medicine (EM). The evolution of continuous certification has been at the forefront of these activities:

- The ConCert Exam had its first spring administration in 2019
- In spring 2020, an online reference will be available to test takers

ABEM-certified physicians were seeking an alternative to the ConCert Exam, an assessment that would help them become better doctors, without being burdensome, and maintaining the high standard set by ABEM. What resulted was MyEMCert, which consists of online, content-based modules. Development of MyEMCert has progressed at a rapid pace. Decisions about the assessment made this year include:

- Physicians with certification ending in 2022 or later can maintain certification using MyEMCert
- Eight modules required by certification end date
- Online format, taken remotely
- No collaboration
- Three attempts to pass each module

ABEM-certified, clinically active volunteers are developing scenarios and writing questions that will be included in the assessment. A pilot will take place in 2020, and if successful, MyEMCert will launch in 2021. I applaud directors and volunteers who are working so intensely to develop this unique assessment.

Another change to continuing certification requirements included dropping the need to attest to CME credits. ABEM recognized this requirement overlapped other activities.

MyEMCert

Physicians with certification end date of 2022 or later can recertify using MyEMCert

Added Opportunities

Two additional certification opportunities were approved this year: Neurocritical Care and a Focused Practice Designation in Advanced Emergency Medicine Ultrasonography (see page 13 for details).

Gratitude

I would like to thank my fellow directors; without their incredible vision and hard work, the strides made this year would have been impossible.

A huge debt of gratitude goes to the hundreds of emergency physicians who volunteer their time—as oral examiners, question writers, subspecialty representatives, standard setting panel members, and more.

You willingly take time from your busy clinical practices to produce and administer ABEM examinations; we could not accomplish this without your dedication.

The strides made in the last year have been phenomenal, and we could not have done it without the incredible work ethic displayed by the ABEM staff. Their efforts are extraordinary.

I would especially like to thank all the ABEM-certified physicians, whose tireless work, constant compassion, and endless devotion to their patients and the specialty have made Emergency Medicine what it is today: a leader in the house of medicine.

LEADERSHIP

Board of Directors

Executive Committee

Robert L. Muelleman, M.D., *President*
Jill M. Baren, M.D., *President-Elect*
Terry Kowalenko, M.D., *Immediate-Past-President*
O. John Ma, M.D., *Secretary-Treasurer*
Michael S. Beeson, M.D., *Member-at-Large*
Robert P. Wahl, M.D., *Senior-Member-at-Large*

Directors

Felix K. Ankel, M.D.
Kerryann B. Broderick, M.D.
Wallace A. Carter, M.D.
Carl R. Chudnofsky, M.D.
Marianne Gausche-Hill, M.D.
Diane L. Gorgas, M.D.
Deepi G. Goyal, M.D.
Leon L. Haley, Jr., M.D.
Ramon W. Johnson, M.D.
Samuel M. Keim, M.D.
Mary Nan S. Mallory, M.D.
Lewis S. Nelson, M.D.
James D. Thomas, M.D.

Executive Staff

Earl J. Reisdorff, M.D., *Executive Director*
Melissa A. Barton, M.D., *Director of Medical Affairs*
Kathleen C. Ruff, M.B.A., *Chief Administrative Officer*
Susan K. Adsit, *Associate Executive Director, Organizational Services*
Timothy J. Dalton, *Associate Executive Director, Evaluation and Research*
Jennifer L. Kurzynowski, *Associate Executive Director, Operations*
Angela J. McGoff, *Associate Executive Director, Certification Services*
Michele C. Miller, *Associate Executive Director, Systems and Technology*

Front row, left to right: Diane L. Gorgas, M.D.; Robert L. Muelleman, M.D.; Marianne Gausche-Hill, M.D.; Michael S. Beeson, M.D.; Kerryann B. Broderick, M.D.

Back row: Felix K. Ankel, M.D.; Ramon W. Johnson, M.D.; Carl R. Chudnofsky, M.D.; Wallace A. Carter, M.D.; Terry Kowalenko, M.D.; Jill M. Baren, M.D.; Lewis S. Nelson, M.D.; James D. Thomas, M.D.; Samuel M. Keim, M.D.; Mary Nan S. Mallory, M.D.; Robert P. Wahl, M.D.; O. John Ma, M.D.; Leon L. Haley, Jr., M.D.; Deepi G. Goyal, M.D.

ABEM-CERTIFIED PHYSICIANS

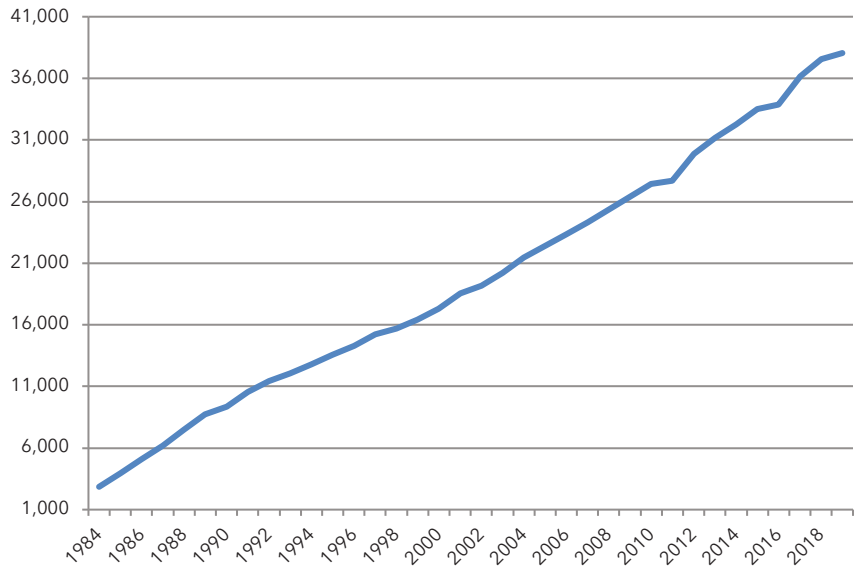
38,052 current ABEM-certified physicians (4% increase from 2018)

6.4% hold subspecialty certification (2,433)

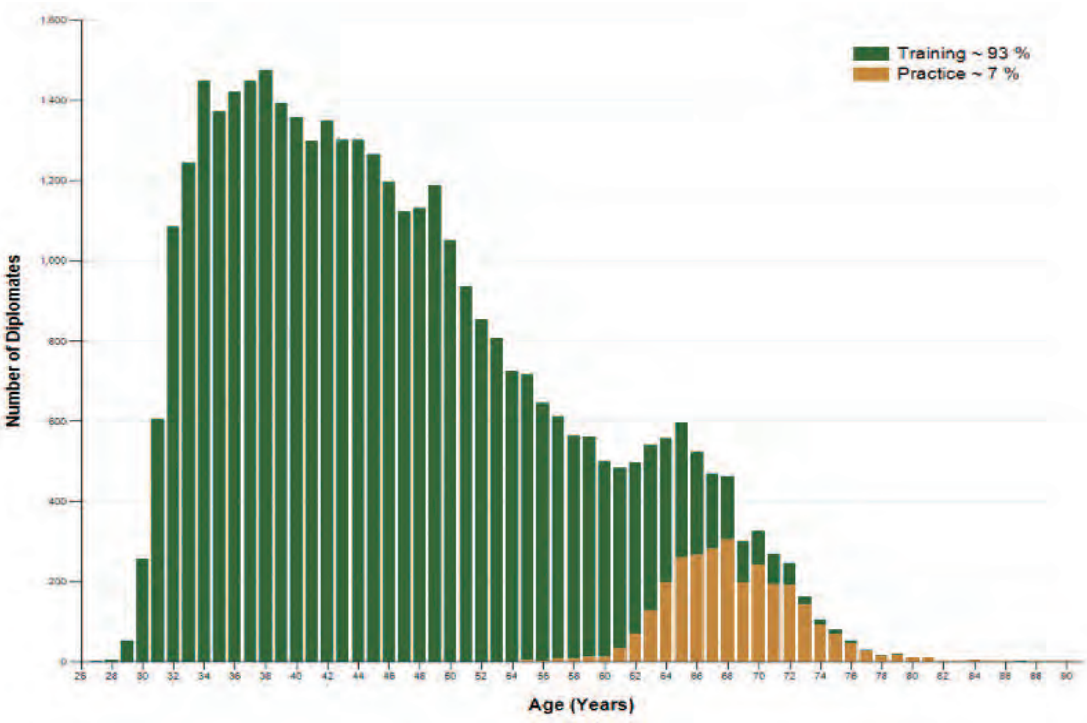
92.5% are residency trained

Data as of June 2019

Number of Current ABEM-certified Physicians



Distribution of ABEM-certified Physicians by Age and Training



EXAMINATION ACTIVITY

In 2018-2019, nearly 16,000 proctored examinations were administered, and over 24,000 LLSA tests were completed.

2,101
took the Qualifying Exam

among first-time test takers

2,113
took the Oral Certification Exam

among first-time test takers

3,629
took the ConCert Exam

among ABEM-certified physicians

8,043
took the In-training Exam

2,055
Newly Certified Physicians

138
Regained Certification

Detailed, longitudinal statistics are available in the tables beginning on page 18, and on the ABEM website.

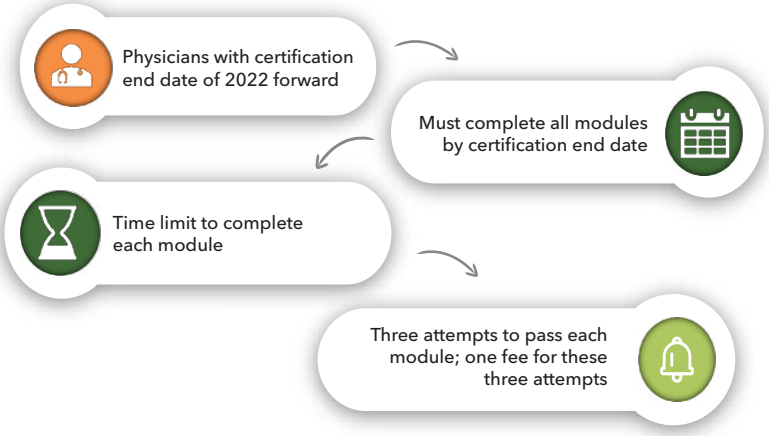
STAYING CERTIFIED

The purpose of continuing certification is to maintain the highest standards of Emergency Medicine by partnering with physicians in their ongoing professional development; maintaining core knowledge, judgment, and skills; and integrating new medical advances in patient-centered care.

New Assessment Option Being Developed

The pace of development of **MyEMCert**–ABEM's new option for maintaining certification–quickened in 2018-2019. MyEMCert will be piloted in 2020, and if successful, will be available in 2021 to physicians with certification end dates in 2022 and later. MyEMCert will be composed of eight short assessments, or modules, each on a specific clinical presentation, plus new advances in EM. All eight modules must be completed by a physician's certification end date, no matter how soon that would occur. There will be a time limit to complete each module, and physicians will have three attempts to pass each module. ABEM will provide additional information as it becomes available; the ABEM website is a great source for the most recent updates. www.abem.org/MyEMCert

MyEMCert



ConCert Enhancements

The **ConCert Exam** (along with the completion of the required number of LLSA tests) remains an option for continuing certification. The first administration of a spring exam was in 2019. Beginning in 2020 an online resource will be available during the exam.

No More CME Attestation

The requirement that ABEM-certified physicians attest to completing an average of **25 CME credits every year** has been removed. The ABMS approved this change for ABEM because LLSA activities are essentially CME activities for which CME credit can be claimed. The requirement was dropped in 2019.

Earn CME from Your ABEM Activities

Beginning in 2018, physicians who passed the ConCert Exam or Oral Certification Exam can receive **60 *AMA PRA Category 1 Credits*™ at no cost.** ABEM reached an agreement with the AMA to provide the credits as a benefit to ABEM-certified physicians. Physicians can request the credits via their ABEM Personal Page.

New LLSA Test

The 2019 **Pediatric Emergency Medicine LLSA** reading list and test became available, which provides another opportunity for ABEM-certified physicians to tailor learning to their clinical practices.

ABEM believes that continuing certification assists physicians in realizing their intrinsic desire to be better clinicians, and deliver safe, high-quality care.

Lifelong Learning and Self-Assessment

ABEM-certified physicians participate in the Lifelong Learning and Self-Assessment component of the continuing certification process:

- Four tests must be completed in each five-year period of certification
- Low-cost CME activities are available with most tests

24,110

LLSA tests completed

16,754

LLSA CME activities completed
Almost 200,000 credits earned

Practice Improvement Measures

Emergency physicians are committed to raising the quality of care for their patients by participating in practice improvement projects. Those who participate can get credit for activities they are already doing by attesting through their ABEM Personal Page. Others can design a project that follows the four required steps: measure, compare to a standard, implement an improvement, and re-measure.

2018 Top Five Distinct Number of Practice Improvement Attestations

1,302	Time-related (throughput time, ED length-of-stay, and other process time measures)
762	Stroke-related
600	Infectious Disease-related
459	Other
427	Cardiac-related
5,340	**Total PI Attestations**

SUBSPECIALTY CERTIFICATION

2,433 ABEM-certified Physicians Hold a Subpecialty Certificate

In 2018-2019, ABEM issued 184 subspecialty certificates in seven subspecialties. ABEM-certified physicians also have access to subspecialty certification in Addiction Medicine, Brain Injury Medicine, Clinical Informatics, and Surgical Critical Care through other ABMS Boards.

Subspecialty	Certificates Issued in 2018-19	Total Current Subspecialists
Emergency Medical Services*	0 *	626
Medical Toxicology	49	419
Pediatric Emergency Medicine	39	277
Sports Medicine	19	199
Clinical Informatics	– **	197
Internal Medicine-Critical Care Medicine	26	196
Hospice and Palliative Medicine	31	161
Undersea and Hyperbaric Medicine	2	149
Addiction Medicine	– **	106
Anesthesiology-Critical Care Medicine	16	65
Surgical Critical Care	– **	27
Pain Medicine	2	10
Brain Injury Medicine	– **	1
Neurocritical Care	0 ***	0
Total	**184**	**2,433**

* Certification examination not offered in 2018.

** Information not available; certificates issued by other ABMS Boards

*** First examination will be administered in 2021.

Effective in 2018, ABEM-certified physicians who also hold a subspecialty certificate are no longer required to maintain their EM certification for their subspecialty certificate to remain valid as long as they are participating in an ABEM-accepted continuing certification process.

VOLUNTEERS

More than 500 clinically active physicians volunteer their services to ABEM, a force that we could not operate without. Hundreds of examiners attend each spring and fall Oral Exam administrations. Fifty item writers produce new questions for multiple choice tests each year for Emergency Medicine certification, recertification, and subspecialty exams. Additional ABEM activities supported by volunteers are:

- Standard-setting panels review each multiple choice question or Oral Exam case, rate its difficulty, and assess its importance to the certification of emergency physicians
- Fairness and bias panels evaluate whether different outcomes (among different groups) on test questions or cases are due to knowledge or experience not relevant to the practice of EM
- Job analysis panels identify the tasks, skills, and responsibilities necessary in the practice of EM, the results of which are the basis for what is measured in an examination
- Other task forces and advisory groups, such as the LLSA CME reading group and the Stimulus Collection and Review Panel, that assist in the certification and recertification processes

Each of these volunteer physicians donate their time and effort to help assure that anyone certified in EM or any of its subspecialties meets the high standards expected of our specialty. Thank you!

A complete list of ABEM volunteers is available on the ABEM website. (www.abem.org/volunteer)

489 Oral Examiners

50 Item Writers and Editors

37 Standard Setting Panel Participants

21 Subboards and Exam Committees

39 Task Forces, Advisory Groups, etc.

19 Members of the Board of Directors

Pictured top: Job Analysis Advisory Panel
Pictured below: Spring Oral Exam Standard Setting Advisory Panel
[Captions on page 21.]

Subspecialty Representatives – ABEM Appointees

Emergency Medical Services Examination Committee

Theodore R. Delbridge, M.D.
Sophia K. Dyer, M.D.
Jeffrey M. Goodloe, M.D.
Alexander P. Isakov, M.D.
Douglas F. Kupas, M.D.
Vincent N. Mosesso, Jr., M.D.
Peter T. Pons, M.D., Chair
Kathy J. Rinnert, M.D.
Marianne Gausche-Hill, M.D., Director Liaison

Medical Toxicology Subboard

Theodore C. Bania, M.D., Chair
Robert G. Hendrickson, M.D.
Michael G. Holland, M.D.
Joshua G. Schier, M.D.
Andrew I. Stolbach, M.D.
Lewis S. Nelson, M.D., Director Liaison

Neurocritical Care Examination Committee

Jordan B. Boramo, M.D.
Evadne G. Marcoloni, M.D.

Pediatric Emergency Medicine Subboard

Robert L. Cloutier, M.D.
Timothy A.M. Horeczko, M.D.
Nathan W. Mick, M.D.
Stacy L. Reynolds, M.D.
Ramon W. Johnson, M.D., ABEM Director Liaison

Sports Medicine Examination Committee

Moira Davenport, M.D.
Andrew D. Perron, M.D.

Undersea and Hyperbaric Medicine Examination Committee

Charles S. Graffeo, M.D.
Tracy L. LeGros, M.D.

Pictured top: EMS Examination Committee
Pictured bottom: Medical Toxicology Subboard
[Captions on page 21.]

2018-2019 HIGHLIGHTS

Newly Elected Directors

The Board of Directors elected two new members in 2019: Yvette Calderon, M.D., and John L. Kendall, M.D. Their terms begin at the close of the summer 2019 Board of Directors meeting. Dr. Calderon practices clinically at Mount Sinai Beth Israel in New York, New York. Dr. Kendall's clinical practice is with Denver Health Medical Center in Denver, Colorado.

Yvette Calderon, M.D.

John L. Kendall, M.D.

Neurocritical Care

Neurocritical Care (NCC) was approved as the newest subspecialty available to ABEM-certified physicians. NCC is devoted to the comprehensive multisystem care of the critically ill patient with neurological diseases/conditions. The NCC subspecialty is co-sponsored by the American Board of Anesthesiology, ABEM, the American Board of Neurological Surgery, and the American Board of Psychiatry and Neurology. The first examination for certification in NCC will take place in 2021. Eligibility criteria are available on the ABEM website.

Advanced Emergency Medicine Ultrasonography

A Focused Practice Designation (FPD) in Advanced Emergency Medicine Ultrasonography (AEMUS) was approved this year by the ABMS. Only ABEM-certified physicians will be eligible for the designation. The FPD will recognize expertise held by emergency physicians with sophisticated, comprehensive knowledge of advanced emergency ultrasonography. The first examination will be offered in 2022. Eligibility criteria are available on the ABEM website.

Milestone Recognition for 697 Physicians

ABEM recognizes physicians who mark 30 years of being board certified in Emergency Medicine with a special certificate. This year's recipients included 697 physicians who had been board certified for 30 years as of December 31, 2018. Certificates are awarded annually to diplomates who achieve this milestone. ABEM applauds these physicians who have demonstrated a career-long commitment to excellence. A list of the 2019 recipients is posted on the ABEM website.

Coalition on Medical Merit Badges

ABEM continues to collaborate with nearly every major EM organization through the Coalition on Medical Merit Badges (COMMB). The Coalition promotes that ABEM certification supersedes the need for certified physicians to complete mandatory short courses or additional certifications ("merit badges") often needed for hospital privileges. This year the Coalition worked to:

- Eliminate out-of-operating-room airway management (OORAM) requirements for ABEM-certified physicians working in the VA hospital system
- Provide a letter that ABEM-certified physicians can submit to hospital lab directors to allow them to be trained to directly provide point-of-care testing (bedside lab tests)

COMMB will continue to promote that short courses are not necessary for ABEM-certified physicians because of the high standard that certification represents.

Purpose of Initial Certification

The purpose of initial certification is to objectively and independently confirm that physicians who complete an Emergency Medicine residency demonstrate core knowledge, skills, and abilities needed to practice Emergency Medicine at the highest standards.

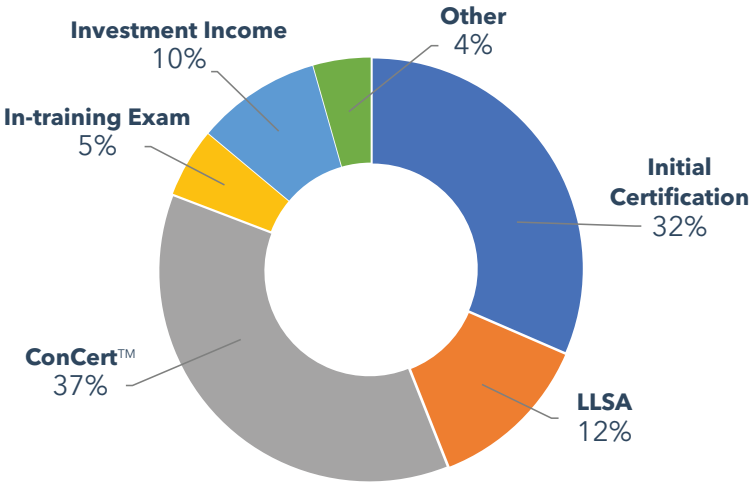
ABEM uses rigorous assessments to ensure that physicians graduating from Emergency Medicine residencies across the country demonstrate the knowledge and skills needed to provide safe, high-quality emergency care. Given the importance of initial certification, it is appropriate to have a secure, high-stakes assessment. This is especially important as patients cannot select their emergency physician.

FINANCES

As reported on ABEM's 2018 990, net revenue totaled $1,438,416. At the same time, $1,920,609 came from investment income. This means ABEM had a negative net revenue from operations of $482,193. That deficit led the Board to slightly increase some exam fees.

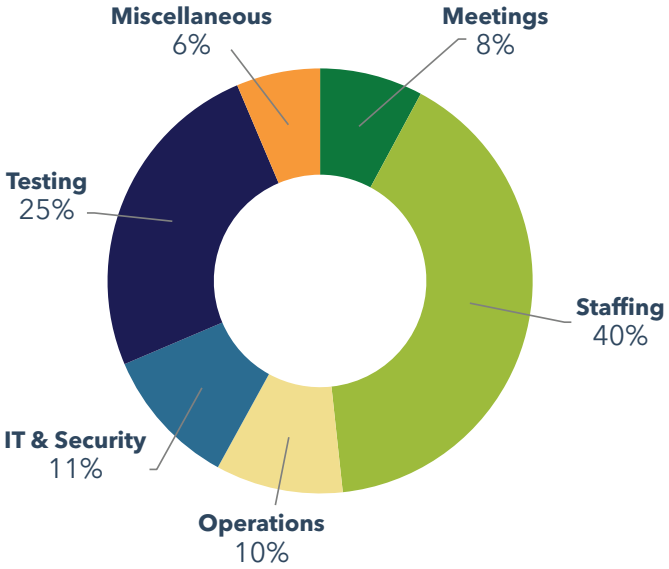
Revenue by Category

2018-2019*



Spending by Category

2018-2019*



* Unaudited data

Audited Statement of Financial Position

June 30, 2018

Assets	
Current assets	
Cash and cash equivalents	$1,983,074
Accrued investment income	108,235
Investments	35,087,822
Prepaid expenses	157,220
Total current assets	37,336,351
Property, equipment, and software	8,295,683
Less: accumulated depreciation and amortization	(3,635,162)
Net property, equipment, and software	4,660,521
Other assets	
Deposits	95,638
Total assets	**$42,092,510**
Liabilities and Net Assets	
Current liabilities	
Accounts payable	$111,475
Accrued payroll	123,337
Accrued payroll tax	8,010
Deferred revenue	3,938,090
Current portion of capital lease payable	9,362
Current portion of note payable	–
Total current liabilities	4,190,274
Long-term liabilities	
Compensated absences	583,296
Capital lease payable, net of current portion	–
Note payable, net of current portion	–
Total long-term liabilities	583,296
Total liabilities	4,773,570
Net assets	
Unrestricted and undesignated	37,318,940
Total liabilities and net assets	**$ 42,092,510**
Revenues	**$14,989,167**
Expenses	
Direct Certification Expense	$ 6,634,508
Governance	1,967,196
International	6,255
Office administration	2,816,643
Outreach/liaison	1,205,975
Program development	573,079
Research	178,921
Subspecialties	752,659
Training/academic relations	785,599
Miscellaneous	62,945
Total expenses	**$14,983,780**
Change in net assets*	**2,387**
Other income (expense)	**1,777,801**
Change in net assets	1,780,188
Net assets, at beginning of year	$35,538,752
Net assets, at end of year	**$37,318,940**

* Before other income and gains

SENIOR DIRECTORS

Thank you for your legacy and contributions to the specialty of Emergency Medicine.

Gail V. Anderson, Sr., M.D. 1976–1989
Walter R. Anyan, Jr., M.D. 1995–2003
William G. Barsan, M.D. 1993–2001
Carol D. Berkowitz, M.D. 2003–2006
Howard A. Bessen, M.D. 2002–2010
Michael D. Bishop, M.D. 1988–1996
Brooks F. Bock, M.D. 1995–2004
G. Richard Braen, M.D. 1988–1996
Glenn D. Braunstein, M.D. 2002–2006
Dick D. Briggs, Jr., M.D. 1994–2002
Paul D. Bruns, M.D. 1980–1983
Michael L. Carius, M.D. 2009–2018
Joseph E. Clinton, M.D. 1986–1994
Robert E. Collier, M.D. 2004–2012
Lily C. A. Conrad, M.D. 2002–2010
Francis L. Counselman, M.D. 2008–2016
Rita Kay Cydulka, M.D. 2002–2010
Robert H. Dailey, M.D. 1976–1982
Daniel F. Danzl, M.D. 1991–1999
Steven J. Davidson, M.D. 1986–1995
John H. Davis, M.D. 1979–1984
Richard E. Dean, M.D. 1991–1994
James J. Dineen, M.D. 1976–1980
Frank A. Disney, M.D. 1979–1980
Lynnette Doan-Wiggins, M.D. 1999–2008
E. John Gallagher, M.D. 1995–2003
Joel M. Geiderman, M.D. 2003–2011
William E. Gotthold, M.D. 1994–2003
Jeffrey G. Graff, M.D. 1996–2005
Harris B. Graves, M.D. 1980–1987
R. R. Hannas, Jr., M.D. 1976–1988
Gerald B. Healy, M.D. 1988–1992
Barry N. Heller, M.D. 2008 – 2017
Robert S. Hockberger, M.D. 1995–2004
Gwendolyn L. Hoffman, M.D. 1994–2003
Leonard D. Hudson, M.D. 1990–1994
Bruce D. Janiak, M.D. 1986–1995
Carl Jelenko, III, M.D. 1976–1980
James H. Jones, M.D. 2005–2015
R. Scott Jones, M.D. 1988–1991
Allen P. Klippel, M.D. 1976–1982
Robert K. Knopp, M.D. 1988–1993
David A. Kramer, M.D. 2009–2013
Ronald L. Krome, M.D. 1976–1988
Jo Ellen Linder, M.D. 2004–2012
Louis J. Ling, M.D. 1997–2007
Catherine A. Marco, M.D. 2009–2018
Mark A. Malangoni, M.D. 1998–2002
Vincent J. Markovchick, M.D. 1994–2002
M. J. Martin, M.D. 1990–1994, 1996–1998
John B. McCabe, M.D. 1996–2006
Henry D. McIntosh, M.D. 1979–1986
W. Kendall McNabney, M.D. 1982–1986
Harvey W. Meislin, M.D. 1986–1994
J. Mark Meredith, M.D. 2004–2012
Sheldon I. Miller, M.D. 1999–2006
James D. Mills, M.D. 1976–1988
John C. Moorhead, M.D. 2004–2014
John F. Murray, M.D. 1986–1989
Robert C. Neerhout, M.D. 1986–1994
Richard N. Nelson, M.D. 2004–2013
Michael S. Nussbaum, M.D. 2002–2006
Thomas K. Oliver, Jr., M.D. 1980–1981
Debra G. Perina, M.D. 2003–2011
Nicholas J. Pisacano, M.D. 1979–1986
Roy M. Pitkin, M.D. 1990–1998
George Podgorny, M.D. 1976–1988
Peter T. Pons, M.D. 1996–2004
J. David Richardson, M.D. 1994–1998
Leonard M. Riggs, Jr., M.D. 1981–1986
Frank N. Ritter, M.D. 1979–1988
Peter Rosen, M.D. 1976–1986
Robert J. Rothstein, M.D. 1996–2004
Douglas A. Rund, M.D. 1988–1997
Earl Schwartz, M.D. 1994–2002
Richard I. Shader, M.D. 1980–1990
Roger T. Sherman, M.D. 1984–1988
Rebecca Smith-Coggins, M.D. 2007–2015
Mark T. Steele, M.D. 2003–2012
Richard M. Steinhilber, M.D. 1979–1980
Richard L. Stennes, M.D. 1988–1996
Robert W. Strauss, M.D. 2007–2015
Henry A. Thiede, M.D. 1979–1980, 1984–1990
Harold A. Thomas, M.D. 2001–2010
Judith E. Tintinalli, M.D. 1982–1991
Robert Ulstrom, M.D. 1982–1986
Michael V. Vance, M.D. 1986–1995
David K. Wagner, M.D. 1976–1988
Edward E. Wallach, M.D. 1998–2006
Gerald P. Whelan, M.D. 1988–1998
John G. Wiegenstein, M.D. 1976–1986

EXAMINATION STATISTICS

Certification

		Qualifying Examination						Oral Certification Examination					
		EM Residency-eligible First-time Takers			Total Candidates[3]			EM Residency-eligible First-time Takers			Total Candidates[3]		
Date	App's Rec'd	# Took	# Pass	% Pass	# Took	# Pass	% Pass	# Took	# Pass	% Pass	# Took	# Pass	% Pass
1980 and prior	1,875	-	-	-	1,496	998	67	-	-	-	399	248	62
1981	1,035	-	-	-	1,142	825	72	-	-	-	548	356	65
1982	1,149	-	-	-	1,254	869	69	-	-	-	998	571	57
1983	1,242	-	-	-	1,335	885	66	-	-	-	1,293	766	59
1984	1,399	-	-	-	1,694	1,108	65	-	-	-	1,339	912	68
1985	1,600	-	-	-	2,016	1,274	63	-	-	-	1,066	801	75
1986	1,709	-	-	-	2,147	1,124	52	-	-	-	1,425	993	70
1987	1,977	-	-	-	2,479	1,429	58	-	-	-	1,503	1,192	79
1988	2,915	-	-	-	2,607	1,375	53	-	-	-	1,602	1,227	77
1989	886	Postponed to 5/30/90						-	-	-	1,627	1,266	78
1990	1,069	-	-	-	3,446	1,953	57	-	-	-	1,350	1,059	78
1991	624	-	-	-	1,510	853	56	-	-	-	1,464	1,185	81
1992	742	-	-	-	1,396	820	59	-	-	-	1,446	1,146	79
1993	964	-	-	-	1,281	822	64	-	-	-	977	753	76
1994	785	-	-	-	1,329	781	59	-	-	-	1,095	894	82
1995[1]	847	753	664	88	1,249	769	62	692	669	97	1,028	890	87
1996	860	839	756	90	1,290	899	70	703	658	94	968	808	84
1997	943	920	811	89	1,335	903	68	795	711	89	934	795	85
1998	1,005	1,003	909	91	1,426	1,036	73	864	788	91	1,059	895	85
1999	1,099	1,092	972	89	1,457	1,053	72	988	851	86	1,083	901	83
2000	1,108	1,087	985	91	1,488	1,085	73	1,040	957	92	1,272	1,124	88
2001	1,173	1,155	1,026	89	1,471	1,135	77	1,064	1,000	94	1,257	1,133	90
2002	1,171	1,176	1,057	90	1,516	1,181	78	1,142	1,040	91	1,291	1,140	88
2003	1,198	1,179	1,092	93	1,496	1,205	81	1,158	1,058	91	1,278	1,140	89
2004	1,256	1,242	1,099	88	1,490	1,188	80	1,204	1,142	95	1,335	1,237	93
2005	1,299	1,287	1,164	90	1,593	1,283	81	1,197	1,132	95	1,325	1,233	93
2006	1,329	1,302	1,200	92	1,606	1,344	84	1,239	1,166	94	1,289	1,204	93
2007	1,411	1,408	1,267	90	1,645	1,363	83	1,328	1,254	94	1,431	1,340	94
2008	1,387	1,366	1,246	91	1,638	1,371	84	1,357	1,288	95	1,434	1,353	94
2009	1,448	1,430	1,295	91	1,717	1,429	83	1,408	1,337	95	1,484	1,397	94
2010	1,517	1,519	1,381	91	1,779	1,515	85	1,416	1,335	94	1,470	1,378	94
2011	1,584	1,560	1,417	91	1,827	1,540	84	1,534	1,487	97	1,665	1,603	96
2012	1,612	1,615	1,511	94	1,898	1,653	87	1,548	1,515	98	1,643	1,599	97
2013	1,711	1,704	1,520	89	1,952	1,617	83	1,704	1,675	98	1,712	1,678	98
2014	1,739	1,709	1,536	90	2,028	1,676	83	1,620	1,559	96	1,638	1,571	96
2015	1,811	1,807	1,639	91	2,118	1,788	84	1,684	1,648	98	1,729	1,682	97
2016	1,867	1,853	1,732	93	2,129	1,893	89	1,765	1,722	98	1,827	1,778	97
2017	1,986	1,975	1,834	93	2,215	1,961	89	1,894	1,818	96	1,952	1,868	96
2018	2,133	2,101	2,000	95	2,365	2,173	92	1,954	1,895	97	2,006	1,943	97
Total	**53,465**	**33,082**	**30,113**	**91**[2]	**65,860**	**48,176**	**73**[2]	**31,298**	**29,705**	**95**[2]	**52,242**	**45,059**	**86**[2]

[1] 1995 was the first year that a reference group of EM residency-eligible, first-time test takers was used to construct the written certification examination, now known as the qualifying examination.
[2] Number indicates the percent of the total that passed.
[3] Candidates do not include former diplomates attempting to regain certification through the qualifying and/or oral examination.

Subspecialty Certification

Year	ACCM	EMS	HPM	IM-CCM	Med Tox	Pain	Ped EM	SPM	UHM	**Total**
1993							38	8		46
1994							23	0		69
1995					51		0	12		134
1996					0		0	0		132
1997					32		39	8		213
1998					0		0	0		213
1999					42		20	8		283
2000					24		0	0		307
2001					0		23	4	7	341
2002					30		0	2	7	380
2003					0		12	2	11	405
2004					30		19	3	42	499
2005					0		0	3	17	519
2006					39		10	12	7	587
2007					0		0	5	6	598
2008			12		31		0	12	12	665
2009			0		0	1	19	9	21	715
2010			23		39	2	0	13	38	830
2011			0		0		26	14	15	885
2012			60	25	38	1	0	11	5	1,024
2013		225	0	19	0	2	35	16	5	1,326
2014	12	0	20	25	48	0	0	14	4	1,449
2015	9	220	0	28	0	1	30	16	3	1,756
2016	17	0	32	40	53	0	0	26	6	1,930
2017	11	183	0	34	0	1	27	17	2	2,205
2018	16	0	31	26	49	2	0	19	2	2,350
Total Certificates Issued	**65**	**628**	**177**	**197**	**508**	**10**	**321**	**234**	**210**	**2,350**
Total Current Diplomates	**65**	**626**	**161**	**196**	**419**	**10**	**277**	**199**	**149**	**2,102**

ACCM: Anesthesiology Critical Care Medicine
EMS: Emergency Medical Services
HPM: Hospice and Palliative Medicine
IM-CCM: Internal Medicine – Critical Care Medicine
MedTox: Medical Toxicology
Pain: Pain Medicine
PedEM: Pediatric Emergency Medicine
SPM: Sports Medicine
UHM: Undersea and Hyperbaric Medicine

ConCert™ Examination

	Diplomates			Former Diplomates		
Year	**# Took**	**# Pass**	**% Pass**	**# Took**	**# Pass**	**% Pass**
2004	1,264	1,169	92	127	60	47
2005	1,407	1,295	92	157	92	59
2006	1,367	1,296	95	206	129	63
2007	1,569	1,483	95	135	81	60
2008	1,778	1,687	95	138	104	75
2009	1,657	1,576	95	119	82	69
2010	1,955	1,897	97	121	94	78
2011	2,022	1,943	96	147	99	67
2012	1,762	1,681	95	154	100	65
2013	1,971	1,895	96	189	132	70
2014	2,391	2,335	98	142	19	31
2015	2,503	2,412	96	124	74	60
2016	2,582	2,478	96	136	78	57
2017	2,653	2,535	96	146	79	54
2018	2,606	2,495	96	86	20	23
Total	**29,487**	**28,177**	**96**[1]	**2,127**	**1,326**	**62**[1]

[1] Number indicates the percent of the total who passed.

Statistics are reported by calendar year. The statistics accurately reflect the examinations administered during the designated periods, and all examination data are included. Candidates who took more than one examination are included more than once.

Total number of active diplomates on 12/31/2018 was 37,576.

PHOTO CAPTIONS

Page 11: Job Analysis Advisory Panel (top, right). Back row standing (left to right): Dorian L.A. Alexander, M.D.; Jonathan L. Hansen, M.D.; Manuel A. Celedon, M.D.; K. Scott Hickey, M.D.; Terry Kowalenko, M.D.; Allison J.N. Harriott, M.D.; Fernando C. Cortes, M.D.; and Leigh-Ann J. Webb, M.D. Front row seated (left to right): Garreth C. Debiegun, M.D.; Krishna R. Prasad, M.D.; M. Victoria Conti, M.D.; David F. Gaieski, M.D.; Marie S. Romney, M.D.; and Marion C. McDevitt, D.O.

Page 11: 2019 Spring Oral Exam Standard Setting Advisory Panel (bottom left): Back row (left to right): Carl R. Chudnofsky, M.D.; Jeffrey Sankoff, M.D.; Osman Sayan, M.D.; David S. Bullard, M.D.; Terrell S. Caffery, M.D.; Robert A. Czincila, D.O.; Matthew C. Gratton, M.D.; Tony P. Kanluen, M.D.; Scott H. Burner, M.D.; Penelope C. Lema, M.D.; Mark D. Levine, M.D.; Ilse M. Jenouri, M.D.; David Seltzer, M.D.; and Debra J. Paulson, M.D. Front row (left to right): Jill M. Baren, M.D.; Matthew D. Bitner, M.D.; Marc A. Borenstein, M.D.; Cristina E. Grijalva, M.D.; and Salvador J. Suau, M.D. Not pictured: Matthew T. Emery, M.D.

Page 12 (top) EMS Examination Committee: Left to right: Debra G. Perina, M.D.; Peter T. Pons, M.D.; Ritu Sahni, M.D.; Douglas F. Kupas, M.D.; Jeffrey M. Goodloe, M.D.; ABEM Director Liaison Marianne Gausche-Hill, M.D.; Theodore R. Delbridge, M.D.; Kathy J. Rinnert, M.D.; Vincent N. Mosesso, Jr., M.D.; K. Sophia Dyer, M.D.; and Alexander P. Isakov, M.D.

Page 12: (bottom) Medical Toxicology Subboard: Standing, left to right: Michael G. Holland, M.D.; Carl R. Baum, M.D.; Robert G. Hendrickson, M.D.; Theodore C. Bania, M.D.; Sean M. Bryant, M.D.; and ABEM Director Liaison Lewis S. Nelson, M.D. Seated left to right: Andrew I. Stolbach, M.D.; Diane P. Calello, M.D.; Joshua G. Schier, M.D.; and Michael I. Greenberg, M.D.

American Board of Emergency Medicine
3000 Coolidge Road • East Lansing, Michigan 48823-6319
517.332.4800 • www.abem.org
A MEMBER BOARD OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES

45 EMRA years established 1974

EMRA

EMRA FY 2019 Annual Report

Membership: 15,625

90%+ of EM Residents are EMRA members

200+ 100% EMRAfied programs with 100% membership

$3M+ annually invested into members

14% revenue growth between 2018 - 2019

EMRA helps you become the BEST DOCTOR you can be.

1 new comprehensive app, **MobilEM**, launching winter 2019

6 new publications

32 *books, reference cards, & mobile apps*

6 major EM conferences with EMRA presence (ACEP, LAC, CORD, EEM, EDPMA, FemInEM & EmCrit) AND **30+** *regional meetings funded in collaboration with ACEP*

21,000+ EMRA CAST downloads since July 2018

30,000+ EM Resident unique monthly online views and print distribution of **16,000**

500,000+ EMRA Match searches of EMRA Match & Clerkship Match, Fellowship Match in development

EMRA helps you become the BEST LEADER you can be.

3 new committees

EMRA Administration & Operations, EMRA Government Services, EMRA Social EM totalling **20** committees

40+ awards, scholarships & grants totalling **$125,000+**

120+ funded national leadership opportunities for members

204 Leadership Academy fellows

EMRA and ACEP Leadership Academy

400+ EMRA's 45 Under 45 Influencers in Emergency Medicine nominations received

5,016 members of EMRA's 20 Committees

EMRA helps EM become the BEST SPECIALTY we can be.

1 All EM Resident & Student Organization, **AEROS**, created by EMRA to foster collaboration

6 EMRA and ACEP Health Policy Academy Fellows

9+ partnerships to advance our mission (ACEP, EMF, EMAF, NEMPAC, EDPMA, AFFIRM, FemInEM, PolicyRx, AMA)

100+ programs with active representation in our policy-making Representative Council

SVI oppose further study of AAMC SVI pilot project

Defends the value of residency training on the ACEP Workforce & PA/NP Scope of Practice Task Forces

Advocating for residents and faculty in the ACGME's **Program Requirements**

ANNUAL REPORT TO THE ACEP COUNCIL:

EMRA is the voice of EM physicians-in-training and helps our members become the best doctor they can be (with our clinical resources), the best leader they can be (through leadership opportunities & training), and helps EM become the best specialty it can be (through advocacy).

Over the last 45 years, we've worked closely with ACEP on a series of incredible achievements for advancing the field of emergency medicine.

June 2019 was a monumental month for EMRA & ACEP, when our two organizations approved and signed a brand-new shared services agreement for the next five years! This agreement further solidifies our partnership and alliance, through joint membership for students, residents & fellows and through co-branding major initiatives (such as the EMRA and ACEP Leadership Academy, the EMRA and ACEP Health Policy Academy, and various awards and scholarships).

The remainder of this report details our activities, strategies, and vision for fiscal year 2019 focusing on three ways we worked with ACEP to support the College and fulfill our shared services agreement. We have also attached our annual report infographic to highlight our major initiatives and collaborations.

Thank you for your partnership and support!

Omar Z. Maniya, MD, MBA

President, EMRA

Erik J. Blutinger, MD, MSc

Resident Representative to ACEP

1. ***ADVOCACY:*** *Help EM become the* ***Best Specialty*** *we can be.*

As our specialty continues to face a series of challenges, both ACEP and EMRA continue to advocate on our collective behalf. EMRA has worked hard to ensure there is local engagement of EM physicians-in-training to get them involved at the ACEP Chapter level and this year, created a resident councillor mixer at ACEP19 to encourage collaboration among residents serving as state councillors.

ACEP and EMRA have also worked together on a series of key initiatives needing our specialty voice. Our two organizations crafted a policy statement in response to the Accreditation Council for Graduate Medical Education (ACGME) new **Common Program Requirements (CPR)**, arguing against the possible reduction of dedicated protected time for core faculty. We have remained strongly opposed to any changes affecting the high quality of education including the removal of the specific amount of time for core faculty.

At every opportunity, EMRA and ACEP have worked on upholding the tenants of high-quality EM education. Earlier this year, EMRA advocated on behalf of broadly defining **scholarly activity** and recognizing its enormous value for trainees, publishing a letter in the Western Journal of Emergency Medicine (February, 2019). The initiative was a joint collaboration of several organizations including CORD, ACOEP and AAEM.

Besides supporting **protected faculty time** and broadly defined scholarly activity, we also spoke out against the Association of American Medical Colleges (AAMC) in response to their operational "**Standardized Video Interview (SVI)**" pilot. We continue to work with all of the major EM organizations on making the residency interview process more valuable without implementing unpopular and unproven interventions .

Over the past year, we've also collaborated with and supported ACEP's SAMHSA grant application to create a **substance abuse disorders curriculum** for EM residency programs, and appointed a resident representative to the task force. EMRA has also been very supportive of ACEP's recent survey on Firearm Injury Prevention Research.

We've also created the EMRA and ACEP Health Policy Academy, to teach high potential residents the intricacies of effecting change in organized medicine, and will be bringing 6 Fellows to ACEP Council to serve as EMRA Alternate Delegates this year.

2. LEADERSHIP: *Helps you become the* ***Best Leader*** *you can be.*

This year on our 45th birthday, EMRA continues to be the launching pad for numerous leadership opportunities for the next generation of EM physicians. Our EMRA and ACEP **Leadership Academy**, a one year flipped classroom learning experience for emerging leaders in EM, has become even more successful with the help of ACEP leaders and mentors. In just our second year of operation, we had 200+ participants alone!

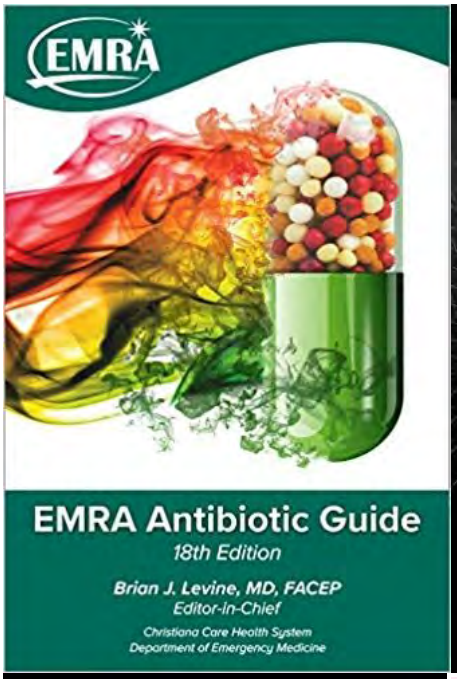
At ACEP's LAC Conference, we added a Spring **Medical Student Forum** which included 100+ registrants, and continued our Health Policy Primer. For ACEP19, we already have over 400 medical student registrants. Bringing these students into the EMRA and ACEP fold will make our organizations even stronger.

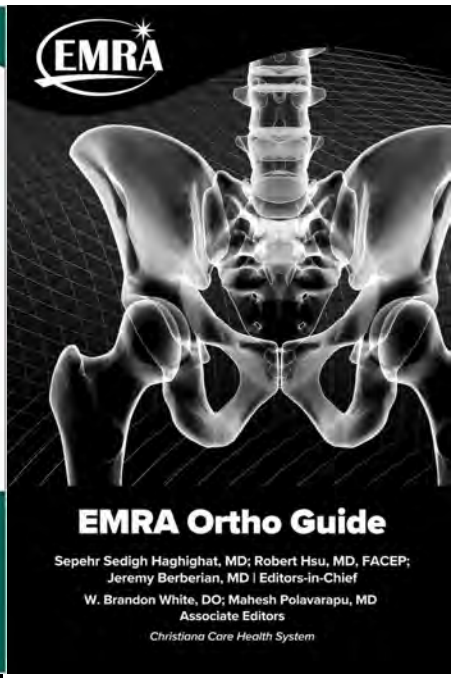
EMRA is also privileged to attract and fund over 120 national resident and student leaders through our 20 committees, which span the breadth of our specialty. And this year, to celebrate our 45th anniversary, EMRA recognized 45 superb influencers under 45 who have made a difference in EM. We received a total of 400+ applications, and are excited to celebrate their inspirational stories at ACEP19.

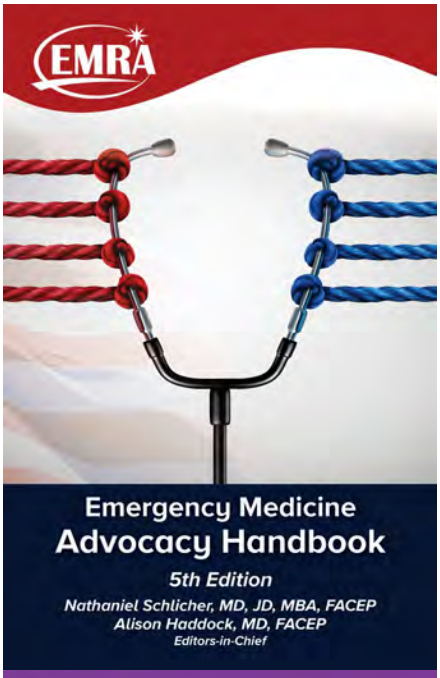
3. EDUCATION: *Helps you become the* ***Best Doctor*** *you can be.*

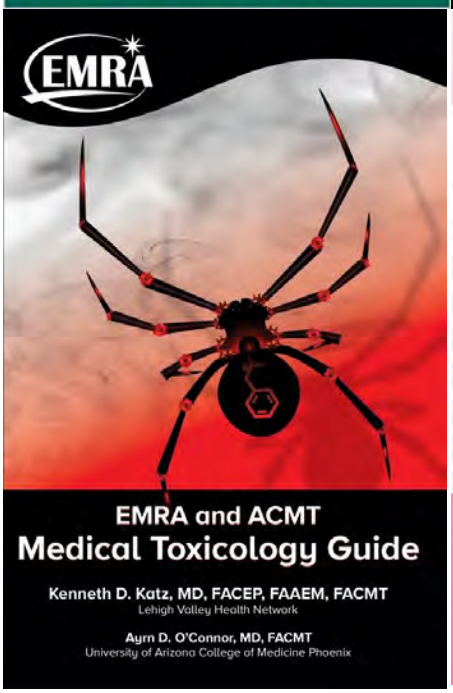
At ACEP19, EMRA is excited to announce the brand new launch of **MobilEM**, an all-inclusive platform containing our numerous clinical applications, under the direction of EMRA Director of Technology Dr. Nick Salerno & EMRA's Managing Editor Valerie Hunt. With MobilEM, our existing clinical products will be converted into app form, all housed in one convenient app platform for both Apple and Android devices.

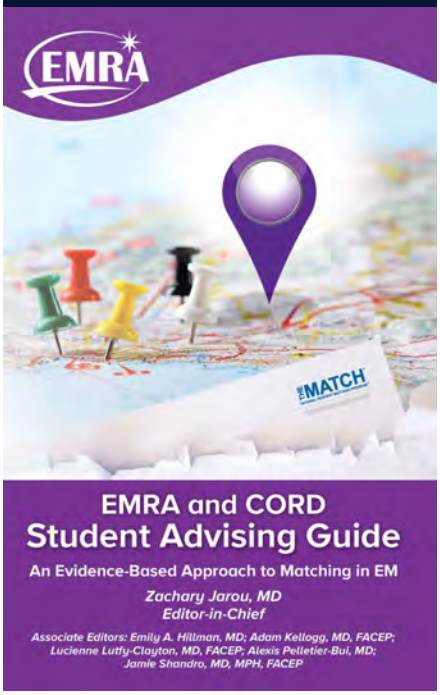
Furthermore, our arsenal of clinical resources continues to grow at an incredible rate, with **6 new clinical resources** this year:











Additionally, we are partnering with ACEP to create an Administrative curriculum for residents to introduce them to the “business side of medicine.” We’re also working on updating EMRA PressorDex, Basics of EM & Basics of EM: Pediatrics, EM Fundamentals, and creating new Pediatric Emergency Medicine and Pain Management Resources.

Our magazine ***EM Resident*** continues to be the world’s best resident magazine with a print circulation of over 15,000, receiving 40,000 unique page views on EMResident.org in the month of June alone! This would not be possible without our dedicated authors & Editor-In-Chief Dr. Tommy Eales. This year, Dr. Eales earned an Excel Award for his commentary on firearm injury prevention - standing out in a category that included the former U.S. Ambassador to VietNam as a finalist. Our unique **EMRA*Cast** podcast series keeps growing as well, now with over 21,000 unique downloads thanks to the hard work performed by EMRA’s Director of Education Dr. Sara Paradise-Dimeo.

Finally, we’ve adjusted our conference strategy to meet our members where they are. In addition to supporting our flagship events at ACEP Scientific Assembly & CORD Academic Assembly, we’ve expanded and now have a presence at 4 more major conferences (FemInEM, EMCrit, Essentials of EM & LAC). Additionally, EMRA and ACEP support over 30 regional meetings across the country. Together, these initiatives will dramatically increase our organizations' reach and impact.

We remain grateful for the close partnership between ACEP and EMRA and remain so excited for all that’s yet to come in 2020!

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: Board of Directors
Council Officers

From: Mark S. Rosenberg, DO MD, FACEP
Secretary-Treasurer

Date: September 17, 2019

Subj: FY 2018-19 Financial Report

This report of the FY 2018-19 encompasses the College's activities from July 1, 2018, through June 30, 2019. Additional details can be found in the June 30, 2019 Financial Statements.

Membership

Total membership increased by 998 to a total of 39,345 (2.60%). Regular membership increased by 271 to 21,049 (1.3%). Candidate membership increased by 787 to 14,155 (5.8%). International membership increased by 106 to 1,307 (8.82%). Life membership decreased by 169 to 2,797 (-5.6%). Honorary membership increased by 3 to 37 (8.82%).

Revenue

Total revenue was $43,011,877. Membership dues accounted for $13,499,966 (31% of the total revenue). Meetings, sale of products, and royalties generated $19,382,333 (45% of the total revenue). Grants, investments, CEDR, and other contributions accounted for $10,129,578 (24% of total revenue).

Expenses

Total expenses were $42,363,884. Salaries and accrued vacations were $14,884,482 (35% of expenses). Facility and meal costs were $6,737,847 (16% of expenses). Consulting and legal fees were $6,259,552 (15% of expenses). Staff benefits were $4,510,125 (11% of expenses).

Net from Operations

Revenue	$43,011,877
Expenses	$42,363,884
Net	$647,992

Liquid Reserve

Liquid reserve represents the amount of cash on hand minus the amount due to chapters and deferred revenue.

Cash equivalents	$24,497,733
Due to chapters	$2,332,005
Deferred revenue	$13,218,932
Liquid reserve	$8,946,795 (21% of operating budget)

ACEP's policy is to have at least 15% of the operating budget in liquid reserves. The FY 2018-19 operating budget was $42,872,042 and 15% would equal $6,430,806. Therefore, we have excess liquid reserves of $2,515,989.

HEADQUARTERS
Post Office Box 619911
Dallas, Texas 75261-9911

4950 W Royal Ln
Irving, TX 75063-2524

972-550-0911
800-798-1822
www.acep.org

BOARD OF DIRECTORS
Vidor E. Friedman, MD, FACEP
President
William P. Jaquis, MD, FACEP
President-Elect
Stephen H. Anderson, MD, FACEP
Chair of the Board
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Vice President
Mark S. Rosenberg, DO, MBA, FACEP
Secretary-Treasurer
Paul D. Kivela, MD, MBA, FACEP
Immediate Past President
James J. Augustine, MD, FACEP
L. Anthony Cirillo, MD, FACEP
John T. Finnell II, MD, MSc, FACEP
Alison J. Haddock, MD, FACEP
Christopher S. Kang, MD, FACEP
Kevin M. Klauer, DO, EJD, FACEP
Aisha T. Liferidge, MD, MPH, FACEP
Debra G. Perina, MD, FACEP
Gillian R. Schmitz, MD, FACEP

COUNCIL OFFICERS
John G. McManus, Jr, MD, MBA, FACEP
Speaker
Gary R. Katz, MD, MBA, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Dean Wilkerson, JD, MBA, CAE

Contributions to Equity and Staff Bonuses
The amount available is calculated from the net revenue after realized gains and the net budget is subtracted. This year that totaled $199,322; 40% was allocated to the staff bonus pool and 60% was allocated to member equity. The operating revenue over expense excludes the in-kind revenue of $7,264 and the in-kind depreciation expense of $52,525.

Adjusted Operating Revenue Over Expense	$693,254
Less Positive Realized Gains Variance	($439,639)
Less Target Budgeted Net	$54,293
Adjusted Excess	$199,322

Equity
Current member's equity is $22,561,651. The total contribution to equity this year was $300,433, which is a $579,050 decrease over last year.

Assets	$47,114,017
Liabilities	$24,552,366
Equity	$22,561,651

Equity per regular member is a useful means to measure growth in equity. Equity per regular member this fiscal year was $1,085, an increase of $15, a 1.4% gain.

Staff Bonuses
$79,729 was distributed to the staff bonus award pool, a decrease of $41,617 or 34% over last year. After taxes were paid (7.65%), the bonus award pool was $74,063.

Investment Portfolio
Additional details can be found in the June 30, 2019, Financial Statements. The current distribution is approximately 38% in equities and 62% in fixed income investments. The fiscal year return was 3.35%. Since the fund was created in 2009, the average annual return has been 10.72%.

2018 – 19 Activity Highlights

Geriatric Emergency Department Accreditation Program (GEDA)
GEDA completed its first year of accrediting EDs in May. As of May 16, 2019, there are a total of 59 accredited EDs (one accredited ED is in Barcelona, Spain) and 32 applications are currently being reviewed. The "Upgrade" feature launched in January allows for those EDs who gained accreditation as a Level 2 or Level 3 to move to a higher level of accreditation. There are currently seven accredited EDs interested in this upgrade feature. Discussions with the VA and non-VA stakeholders occurs every week with an end goal of bring 100+ VA EDs into the accreditation program. ACEP hosted the successful GEDA Pre-conference Becoming an Accredited Geriatric Emergency Department: How and Why? At *ACEP18.* This pre-conference had 85 attendees, representing 41 EDs across the country. Once again, ACEP is helping lead the U.S. Health Care System in its needed evolution to meet the needs of our shared patients.

Clinical Emergency Data Registry (CEDR)
ACEP's Quality Line of Service (LOS) is leading the national quality movement to redefine and rebrand emergency care. The Quality LOS is successfully providing cross functional member interaction and best practice development-related quality data tracking and reporting: Quality Collaboration, Policy, Patient Safety, Informatics, Performance

This report will be provided when available.

Measurement, Quality Improvement, Health Information Technology, Analytics, Research, Innovation, Education, Training, and Quality Strategy. With a humble beginning in FY 2015-16, CEDR started with five emergency medicine groups representing 14 EDs and has grown rapidly in FY 2018-19 to 210 emergency medicine groups representing more than 850 EDs. CEDR is now sustainable financially and is likely to be a significant driver for ACEP's financial diversity and membership growth and value.

Public Affairs & Advocacy

ACEP was able to obtain clarification from The Join Commission on the ability of emergency physicians to eat and drink at their work stations during shifts. ACEP created a tool kit of resources for members.

ACEP's Executive Director Dean Wilkerson attended the signing ceremony for the "SUPPORT for Patients and Communities Act" (H.R. 6/P.L. 115-271) at a small White House ceremony on October 24, 2018. ACEP was one of only a few medical societies in attendance.

Secured the opportunity for ACEP President Vidor Friedman to testify in front of the House Energy & Commerce Health Subcommittee on Out-of-Network billing to represent emergency medicine.