American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

# COUNCIL MEETING

## September 5-6, 2025

**Hyatt Regency Hotel**
**Salt Lake City, UT**

Scientific Assembly SALT LAKE CITY 25

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

# POLICY STATEMENT

Approved January 2019

## *Antitrust*

Reaffirmed January 2019, June 2013 and October 2007

Revised October 2001 and June 1996

Approved April 1994

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

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

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

In order to ensure that the College and its members comply with the antitrust laws, the following principles will be observed:

Copyright © 2019 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.
- 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 © 2019 American College of Emergency Physicians. All rights reserved.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

# POLICY STATEMENT

Approved April 2023

# *Conflict of Interest*

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

Reaffirmed October 2001

Revised September 1997

Originally approved January 1996

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

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

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

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

Copyright © 2023 American College of Emergency Physicians. All rights reserved.

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

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

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

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

A. General

1. All individuals who serve in positions of responsibility within the College need not only to avoid conflicts of interest, but also to avoid the appearance of a conflict of interest. This responsibility pertains to Key Leaders and other elected or appointed leaders, and staff. Decisions on behalf of the College must be based solely on the interest of the College and its membership. Decisions must not be influenced by desire for personal profit, loyalty to other organizations, or other extraneous considerations.
2. Key Leaders shall annually sign a statement acknowledging their fiduciary responsibility to the College and agree to avoid conflicts of interest or the appearance of conflicts of interest. The issue of conflicts of interest with regard to the remainder of the staff shall be the responsibility of the Executive Director. The issue of adherence to this policy regarding conflicts of interest of Section and Task Force Members who participate in the development of policy and resources on behalf of the College shall be the responsibility of the Section and Task Force Chairs.
3. Key Leaders shall annually complete a form designated by the Board of Directors that includes the disclosure of pertinent financial and career-related information and shall update that information as necessary to continuously keep it current and active.
4. Key Leaders shall annually sign a statement acknowledging that they may have access to confidential information and agree to protect the confidentiality of that information.
5. Officers, Board Members, the Executive Director, Chief Operating Officer, and members of the Senior Management Team shall annually agree to clarify their position when speaking on their own behalf as opposed to speaking on behalf of the College, or as an Officer or member of the Board of Directors or members of the Senior Management Team.
6. Officers, Board Members, the Executive Director, the General Counsel, or their designees will periodically review the conflict of interest disclosure statements submitted to the College to be aware of potential conflicts that may arise with others.
7. When an Officer, Board Member, the Executive Director, or General Counsel believes that an individual has a conflict of interest that has not been properly recognized or resolved, the Officer, Board Member, Executive Director, or General Counsel will raise that issue and seek proper resolution.

Copyright © 2023 American College of Emergency Physicians. All rights reserved.

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

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

Copyright © 2023 American College of Emergency Physicians. All rights reserved.

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

3. Except as provided in Section 5 below, completed disclosure forms shall be submitted to the President and the Executive Director, or other designee(s), no later than thirty (30) days prior to commencement of the annual meeting of ACEP's Council. For Officers and Board Members newly elected during a meeting of ACEP's Council, the forms shall be submitted no later than thirty (30) days following their election if they were not previously submitted. Any Key Leader who has not submitted a completed disclosure form by the applicable deadline will be ineligible to participate in those specific College activities for which they have been appointed or elected until their completed disclosure forms have been received and reviewed as set forth in this policy.
4. Information disclosed by Officers, Board Members, and the Executive Director pursuant to this policy will be placed in the General Reference Notebook available at each Board meeting for review by Officers and Board Members. Committee, Section, and Task Force Chairs will have access to the disclosure forms of the members of the entity they chair. In addition, any College member may request a copy of a Key Leader's disclosure form upon written request to the ACEP President.
5. Completed disclosure forms required from Section and Task Force Members will be submitted to the relevant Section or Task Force staff liaison, or other designee(s), within thirty (30) days of appointment or assignment.
6. The College may provide to its members and the public the disclosure forms of its Key Leaders and anyone who speaks at the Council meeting.

C. Additional Rules of Conduct
   1. Prior to participating in any deliberation or vote on an issue in which they may have a conflict, Key Leaders shall disclose the existence of any actual or possible interest or concern of:
      a. The individual;
      b. A member of that individual's immediate family; or
      c. Any party, group, or organization to which the individual has allegiance that can cause the College to be legally or otherwise vulnerable to criticism, embarrassment, or litigation.
   2. After disclosure of the interest or concern that could result in a conflict of interest as defined in this policy and all material facts, the individual shall leave the Board, Committee, Section, or Task Force meeting while the determination of a conflict of interest is discussed and voted upon. The remaining Board, Committee, Section, or Task Force members shall decide by majority vote if a conflict of interest exists. If a conflict of interest is determined to exist, the individual having the conflict shall retire from the room in which the Board, Committee, Section, or Task Force is meeting and shall not participate in the deliberation or decision regarding the matter under consideration. However, that individual shall provide the Board, Committee, Section, or Task Force with any and all relevant information requested.
   3. The minutes of the Board, Committee, Section, or Task Force meeting shall contain:
      a. The name of the individual who disclosed or otherwise was found to have an interest or concern in connection with an actual or possible conflict of interest, the nature of the interest, any action taken to determine whether a conflict of interest was present, and the Board's, Committee's, Section's, or Task Force's decision as to whether a conflict of interest existed;
      b. The extent of such individual's participation in the relevant Board, Committee, Section, or Task Force meeting on matters related to the possible conflict of interest; and
      c. The names of the individuals who were present for discussion and votes relating to the action, policy, or arrangement in question, the content of the discussion including alternatives to the proposed action, policy, or arrangement, and a record of any votes taken in connection therewith.

Copyright © 2023 American College of Emergency Physicians. All rights reserved.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

# POLICY STATEMENT

Approved June 2018

# *Meeting Conduct Policy*

Originally approved June 2018

**Background**

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

**Prohibited Behavior**

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

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

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

**Application of Rules**

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

Copyright © 2018 American College of Emergency Physicians. All rights reserved.

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

**Reporting Prohibited Behavior**

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

**Potential Consequences**

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

Copyright © 2018 American College of Emergency Physicians. All rights reserved.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Council Meeting Schedule of Events

**Hyatt Regency Salt Lake City**
September 4-6, 2025
Salt Lake City, UT

**Thursday, September 4**

| | |
|---|---|
| 3:00 pm – 8:00 pm | Councillor Credentialing – Regency North Foyer (Level 4) |
| 4:30 pm – 6:00 pm | Candidate Forum Subcommittee – Park City (Level 3) |
| 6:00 pm – 7:00 pm | Steering Committee Meeting – Wasatch C (Level 4) |
| 7:00 pm – 8:00 pm | Tellers, Credentials, & Elections Committee – Salt Lake AB (Level 2) |
| 7:00 pm – 8:00 pm | Reference Committee Briefing – Alta (Level 3) |
| 8:00 pm – 9:00 pm | Councillor Orientation – Salt Lake DE (Level 2) |

**Friday, September 5**

| | |
|---|---|
| 7:30 am – 5:30 pm | Councillor Credentialing – Regency North Foyer (Level 4) |
| 8:00 am – 9:50 am | Council Meeting – Regency Ballroom (Level 4) |
| 10:00 am – 1:00 pm | Reference Committee A – Salt Lake AB (Level 2) |
| 10:00 am – 1:00 pm | Reference Committee B – Salt Lake C (Level 2) |
| 10:00 am – 1:00 pm | Reference Committee C – Salt Lake DE (Level 2) |
| 11:00 am – 12:30 pm | Reference Committee Boxed Luncheon – Salt Lake Foyer (Level 2) |
| 1:00 pm – 2:30 pm | Reference Committee Executive Sessions<br>A – Salt Lake AB (Level 2)<br>B – Salt Lake C (Level 2)<br>C – Salt Lake DE (Level 2) |
| 1:15 pm – 2:00 pm | Town Hall Meeting – Regency Ballroom (Level 4) |
| 2:05 pm – 2:35 pm | Candidate Forum – President-Elect Candidates – Regency Ballroom (Level 4) |
| 2:45 pm – 4:30 pm | Candidate Forum – Board of Directors and Council Officer Candidates<br>*Candidates will rotate through each of the Reference Committee meeting rooms.* |
| 2:45 pm – 4:30 pm | Candidate Waiting Room (Candidates and "entourage" members only) – The Nest (Level 2) |
| 4:45 pm – 6:00 pm | Council Meeting Reconvenes Regency Ballroom (Level 4) |
| 6:15 pm – 7:15 pm | Candidate Reception – Sundance Terrace (Level 6) |

**Saturday, September 6**

| | |
|---|---|
| 7:00 am – 5:30 pm | Councillor Credentialing – Regency North Foyer (Level 4) |
| 8:00 am – 12:00 pm | Council Meeting – Regency Ballroom (Level 4) |
| 12:00 pm – 1:30 pm | Council Awards Luncheon – Salt Lake ABC (Level 2) |
| 1:40 pm – 5:45 pm | Council Reconvenes – Regency Ballroom (Level 4) |
| 5:10 pm – 5:40 pm | Elections Regency Ballroom (Level 4) |

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 Council Meeting

**September 5-6, 2025**
**Pre-Meeting Events Occur Thursday Evening, September 4, 2025**
**Hyatt Regency Salt Lake City, Regency Ballroom (Level 4)**
**Salt Lake City, UT**

## TIMED AGENDA

**Friday, September 5, 2025**

| | | |
|---|---|---|
| ***Continental breakfast available – Regency North Foyer (Level 4)*** | | ***7:30 am*** |
| 1. Call to Order | Dr. Costello | 8:00 am |
| A. Meeting Dedication | Dr. Costello | |
| B. Pledge of Allegiance | Dr. Costello | |
| C. National Anthem | Dr. Wiltz | |
| 2. Introductions | Dr. Costello | 8:10 am |
| 3. Welcome from UT Chapter President | Dr. Smith (video) | 8:12 am |
| 4. Tellers, Credentials, & Election Committee | Dr. Char | 8:14 am |
| A. Credentials Report | | |
| B. Meeting Etiquette | | |
| 5. Changes to the Agenda | Dr. Costello | 8:16 am |
| 6. Council Meeting Website Overview | Ms. Bocchieri | 8:16 am |
| 7. EMF Council Challenge | Dr. Wilcox | 8:21 am |
| 8. NEMPAC Council Challenge | Dr. Parker | 8:23 am |
| 9. Review and Acceptance of Minutes | Dr. Costello | 8:25 am |
| A. Council Meeting – September 27-28, 2024 | | |
| 10. Approval of Steering Committee Actions | Dr. Costello | 8:26 am |
| A. Steering Committee Meeting – January 21, 2025 | | |
| B. Steering Committee Meeting – April 27, 2025 | | |
| 11. Interim Executive Director's Report | Dr. Schneider | 8:27 am |
| 12. Call for and Presentation of Emergency Resolutions | Dr. Costello | 8:47 am |
| 13. Steering Committee's Report on Late Resolutions | Dr. Costello | 8:50 am |
| A. Reference Committee Assignments of Allowed Late Resolutions | | |
| B. Disallowed Late Resolutions | | |
| 14. Nominating Committee Report | Dr. Costello | 8:55 am |
| A. Speaker | | |
| 1. Slate of Candidates | | |
| 2. Call for Floor Nominations | | |
| B. Vice Speaker | | |
| 1. Slate of Candidates | | |
| 2. Call for Floor Nominations | | |
| C. Board of Directors | | |
| 1. Slate of Candidates | | |
| 2. Call for Floor Nominations | | |

D. President-Elect
   1. Slate of Candidates
   2. Call for Floor Nominations

| | | |
|---|---|---|
| 15. Candidate Opening Statements | Dr. Costello | |
| A. Speaker Candidates (2 minutes each) | | 9:00 am |
| B. Vice Speaker Candidates (2 minutes each) | | 9:02 am |
| C. Board of Directors Candidates (2 minutes each) | | 9:10 am |
| D. President-Elect Candidates (5 minutes each) | | 9:20 am |
| 16. Reference Committee Assignments | Dr. Costello | 9:40 am |
| ***BREAK*** | | ***9:45 am – 10:00 am*** |
| 17. Reference Committee Hearings | | 10:00 am – 1:00 pm |
| A – Governance & Membership – *Salt Lake AB (Level 2)* | | |
| B – Advocacy & Public Policy – *Salt Lake C (Level 2)* | | |
| C – Emergency Medicine Practice – *Salt Lake DE (Level 2)* | | |
| ***Boxed Lunches Available – Salt Lake Foyer*** | | ***11:00 am – 12:30 pm*** |
| 18. Reference Committee Executive Sessions | | 1:00 pm – 2:30 pm |
| A – *Salt Lake AB (Level 2)* | | |
| B – *Salt Lake C (Level 2)* | | |
| C – *Salt Lake DE (Level 2)* | | |
| ***BREAK – Return to main Council meeting room – Regency Ballroom (Level 4)*** | | ***1:00 pm – 1:15 pm*** |
| 19. Town Hall Meeting | Dr. McCrea | 1:15 pm – 2:00 pm |
| A. ED Accreditation: Why ED Accreditation is Right for Your ED! | | |
| 20. Candidate Forum for President-Elect Candidates | Dr. Costello | 2:05 pm – 2:35 pm |
| ***BREAK – Return to Reference Committee meeting rooms*** | | ***2:35 pm – 2:45 pm*** |
| *Salt Lake AB, C, DE (Level 2)* | | |
| 21. Candidate Forum for Board of Directors and Council Officer Candidates | | 2:45 pm – 4:30 pm |
| *Candidates rotate through Reference Committee meeting rooms.* | | |
| ***BREAK – Return to main Council meeting room – Regency Ballroom (Level 4)*** | | ***4:30 pm – 4:45 pm*** |
| 22. Speaker's Report | Dr. Costello | 4:45 pm |
| 23. In Memoriam | Dr. Costello | 5:00 pm |
| A. Reading and Presentation of Memorial Resolutions | Dr. McCrea | |
| *Adopt by observing a moment of silence.* | | |
| B. Presentation of Diane K. Bollman Chapter Advocate Award *(posthusmously for Jan Resinger, CAE)* | | |
| 24. EMRA Report | Dr. Wilson | 5:15 pm |
| 25. ABEM Report | Dr. Thomas | 5:20 pm |
| 26. AMA Section Council on Emergency Medicine Report | Dr. Epstein/Dr. Heine | 5:25 pm |
| 27. Secretary-Treasurer's Report | Dr. Knowles | 5:30 pm |
| 28. President's Address | Dr. Haddock | 5:35 pm |
| ***RECESS*** | | ***5:55 pm*** |

**Candidate Reception ● 6:15 pm – 7:15 pm ● Sundance Terrace (Level 6)**

**Saturday, September 6, 2025**

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 Council Meeting

Table of Contents


TAB

01 2025 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 27-28, 2024
- b. Steering Committee Meeting Minutes – January 21, 2025
- c. Steering Committee Meeting Minutes – April 27, 2025

10 Definition of Council Actions

11 Reference Committee Assignments

12 2025 Resolutions

13 Reports from the Board of Directors
- ACEP Composition Annual Report
- Compensation Committee Report

14 Town Hall Meeting Description
- ED Accreditation: Why ED Accreditation is Right for Your ED!

15 Board Action on 2024 Council Resolutions

16 Board Action on 2023 Council Resolutions

17 Board Action on 2022 Council Resolutions

18 President-Elect Candidates
- Jeffrey M. Goodloe, MD, FACEP
- Gabor D. Kelen, MD, FACEP
- Ryan A. Stanton, MD, FACEP

19 Board of Directors Candidates
- Daniel Freess, MD, FACEP
- Robert Hancock, DO, FACEP
- Steven B. Kailes, MD, MPH, FACEP
- Kristen B. McCabe-Kline, MD, FACEP
- Bing S. Pao, MD, FACEP

20 Council Officer Candidates

Council Speaker Candidate
- Michael J. McCrea, MD, FACEP

Council Vice Speaker Candidates
- Kurtis A. Mayz, JD, MD, MBA, FACEP
- Larisa M. Traill, MD, FACEP
- Aine Yore, MD, FACEP

21 2025 Award Recipients

22 Strategic Plan

23 Emergency Medicine Foundation Report

24 National Emergency Medicine Political Action Committee Report

25 Emergency Medicine Residents' Association Report

26 Secretary-Treasurer's Report

# 2025 Council Steering Committee

*Updated January 2025*



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

Mobile, AL



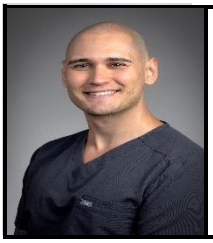
**Michael J. McCrea, MD, FACEP**
**Vice Speaker**

Perrysburg, OH



**Sara Ann Brown, MD, FACEP**

Monroeville, IN



**Joshua S. da Silva, DO, FACEP**

Columbus, OH



**Emily Fitz, MD, FACEP**

Zionsville, IN



**Deborah Fletcher, MD, FACEP**

Shreveport, LA



**Puneet Gupta, MD, FACEP**

Long Beach, CA



**Robert Hancock, DO, FACEP**

Roanoke, TX



**Jolie C. Holschen, MD, FACEP**

Chicago, IL



**Antony Hsu, MD, ACEP**

Ann Arbor, MI



**Amanda K. Irish, MD, MPH**

Iowa City, IA



**Greg A. Juhl, MD, FACEP**

Reno, NV



**David Nestler, MD, MS, FACEP**

Rochester, MN



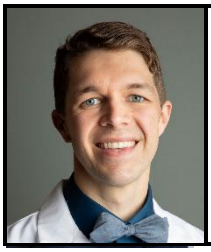
**Scott Pasichow, MD, MPH, FACEP**

Maplewood, NJ



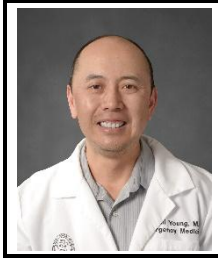
**Christopher S. Sampson, MD, FACEP**

Columbia, MO



**William Weber, MD, MPH, FACEP**

Chicago, IL



**Randall J. Young, MD, FACEP**

Poway, CA



**Jacob M. Altholz, MD**
**(EMRA REP to Steering Committee)**

Denver, CO

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Procedures for Councillor and Alternate Seating

**Councillor Credentialing**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Voting Cards and Electronic Voting**

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

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

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

**Seating Exchange Between Credentialed Councillors and Alternates**

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

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

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

# 2025 Councillor Seating Chart

SECRETARY PARLIAMENTARIAN SPEAKER VICE SPEAKER

| | | | | |
|---|---|---|---|---|
| | PROJECTION STAFF | | **436 + 43 Leaders=479** | |
| 1 | WA=11 UT=4 | WI=6 WV=3 WY=1 Undersea=1 Wellness=1 YPS=1 | TX=9 Toxicology=1 VT=2 Wilderness=1 Workforce=1 | 1 |
| 2 | VA=14 | NY-5 TN=5 Sports Med=1 Tactical=1 Trauma=1 | TX=14 Ultrasound=1 | 2 |
| 3 | QPS=1 RI=3 SAEM=1 SC=5 SD=1 Social EM=1 | NY=15 | PA=14 | 3 |
| 4 | NJ=13 Palliative=1 | NY=12 Telehealth=1 | OH=8 PA=6 | 4 |
| 5 | MO-7 NM=5 Obs=1 Pain Mgmt=1 | MI=10 OK=4 | OH=10 OR=5 | 5 |
| 6 | MD=8 MS=3 ND=1 NH=2 | MI=10 NV=4 | NC=12 Peds=1 Research=1 Rural=1 | 6 |
| 7 | KY=4 IN=7 ME=3 MT=1 | Locums=1 LA=4 MA=10 | Med Directors=1 Med Humanities=1 MN=8 NE=2 PR=2 | 7 |
| 8 | CT=8 Expl Retirement=1 ID=3 KS=3 | IA=2 IL=13 | FL=14 | 8 |
| 9 | CA=9 Democractic=1 DE=2 | GS=14 International=1 | FL=15 | 9 |
| 10 | CA=15 | EMRA=8 Event Med=1 Forensics=1 Freestanding=1 HI=2 Informatics=1 | DC=3 GA=10 Geriatrics=1 | 10 |
| 11 | CA=15 | CO=8 Cruise Ship=1 Disaster=1 Dual=1 EMPMHP=1 EMS=1 | AZ=-10 Careers=1 CORD=1 Critical Care=1 | 11 |
| | AACEM=1 ABC = 1 AL=5 AK=1 AR=3 Air Medical=1 AAWEP=1 | Board | | |
| | | Board | | |

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 2025 councillor seating chart includes the following:

| | |
|---|---|
| Alabama | 4 councillors + 1 past leader attending not serving as a councillor = 5 seats |
| Arizona | 8 councillors + 2 past leaders attending not serving as councillors = 10 seats |
| California | 34 councillors + 5 past leaders attending not serving as councillors = 39 seats |
| Colorado | 7 councillors + 1 past leader attending not serving as a councillor =8 seats |
| Connecticut | 6 councillors + 2 past leader attending not serving as a councillor = 8 seats |
| Florida | 22 councillors + 7 past leaders attending not serving as councillors = 29 seats |
| Georgia | 9 councillors + 1 past leaders attending not serving as councillors = 10 seats |
| Government Services | 11 councillors + 3 past leaders attending not serving as councillors = 14 seats |
| Indiana | 6 councillors + 1 past leader attending not serving as a councillor = 7 seats |
| Maryland | 7 councillors +1 past leader attending not serving as a councillor = 8 seats |
| New Jersey | 11 councillors +2 past leaders attending and not serving as councillors = 13 seats |
| New Mexico | 3 councillors + 2 past leaders attending and not serving as councillors = 5 seats |
| New York | 31 councillors + 1 past leader attending not serving as a councillor = 32 seats |
| North Carolina | 11 councillors + 1 past leader attending not serving as a councillor = 12 seats |
| Ohio | 16 councillors + 2 past leaders attending not serving as councillors = 18 seats |
| Pennsylvania | 19 councillors + 1 past leader attending not serving as a councillor = 20 seats |
| Texas | 21 councillors + 2 past leaders attending not serving as councillors = 23 seats |
| Virginia | 10 councillors + 4 past leaders attending not serving as councillors = 14 seats |
| Washington | 7 councillors + 4 past leaders attending not serving as councillors = 11 seats |

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| Chapter/Section | Position | Name |
|---|---|---|
| AACEM | Councillor | Ian B K Martin, MD, MBA, FACEP |
| ALABAMA CHAPTER | Councillor | Jeffrey D Anderson, MD, FACEP |
| | Councillor | William C Davis, MD |
| | Councillor | Stephen William Knight, MD, FACEP |
| | Councillor | Sean Vanlandingham, MD, FACEP |
| ALASKA CHAPTER | Councillor | Camilla Sulak, MD, FACEP |
| ARIZONA CHAPTER | Councillor | Olga Gokova, MD, FACEP |
| | Councillor | Nicole R Hodgson, MD, FACEP |
| | Councillor | Paul Andrew Kozak, MD, FACEP |
| | Councillor | Wendy Ann Lucid, MD, FACEP |
| | Councillor | Wayne A Martini, Jr, MD, FACEP |
| | Councillor | Megan L McElhinny, MD, FACEP |
| | Councillor | Anthony C Wong, MD, FACEP |
| | Councillor | Dale P Woolridge, MD, PhD, FACEP |
| | *Alternate* | Rebecca B Parker, MD, FACEP |
| ARKANSAS CHAPTER | Councillor | J Shane Hardin, MD, PhD, FACEP |
| | Councillor | Leslie Jewett, MD |
| | Councillor | Yusuke Kishimoto, MD |
| CALIFORNIA CHAPTER | Councillor | Amy P Anton, MD, FACEP |
| | Councillor | Jailyn Avila, MD, RDMS |
| | Councillor | Missy Brown, MD |
| | Councillor | Karen Chung, MD |
| | Councillor | Nida F Degesys, MD, FACEP |
| | Councillor | Adam P Dougherty, MD, FACEP |
| | Councillor | Nicole Elizabeth Exeni McAmis, MD |
| | Councillor | Jorge A Fernandez, MD, FACEP |
| | Councillor | Marc Allan Futernick, MD, FACEP |
| | Councillor | Marc Gautreau, MD, FACEP |
| | Councillor | Alicia Mikolaycik Gonzalez, MD, FACEP |
| | Councillor | Kamara W Graham, MD, FACEP |
| | Councillor | Jason Greenspan, MD, FACEP |
| | Councillor | Vikant Gulati, MD, FACEP |
| | Councillor | Puneet Gupta, MD, FACEP |
| | Councillor | Omar Guzman, MD, FACEP |
| | Councillor | Aaron J Harries, MD |
| | Councillor | Christopher Libby, MD, MPH, FACEP |
| | Councillor | Aimee K Moulin, MD, FACEP |
| | Councillor | Leslie Mukau, MD, FACEP |
| | Councillor | Valerie C Norton, MD, FACEP |
| | Councillor | Comfort Arinola Adeola Orebayo , DO |
| | Councillor | Bing S Pao, MD, FACEP |
| | Councillor | Vivian Reyes, MD, FACEP |
| | Councillor | Matthew Richard, MD, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | Councillor | Patrick K Shanovich, MD, FACEP |
| | Councillor | Susanne J Spano, MD, FACEP |
| | Councillor | Thomas Jerome Sugarman, MD, FACEP |
| | Councillor | Neelou Tabatabai, DO |
| | Councillor | Gary William Tamkin, MD, FACEP |
| | Councillor | Ashley Tarchione, MD |
| | Councillor | Lori D Winston, MD, FACEP |
| | Councillor | Anna L Yap, MD |
| | Councillor | Randall J Young, MD, FACEP |
| | *Alternate* | Madeleine Alexeeva, DO |
| | *Alternate* | Rodney W Borger, MD, FACEP |
| | *Alternate* | Fred Dennis, MD, MBA, FACEP |
| | *Alternate* | Cassandra Morgan Dewitt, MD |
| | *Alternate* | Luigi Di Stefano, MD, FACEP |
| | *Alternate* | Douglas Everett Gibson, MD, FACEP |
| | *Alternate* | Andy Hung-Yi Lee, MD, MBA |
| | *Alternate* | Hunter M Pattison, MD |
| | *Alternate* | Carolyn Joy Sachs, MD, MPH, FACEP |
| | *Alternate* | Dina Shakran, DO |
| | *Alternate* | Melanie T Stanzer, DO, FACEP |
| | *Alternate* | Patrick Um, MD, FACEP |
| | *Alternate* | Anna L Webster, MD, FACEP |
| | *Alternate* | Bradley Alan Zlotnick, MD, FACEP |
| COLORADO CHAPTER | Councillor | Ramnik S Dhaliwal, MD, JD |
| | Councillor | Laura Edgerley-Gibb, MD, FACEP |
| | Councillor | Anna Engeln, MD, FACEP |
| | Councillor | Abigail I Leibowitz, MD |
| | Councillor | Kristen Nordenholz, MD, FACEP |
| | Councillor | Paul Pukurdpol, MD |
| | Councillor | Parth Shah, DO |
| | *Alternate* | Douglas M Hill, DO, FACEP |
| | *Alternate* | Rebecca L Kornas, MD, FACEP |
| | *Alternate* | Carla Elizabeth Murphy, DO, FACEP |
| | *Alternate* | James D Thompson, MD, FACEP |
| CONNECTICUT CHAPTER | Councillor | Daniel Freess, MD, FACEP |
| | Councillor | Carlos Patrick Holden, MD, FACEP |
| | Councillor | Elizabeth Schiller, MD, FACEP |
| | Councillor | Gregory L Shangold, MD, FACEP |
| | Councillor | Douglas Anthony Smith, DO, FACEP |
| | Councillor | Listy Anam Thomas, MD, FACEP |
| | *Alternate* | Karen J Jubanyik-Barber, MD |
| | *Alternate* | David E Wilcox, MD, FACEP |
| CORD | Councillor | Laura Roff Hopson, MD |
| DELAWARE CHAPTER | Councillor | Kathryn Groner, MD, FACEP |
| | Councillor | John T Powell, MD, MHCDS, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| DISTRICT OF COLUMBIA CHAPTER | Councillor | Christopher T Clifford, MD |
| | Councillor | Rita A Manfredi-Shutler, MD, FACEP |
| | Councillor | Natasha N Powell, MD MPH MEd, FACEP |
| EMERGENCY MEDICINE RESIDENTS' ASSOCIATION | Councillor | Jacob Mark Altholz, MD |
| | Councillor | Anna Siobhan Heffron, MD |
| | Councillor | Katarina Jones, MD |
| | Councillor | Kelsey Mercedes Morgan, MD |
| | Councillor | Joe-Ann Moser, MD |
| | Councillor | Morgan Danielle Sweere, MD |
| | Councillor | David Wilson, MD |
| | Councillor | Pauline Wiltz, DO |
| | *Alternate* | Brittany Botticelli, MD |
| | *Alternate* | Ian Brodka, MD |
| | *Alternate* | Grace Katherine Bunemann, DO |
| | *Alternate* | Robert Edward Dunn, MD |
| | *Alternate* | Leah Ann Grinshpun, DO, MPH |
| | *Alternate* | Samantha Powell, DO |
| | *Alternate* | Louisa James Weindruch, DO |
| | *Alternate* | Laila Zomorodian, MD |
| FLORIDA CHAPTER | Councillor | Patrick R Anderson, DO |
| | Councillor | Andrew I Bern, MD, FACEP |
| | Councillor | Blake Buchanan, MD, FACEP |
| | Councillor | Stuart James Bumgarner, MD |
| | Councillor | Damian E Caraballo, MD, FACEP |
| | Councillor | Jordan Celeste, MD, FACEP |
| | Councillor | Taylor Norelle Craig, MD |
| | Councillor | Edward A Descallar, MD, FACEP |
| | Councillor | Anton Gomez, DO, FACEP |
| | Councillor | Gabriel Gomez, DO |
| | Councillor | Kelly Gray-Eurom, MD, MMM, FACEP |
| | Councillor | Shayne M Gue, MD, FACEP |
| | Councillor | Saundra A Jackson, MD, FACEP |
| | Councillor | Steven B Kailes, MD, FACEP |
| | Councillor | Joseph M King, MD |
| | Councillor | Mike Lozano, Jr, MD, MSHI, FACEP |
| | Councillor | Ryan T McKenna, DO, FACEP |
| | Councillor | Brandy Milstead, MD |
| | Councillor | Ashley Norse, MD, FACEP |
| | Councillor | Todd L Slesinger, MD, FACEP |
| | Councillor | Ian David Storch, MD, FACEP |
| | Councillor | Zachary C Terwilliger, MD |
| | *Alternate* | Ricki A Brown, MD |
| | *Alternate* | Brandon Joseph Chavez, DO |
| | *Alternate* | Vidor E Friedman, MD, FACEP |
| | *Alternate* | William Paul Jaquis, MD, MS, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | *Alternate* | Carmen J Martinez Martinez, MD, MSMEd, FACEP, FACEP |
| | *Alternate* | David Charles Seaberg, MD, CPE, FACEP |
| | *Alternate* | Ariel E Vera, MD, FACEP |
| GEORGIA CHAPTER | Councillor | Matthew R Astin, MD, FACEP |
| | Councillor | Brett H Cannon, MD JD MBA, FACEP |
| | Councillor | Shamie Das, MD, MBA, MPH, FACEP |
| | Councillor | James Joseph Dugal, MD(E), FACEP(E) |
| | Councillor | Matthew Taylor Keadey, MD, FACEP |
| | Councillor | Jeffrey F Linzer, Sr, MD, FACEP |
| | Councillor | James L Smith, Jr, MD, FACEP |
| | Councillor | Johnny L Sy, DO, FACEP |
| | Councillor | Matthew J Watson, MD, FACEP |
| | *Alternate* | Mark A Griffiths, MD, FACEP |
| | *Alternate* | Brendan Hawthorn, MD, FACEP |
| | *Alternate* | Benjamin Lefkove, MD, FACEP |
| | *Alternate* | Laura Oh, MD, FACEP |
| | *Alternate* | Alison Ruch, MD, FACEP |
| | *Alternate* | Matthew Rudy, MD, FACEP |
| | *Alternate* | Carmen D. Sulton, MD, FACEP |
| | *Alternate* | Kathryn West, MD, FACEP |
| | *Alternate* | John L Wood, MD, FACEP |
| GOVT SERVICES CHAPTER | Councillor | Christine A DeForest, DO, FACEP |
| | Councillor | Alan Jeffrey Hirshberg, MD, MPH, FACEP |
| | Councillor | Aicha M Hull, MD |
| | Councillor | Micaela A LaRose, MD |
| | Councillor | David S McClellan, MD, FACEP |
| | Councillor | Torree M McGowan, MD, FACEP |
| | Councillor | Evan Miller, DO |
| | Councillor | Mike Ramirez, MD |
| | Councillor | Paul James Diggins Roszko, MD, FACEP |
| | Councillor | Justine K Stremick, MD, FACEP |
| | Councillor | Sean Stuart, DO, FACEP |
| | *Alternate* | Linda L Lawrence, MD, CPE, FACEP |
| | *Alternate* | Gillian Schmitz, MD, FACEP |
| | *Alternate* | Robert Eduard Suter, DO, MHA, FACEP |
| HAWAII CHAPTER | Councillor | Mark Baker, MD, FACEP |
| | Councillor | John M Gallagher, MD, FACEP |
| | *Alternate* | Alexander Berk, MD, FACEP |
| IDAHO CHAPTER | Councillor | Ken John Gramyk, MD, FACEP |
| | Councillor | Darin J Lee, MD |
| | Councillor | Travis Marshall, MD, FACEP |
| | *Alternate* | Lauren E Apgar, DO |
| | *Alternate* | Heather S Hammerstedt, MD, FACEP |
| | *Alternate* | Travis Aaron Newby, DO, FACEP |

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| ILLINOIS CHAPTER | Councillor | Halleh Akbarnia, MD, MPH, FACEP |
| | Councillor | Amit D Arwindekar, MD, FACEP |
| | Councillor | Kristen M Donaldson, MD, MPH, FACEP |
| | Councillor | Elisabeth M Giblin, MD |
| | Councillor | Katarzyna Maria Gore, MD, FACEP |
| | Councillor | John W Hafner, MD, FACEP |
| | Councillor | Samantha A Hay, MD |
| | Councillor | Adnan Hussain, MD, FACEP |
| | Councillor | Jason A Kegg, MD, FACEP |
| | Councillor | Janet Lin, MD, FACEP |
| | Councillor | Monika Pitzele, MD, PhD, FACEP |
| | Councillor | Yanina Purim-Shem-Tov, MD, MS, FACEP |
| | Councillor | Willard W Sharp, MD, PhD, FACEP |
| | *Alternate* | Kelly Jester Geldmacher, MD, FACEP |
| | *Alternate* | Jolie C Holschen, MD, FACEP |
| | *Alternate* | Deborah E Weber, MD, FACEP |
| | *Alternate* | William Weber, MD, MPH, FACEP |
| INDIANA CHAPTER | Councillor | Michael D Bishop, MD, FACEP |
| | Councillor | Timothy A Burrell, MD, MBA, FACEP |
| | Councillor | Kyle D English, MD, FACEP |
| | Councillor | Emily M Fitz, MD, FACEP |
| | Councillor | Tracy Rene Rahall, MD, FACEP |
| | Councillor | Eric B Yazel, MD, FACEP |
| | *Alternate* | Sara Ann Brown, MD, FACEP |
| | *Alternate* | Benjamin Chastain, MD |
| | *Alternate* | Daniel W Elliott, MD, FACEP |
| | *Alternate* | Lauren Stanley, MD, FACEP |
| | *Alternate* | Daniel S Udrea, MD |
| | *Alternate* | Lindsay Zimmerman, MD, FACEP |
| IOWA CHAPTER | Councillor | Thomas E Benzoni, DO, FACEP |
| | Councillor | Ryan M Dowden, MD, FACEP |
| | *Alternate* | Hans Roberts House, MD, FACEP |
| | *Alternate* | Rachael Lewis, DO, FACEP |
| KANSAS CHAPTER | Councillor | Joshua J Davis, MD |
| | Councillor | Trevor S Mattox, MD |
| | Councillor | Matthew S Sinnwell, MD, FACEP |
| | *Alternate* | Nancy Blanchat, MD, FACEP |
| | *Alternate* | John F McMaster, MD, FACEP |
| KENTUCKY CHAPTER | Councillor | Christopher W Pergrem, MD, FACEP |
| | Councillor | Isaac Shaw, MD, FACEP |
| | Councillor | Hugh W Shoff, MD MS, FACEP |
| | Councillor | Beth Spurlin, MD, PhD, MBA, FAAP |
| | *Alternate* | Steven Joseph Stack, MD, MBA, FACEP |
| LOUISIANA CHAPTER | Councillor | James B Aiken, MD, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | Councillor | Deborah D Fletcher, MD, FACEP |
| | Councillor | Jamie Kuo, MD, MHLA, FACEP |
| | Councillor | Phillip Luke LeBas, MD, FACEP |
| | *Alternate* | Blake Denley, MD |
| | *Alternate* | Daniel J Sessions, MD |
| | *Alternate* | Michael D Smith, MD MBA CPE, FACEP |
| | *Alternate* | Jordan N Vaughn , MD |
| MAINE CHAPTER | Councillor | Garreth C Debiegun, MD, FACEP |
| | Councillor | Brandon E Giberson, DO, FACEP, FACEP |
| | Councillor | James B Mullen, III, MD, FACEP |
| | *Alternate* | Jesse Austin Butler, MD |
| | *Alternate* | Nathan G Donaldson, DO, FACEP |
| | *Alternate* | Andrew Ehrhard, MD, FACEP |
| | *Alternate* | Jessica Stevens, MD, MPH |
| MARYLAND CHAPTER | Councillor | Michael C Bond, MD, FACEP |
| | Councillor | Gregory Scott Corcoran, MD |
| | Councillor | Daniel Benjamin Gingold, MD, MPH, FACEP |
| | Councillor | Jonathan Lewis Hansen, MD, FACEP |
| | Councillor | Edana Denise Mann, MD, FACEP |
| | Councillor | Patrick McCarville, MD |
| | Councillor | Debra Michele Ravert, MD, FACEP |
| | *Alternate* | Kerry Forrestal, MD, FACEP |
| | *Alternate* | Carolina Mendoza, MD |
| | *Alternate* | Angela Wu, MD |
| MASSACHUSETTS CHAPTER | Councillor | Amy Costigan, MD, FACEP |
| | Councillor | Stephen K Epstein, MD, MPP, FACEP |
| | Councillor | Gayle Marie Galletta, MD, FACEP |
| | Councillor | Kathleen Kerrigan, MD, FACEP |
| | Councillor | Matthew B Mostofi, DO, FACEP |
| | Councillor | Mark D Pearlmutter, MD, FACEP |
| | Councillor | Allison Ramler, MD, FACEP |
| | Councillor | Michele Schroeder, MD, FACEP |
| | Councillor | Sundeep Shukla, MD, MBA, FACEP |
| | Councillor | Joseph C Tennyson, MD, FACEP |
| | *Alternate* | Carly Polcyn, MD |
| | *Alternate* | Natalie Strokes, DO |
| MICHIGAN CHAPTER | Councillor | Michael J Baker, MD, FACEP |
| | Councillor | Abigail Brackney, MD, FACEP |
| | Councillor | Sara S Chakel, MD, FACEP |
| | Councillor | Pamela N Coffey, MD, FACEP |
| | Councillor | Michael P Doyle, DO, FACEP |
| | Councillor | Michael W Fill, DO, FACEP |
| | Councillor | Gregory Gafni-Pappas, DO, FACEP |
| | Councillor | Michael Vincent Gratson, MD, FACEP |
| | Councillor | Antony P Hsu, MD, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | Councillor | Robert T Malinowski, MD, FACEP |
| | Councillor | Therese G Mead, DO, FACEP |
| | Councillor | Emily M. Mills, MD, FACEP |
| | Councillor | James C Mitchiner, MD, MPH, FACEP |
| | Councillor | David T Overton, MD, FACEP |
| | Councillor | Luke Christopher Saski, MD, FACEP |
| | Councillor | Jennifer B Stevenson, DO, FACEP |
| | Councillor | Andrew Taylor, DO, FACEP |
| | Councillor | Larisa May Traill, MD, FACEP |
| | Councillor | Bradley J Uren, MD, FACEP |
| | Councillor | Bradford L Walters, MD, FACEP |
| | *Alternate* | Nikeata Bell, DO |
| | *Alternate* | Miriam A Bukhsh, MD, MPH |
| | *Alternate* | Kathleen Cowling, DO, MS, MBA, FACEP |
| | *Alternate* | Eric Davis, MD |
| | *Alternate* | Bram A Dolcourt, MD, FACEP |
| | *Alternate* | Frank Y Duncan, III, MD, FACEP |
| | *Alternate* | Michele Johnson, DO, FACEP |
| | *Alternate* | Matthew L Kennedy, DO |
| | *Alternate* | Rami R Khoury, MD, FACEP |
| | *Alternate* | Srivarsha Koripella, MD |
| | *Alternate* | David J Kramp, MD |
| | *Alternate* | Jeffrey McGowan, DO, FACEP |
| | *Alternate* | Diane Paratore, MD; MEd, MBA, FACEP |
| | *Alternate* | Michael Tupper, MD, FACEP |
| | *Alternate* | Michelle Annette Wiener, MD |
| MINNESOTA CHAPTER | Councillor | Paul C Allegra, MD, FACEP |
| | Councillor | Heather Ann Heaton, MD, FACEP |
| | Councillor | Matthew E Herold, MD, FACEP |
| | Councillor | Kurt M Isenberger, MD, FACEP |
| | Councillor | Erin R Karl, MD |
| | Councillor | Benjamin Knutson, MD, FACEP |
| | Councillor | David Nestler, MD, MS, FACEP |
| | Councillor | Lisa M Roazen, MD, FACEP |
| | *Alternate* | Donald L Lum, MD, FACEP |
| | *Alternate* | Andrew R Zinkel, MD, MBA, FACEP |
| MISSISSIPPI CHAPTER | Councillor | Lisa M Bundy, MD, FACEP |
| | Councillor | Frederick B Carlton, Jr, MD, FACEP |
| | Councillor | Chester Duane Shermer, MD, FACEP |
| MISSOURI CHAPTER | Councillor | Jeanise Marie Butterfield, MD, FACEP |
| | Councillor | Douglas Mark Char, MD, FACEP |
| | Councillor | Kene A Chukwuanu, MD, FACEP |
| | Councillor | Leslie A Hueschen, MD, FACEP |
| | Councillor | Timothy J Koboldt, MD, FACEP |
| | Councillor | Marc Mendelsohn, MD, MPH, FACEP |
| | Councillor | Robert Francis Poirier, Jr, MD, MBA, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | *Alternate* | Dennis E Hughes, DO, FACEP |
| | *Alternate* | Melissa R Kroll, MD |
| | *Alternate* | Jared Lammert, MD |
| | *Alternate* | Christopher S Sampson, MD, FACEP |
| MONTANA CHAPTER | Councillor | Harry Eugene Sibold, MD, FACEP |
| | *Alternate* | Nathan Allen, MD, FACEP |
| | *Alternate* | Jamiee L Belsky, MD, FACEP |
| | *Alternate* | Robert Sands Redwood, MD, MPH, FACEP |
| NEBRASKA CHAPTER | Councillor | Andrew R Barnett, MD |
| | Councillor | John Ukadike, DO MPH |
| NEVADA CHAPTER | Councillor | Sabina A Braithwaite, MD, FACEP |
| | Councillor | Gregory Alan Juhl, MD, FACEP |
| | Councillor | Nehal S Naik, MD |
| | Councillor | Erin Simmers Pearson, MD, FACEP |
| NEW HAMPSHIRE CHAPTER | Councillor | Kathleen J Clem, MD, FACEP |
| | Councillor | Scott Weston Rodi, MD, MPH, FACEP |
| NEW JERSEY CHAPTER | Councillor | Navin Ariyaprakai, MD, NRP, FAEMS, FACEP, FACEP |
| | Councillor | Tanisha Arora, MD, FACEP |
| | Councillor | Kimberly T Baldino, MD, FACEP |
| | Councillor | Chris Bryczkowski, MD, FACEP |
| | Councillor | Rachelle Ann Greenman, MD, FACEP |
| | Councillor | Patrick Blaine Hinfey, MD, FACEP |
| | Councillor | Steven M Hochman, MD, FACEP |
| | Councillor | Jessica M Maye, DO, FACEP |
| | Councillor | J Mark Meredith, MD, FACEP |
| | Councillor | Scott H Pasichow, MD, MPH, FACEP |
| | Councillor | Chirag N Shah, MD, FACEP |
| | *Alternate* | Barnet Eskin, MD, FACEP |
| | *Alternate* | William Basil Felegi, DO, FACEP |
| | *Alternate* | Michael Joseph Gerardi, MD, FACEP |
| | *Alternate* | Jennifer M Kleven, MD, FACEP |
| | *Alternate* | Marjory E Langer, MD, FACEP |
| NEW MEXICO CHAPTER | Councillor | Dominic DiDomenico, DO, FACEP |
| | Councillor | Riemer C Praamsma, MD |
| | Councillor | Aaron Snyder, MD |
| | *Alternate* | Lionel Michael Candelaria, Jr, MD |
| | *Alternate* | Matthew Gunderson, MD |
| | *Alternate* | Lucas Maestas, MD |
| NEW YORK CHAPTER | Councillor | David O Andonian, MD, FACEP |
| | Councillor | Brahim Ardolic, MD, FACEP |
| | Councillor | Joseph Basile, MD, FACEP |
| | Councillor | Kirby Black, MD, FACEP |

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | Councillor | Erik Blutinger, MD, MSc, FACEP |
| | Councillor | Robert M Bramante, MD, FACEP |
| | Councillor | Jay Miller Brenner, MD, FACEP |
| | Councillor | Lauren J Curato, DO, FACEP |
| | Councillor | Mark Curato, DO, FACEP, FACEP |
| | Councillor | Sydney E DeAngelis, MD, FACEP |
| | Councillor | Ugo A Ezenkwele, MD, FACEP |
| | Councillor | Sanjey Gupta, MD, FACEP |
| | Councillor | Abbas Husain, MD, FACEP |
| | Councillor | Laura Iavicoli, MD, FACEP |
| | Councillor | Marc P Kanter, MD, FACEP |
| | Councillor | Stuart Gary Kessler, MD, FACEP |
| | Councillor | Elyse Katz Lavine, MD, FACEP |
| | Councillor | Penelope Lema, MD, FACEP, FPD-AEMUS |
| | Councillor | Sophia D Lin, MD, FACEP |
| | Councillor | Kurien Mathews, DO MBA, FACEP |
| | Councillor | Laura D Melville, MD |
| | Councillor | Nestor B Nestor, MD, FACEP |
| | Councillor | Norman Liang Ng, DO MBA, FACEP |
| | Councillor | Casey Lynn Palmer, MD |
| | Councillor | Jeffrey S Rabrich, DO, FACEP |
| | Councillor | Eli Rogers, MD |
| | Councillor | Livia M Santiago-Rosado, MD, FACEP |
| | Councillor | Virgil W Smaltz, MD, FACEP |
| | Councillor | Jeffrey J Thompson, MD, FACEP |
| | Councillor | Asa Viccellio, MD, FACEP |
| | Councillor | Luis Carlos Zapata, MD, FACEP |
| | *Alternate* | Koreem Andre Anderson, MD |
| | *Alternate* | Courtney Chiu, MD |
| | *Alternate* | Elizabeth H Hartofilis, MD |
| | *Alternate* | Adam Huynh, MD |
| | *Alternate* | Brandon Nicholas Mallory, DO |
| | *Alternate* | Daniel A Novak, DO |
| | *Alternate* | Carly M Rosen, MD |
| | *Alternate* | Simone Rudnin, DO |
| | *Alternate* | Vinay Saggar, MD |
| | *Alternate* | Samuel E Sondheim, MD |
| NORTH CAROLINA CHAPTER | Councillor | Melanie R Artho, MD, FACEP |
| | Councillor | Jill Lynn Benson, MD, FACEP |
| | Councillor | Thomas N Bernard, III, MD, FACEP |
| | Councillor | Scott W Brown, MD, FACEP |
| | Councillor | Gregory J Cannon, MD, FACEP |
| | Councillor | Christopher Allen Griggs, MD, MPH, FACEP |
| | Councillor | Eric Evan Maur, MD, FACEP |
| | Councillor | Swarup Misra, DO, FACEP |
| | Councillor | Madjimbaye Charles Namde, MD, MBA, FACEP |
| | Councillor | Bret A Nicks, MD, MHA, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | Councillor | Stephen A Small, MD, FACEP |
| | *Alternate* | Smeet R Bhimani, DO, MBA |
| | *Alternate* | Sierra Gaffney Gilder, MD, MPH |
| | *Alternate* | Laura Murphy, MD |
| OHIO CHAPTER | Councillor | Andrew Aten, MD, FACEP |
| | Councillor | Eileen F Baker, MD, PhD, FACEP |
| | Councillor | Marina N Boushra Freiberg, MD |
| | Councillor | Christina Campana, DO, FACEP |
| | Councillor | Joshua S da Silva, DO, FACEP |
| | Councillor | Joanna Elizabeth Henry, DO |
| | Councillor | Thomas W Lukens, MD, MS, PhD, FACEP |
| | Councillor | Anthony T Martella, MD |
| | Councillor | Daniel R Martin, MD, MBA, FACEP |
| | Councillor | Jesse A Park, DO |
| | Councillor | John R Queen, MD, FACEP |
| | Councillor | Brian Scharfenberg, DO, FACEP |
| | Councillor | George Sontag, MD, FACEP |
| | Councillor | Ryan Squier, MD, FACEP |
| | Councillor | K Robert Thompson, III, MD, MBA, FACEP |
| | Councillor | Nicole Ann Veitinger, DO, FACEP |
| | *Alternate* | Michael William Archer, DO |
| | *Alternate* | Max Louis Brummel, MD |
| | *Alternate* | Christopher L Burnsides, DO, FACEP |
| | *Alternate* | Aaron Cain, DO |
| | *Alternate* | Lamont G Clay, MD |
| | *Alternate* | Eric D Drobny, MD, FACEP |
| | *Alternate* | Laura Michelle Espy-Bell, MD, FACEP |
| | *Alternate* | Carlynn Fulp, MD |
| | *Alternate* | Jordan Mirto, DO |
| | *Alternate* | Steffen R Simerlink, MD |
| | *Alternate* | Alexander J Stuber, MD |
| | *Alternate* | Somy Monica Thottathil, MD, FACEP |
| OKLAHOMA CHAPTER | Councillor | Aimee Renee Blagovich, DO, FACEP |
| | Councillor | Laura Janneck, MD, FACEP |
| | Councillor | Derek Martinez, DO |
| | Councillor | Kurtis A Mayz, JD, MD, MBA, FACEP |
| OREGON CHAPTER | Councillor | Brittany N Arnold, MD, FACEP |
| | Councillor | Patsy Chenpanas, MD |
| | Councillor | John C Moorhead, MD, FACEP |
| | Councillor | Charles C Rudy, MD, FACEP |
| | Councillor | Christian Smith, MD, FACEP |
| PENNSYLVANIA CHAPTER | Councillor | Lauren Altomare, DO |
| | Councillor | Blake C Bailey, DO, FACEP |
| | Councillor | Christopher L Berry, MD, FACEP |
| | Councillor | Monisha Bindra, DO, MPH, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | Councillor | Jason R Burkett, DO, FACEP |
| | Councillor | Ankur A Doshi, MD, FACEP |
| | Councillor | Eric Eustice, DO |
| | Councillor | Adriana Facchiano, MD |
| | Councillor | Todd Fijewski, MD, FACEP |
| | Councillor | Avram Flamm, DO, FACEP |
| | Councillor | Richard Hamilton, MD, MBA, FACEP |
| | Councillor | Brian Kelly, DO |
| | Councillor | Zeenah Mansour, MD |
| | Councillor | Scott Mueller, DO, FACEP |
| | Councillor | Jennifer L Savino, DO, FACEP |
| | Councillor | Holly A Stankewicz, DO, FACEP |
| | Councillor | Elizabeth Barrall Werley, MD, FACEP |
| | Councillor | Christopher J Wilson, MD, FACEP |
| | Councillor | Zinta L Zapp, MD, FACEP |
| | *Alternate* | Emma Alley, MD |
| | *Alternate* | Jennifer Axelband, DO |
| | *Alternate* | Angela Cai, MD, MBA |
| | *Alternate* | Pooja Dave, MD |
| | *Alternate* | Ronald V Hall, MD, FACEP |
| | *Alternate* | Marilyn Joan Heine, MD, FACEP |
| | *Alternate* | Catherine Anna Marco, MD, FACEP |
| PUERTO RICO CHAPTER | Councillor | Natalia N. Rivera Mendoza, MD |
| | Councillor | Eddie Gabriel Rodriguez, MD, FACEP |
| 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 | Michelle Lall, MD, FACEP |
| SOUTH CAROLINA CHAPTER | Councillor | Matthew D Bitner, MD, FACEP |
| | Councillor | Allison Leigh Harvey, MD, FACEP |
| | Councillor | Cynthia Oliva, MD, FACEP |
| | Councillor | Angel Alisha Lee Rochester, MD, FACEP |
| | Councillor | Andriana Slavica Saric, DO |
| | *Alternate* | Ryan M Barnes, DO |
| | *Alternate* | Scott B Gutovitz, MD, FACEP |
| | *Alternate* | Kelly M Johnson, MD, FACEP |
| | *Alternate* | Lee Katherine Moore, MD, FACEP |
| SOUTH DAKOTA CHAPTER | Councillor | Donald Neilson, MD |
| | *Alternate* | Michael Frost, MD |
| TENNESSEE CHAPTER | Councillor | Stanton Elseroad, MD, MBA, FACEP |
| | Councillor | Sanford H Herman, MD, FACEP |
| | Councillor | Kito Lord, MD MBA CHCQM-PHYADV, FACEP |
| | Councillor | Thomas R Mitchell, MD, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | Councillor | Sullivan K Smith, MD, FACEP |
| | *Alternate* | Kenneth L Holbert, MD, FACEP |
| | *Alternate* | Daniel A Poor, MD, FACEP |
| | *Alternate* | John H Proctor, MD, MBA, FACEP |
| TEXAS CHAPTER | Councillor | Sara Andrabi, MD, FACEP |
| | Councillor | Jessica Ann Best, MD, FACEP |
| | Councillor | Angela Pettit Cornelius, MD, FACEP |
| | Councillor | Bryan M Dunn, MD, FACEP |
| | Councillor | Hilary E Fairbrother, MD, FACEP |
| | Councillor | Diana L Fite, MD, FACEP |
| | Councillor | Andrea L Green, MD, FACEP |
| | Councillor | Robert D Greenberg, MD, FACEP |
| | Councillor | Robert Hancock, Jr, DO, FACEP |
| | Councillor | Doug Jeffrey, MD, FACEP |
| | Councillor | Alexander J Kirk, MD, FACEP |
| | Councillor | Ira R Nemeth, MD, FACEP |
| | Councillor | Sterling Evan Overstreet, MD, FACEP |
| | Councillor | Heather S Owen, MD, FACEP |
| | Councillor | Daniel Eugene Peckenpaugh, MD, FACEP |
| | Councillor | R Lynn Rea, MD, FACEP |
| | Councillor | Richard Dean Robinson, MD, FACEP |
| | Councillor | Marcus Lynn Sims, II, DO, FACEP |
| | Councillor | Gerad A Troutman, MD, FACEP |
| | Councillor | James M Williams, DO, FACEP |
| | Councillor | Sandra Williams, DO, MPH, FACEP |
| | *Alternate* | Trisha Anest, MD MBA MPH, FACEP |
| | *Alternate* | Chinwe Amanda Anyanwu, DO, MPH |
| | *Alternate* | Clark O Azubuike, MD MPH |
| | *Alternate* | Geovonni Bell, MD |
| | *Alternate* | Adriana Cordova, MD |
| | *Alternate* | Carrie de Moor, MD, FACEP |
| | *Alternate* | Ola Elechi, MD |
| | *Alternate* | Angela F Gardner, MD, FACEP |
| | *Alternate* | Marcus Gonzalez, MD, MBA |
| | *Alternate* | Justin Garrett Hacnik, MD |
| | *Alternate* | Pavitra Krishnamani, MD |
| | *Alternate* | Ben Leeson, MD, FACEP |
| | *Alternate* | Laura N Medford-Davis, MD, FACEP |
| | *Alternate* | Craig Meek, MD, FACEP |
| | *Alternate* | Robert E Mohr, Jr, MD |
| | *Alternate* | Ariel S Noble, MD |
| | *Alternate* | Anant Patel, DO, FACEP |
| | *Alternate* | Jeffery M Pinnow, MD, FACEP |
| | *Alternate* | Jose R. Rosillo, MD, FACEP |
| | *Alternate* | Theresa Tran, MD, FACEP |
| UTAH CHAPTER | Councillor | Jim Antinori, MD, FACEP |
| | Councillor | Bennion D Buchanan, MD MBA FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| | Councillor | Jordan Mabey, MD |
| | *Alternate* | Sean D Slack, DO, FACEP |
| | *Alternate* | Joshua J White, DO |
| VERMONT CHAPTER | Councillor | Matthew S Siket, MD, FACEP |
| | Councillor | Alexandra Nicole Thran, MD, FACEP |
| | *Alternate* | Gary C Starr, MD, FACEP |
| VIRGINIA CHAPTER | Councillor | Benjamin Blackwood, MD |
| | Councillor | Caroline Hollis Cox, MD |
| | Councillor | Joshua Easter, MD |
| | Councillor | James R Humble, MD, FACEP |
| | Councillor | Joshua Lesko, MD, FACEP |
| | Councillor | Brooke Harris Lindborg, MD, FACEP |
| | Councillor | Todd Parker, MD, FACEP |
| | Councillor | Jesse D Spangler, MD, FACEP |
| | Councillor | Theodore J Tzavaras, MD |
| | Councillor | Lauren Webb, MD, FACEP |
| | *Alternate* | Atilio Elias Atencio, MD |
| | *Alternate* | William Burke Best, MD |
| | *Alternate* | Katherine Dickerson Mayes, MD, PhD |
| WASHINGTON CHAPTER | Councillor | Joshua R Frank, MD, FACEP |
| | Councillor | Sarah M Hansen, MD |
| | Councillor | Kevin E Hodges, MD, FACEP |
| | Councillor | Erika Schroeder, MD |
| | Councillor | Vasisht Srinivasan, MD, FACEP |
| | Councillor | Jessica J Wall, MD, MPH, MSCE, FACEP |
| | Councillor | Aine Yore, MD, FACEP |
| | *Alternate* | Herbert C Duber, MD, MPH, FACEP |
| | *Alternate* | Carlton E Heine, MD, PhD, FACEP |
| | *Alternate* | Nathaniel R Schlicher, MD, JD, MBA, FACEP |
| | *Alternate* | Kirstin W Scott, MD, MPhil, PhD |
| | *Alternate* | David Wilson, MD |
| WEST VIRGINIA CHAPTER | Councillor | Adam Thomas Crawford, DO, FACEP |
| | Councillor | Christopher S Goode, MD, FACEP |
| | Councillor | Mark Gustafson, DO, FACEP |
| | *Alternate* | Christopher S Kiefer, MD, FACEP |
| | *Alternate* | Erica B Shaver, MD, FACEP |
| | *Alternate* | Collin C Smith, DO, FACEP |
| | *Alternate* | Carol Lea Wright Becker, MD, MBA, FACEP |
| WISCONSIN CHAPTER | Councillor | Bradley Burmeister, MD, FACEP |
| | Councillor | William D Falco, MD, MS, MBA, FACEP |
| | Councillor | Susan E Good, MD, FACEP |
| | Councillor | Lisa J Maurer, MD, FACEP |
| | Councillor | Christopher Torkilsen, DO, FACEP |
| | Councillor | Stephanie J Wagner, MD, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| WYOMING CHAPTER | Councillor | Eugene Gicheru, MD, FACEP |
| | *Alternate* | Russell Lauver, DO |
| AAWEP SECTION | Councillor | Jayne M Kendall, MD, FACEP |
| | *Alternate* | Laurel J Barr, MD, FACEP |
| ACCESS, BELONGING, AND COMMUNITY SECTION | Councillor | Karen V Douglass, MD, FACEP |
| | *Alternate* | Christopher J Scott, MD, MBA, FACEP |
| AIR MEDICAL TRANSPORT SECTION | Councillor | Woodrow James Sams, MD |
| | *Alternate* | Jeffrey H Luk, MD, FACEP |
| CAREERS IN EMERGENCY MEDICINE SECTION | Councillor | Skyler E Smith, DO |
| | *Alternate* | Grace Gartman, MD |
| CRITICAL CARE MEDICINE SECTION | Councillor | Nicholas Johnson, MD, FACEP |
| | *Alternate* | Katherine Allison Pollard, MD, FACEP |
| CRUISE SHIP MEDICINE SECTION | Councillor | Cai Glushak, MD, FACEP |
| | *Alternate* | Joseph A Scott, MD, FACEP |
| DEMOCRATIC GROUP PRACTICE SECTION | Councillor | David G Hall, MD, FACEP |
| | *Alternate* | Zachary Joseph Jarou, MD, MBA, FACEP |
| DISASTER MEDICINE SECTION | Councillor | George-Thomas M Pugh, MD |
| | *Alternate* | Kylie Hayes Klemann, MD |
| DUAL TRAINING SECTION | Councillor | Katherine Ren, DO |
| | *Alternate* | Allyssa M Abel, MD, MPH |
| EM PRACTICE MGMT AND HEALTH POLICY SECTION | Councillor | Robert M McNamara, MD |
| | *Alternate* | Richard Lee Austin, Jr, MD, FACEP |
| EMERGENCY MEDICAL INFORMATICS SECTION | Councillor | Tricia Smith, MD, FACEP |
| EMERGENCY MEDICINE LOCUM TENENS SECTION | Councillor | Jamila Goldsmith, MD, FACEP |
| | *Alternate* | Joffre Johnson, MD |
| EMERGENCY MEDICINE WORKFORCE SECTION | Councillor | Ricki A Brown, MD |
| | *Alternate* | Leon C Adelman, MD, MBA, FACEP |
| EMERGENCY TELEHEALTH SECTION | Councillor | Iyesatta Massaquoi Emeli, MD, MPH, FACEP |
| | *Alternate* | Kathleen Y Li, MD |

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| EMERGENCY ULTRASOUND SECTION | Councillor | Ami Kurzweil, MD |
| | *Alternate* | Tobias Kummer, MD, FACEP |
| EMS-PREHOSPITAL CARE SECTION | Councillor | Matthew J Levy, DO, MSc, FACEP |
| | *Alternate* | Ryan Winchell, MD |
| EVENT MEDICINE SECTION | Councillor | Melissa D Kohn, MD, FACEP |
| | *Alternate* | David Eng, MD, FACEP |
| EXPLORING RETIREMENT SECTION | Councillor | Charles F Pattavina, MD, FACEP |
| | *Alternate* | Malcolm Bruce Parker, III, MD, FACEP |
| FORENSIC MEDICINE SECTION | Councillor | Lauren Hudak, MD |
| | *Alternate* | Jessica Elizabeth Hobbs, DO, FACEP |
| FREESTANDING EMEGENCY CENTERS | Councillor | Leo Huynh, DO, FACEP |
| | *Alternate* | Jose Felipe Llach, DO, FACEP |
| GERIATRIC EMERGENCY MEDICINE SECTION | Councillor | Angel Li, MD, MBA |
| | *Alternate* | Lynne B McCullough, MD, FACEP |
| INTERNATIONAL EMERGENCY MEDICINE SECTION | Councillor | Andres M Patino, MD, FACEP |
| | *Alternate* | J. Austin Lee, MD MPH, FACEP |
| MEDICAL DIRECTORS SECTION | Councillor | Bruce M Lo, MD, MBA, RDMS, FACEP |
| | *Alternate* | Wesley Zeger, DO, FACEP |
| MEDICAL HUMANITIES SECTION | Councillor | Diane M Birnbaumer, MD, FACEP |
| | *Alternate* | Rachel H Kowalsky, MD |
| OBSERVATION SERVICES SECTION | Councillor | George B. Hughes, MD |
| | *Alternate* | Joseph D Lykins, V, MD |
| PAIN MANAGEMENT SECTION | Councillor | Reuben J Strayer, MD, FACEP |
| | *Alternate* | Donald E Stader, III, MD, FACEP |
| PALLIATIVE MEDICINE SECTION | Councillor | Brian Q Gacioch, MD, FACEP |
| | *Alternate* | Daniel Boron-Brenner, DO |
| PEDIATRIC EMERGENCY MEDICINE SECTION | Councillor | Shobhit Jain, MD |
| | *Alternate* | Paula Jo Whiteman, MD, FACEP |
| QUALITY IMPROVEMENT AND PATIENT SAFETY SECTION | Councillor | Collin Michels, MD |
| | *Alternate* | Clinton J Hobson, MD, FACEP |




# 2025 COUNCILLORS & ALTERNATE COUNCILLORS

| | | |
|---|---|---|
| RESEARCH, SCHOLARLY ACTIVITY AND INNOVATION SECTION | Councillor | Charles B Kemmler, MD, PhD, FACEP |
| RURAL EMERGENCY MEDICINE SECTION | Councillor | Ashley Kochanek Weisman, MD, FACEP |
| SOCIAL EMERGENCY MEDICINE SECTION | Councillor | Kelli L Jarrell, MD, MPH |
| | *Alternate* | Alexis E Kimmel, MD |
| SPORTS MEDICINE SECTION | Councillor | Katie Dolbec, MD, FACEP |
| | *Alternate* | Diego Riveros, MD |
| TACTICAL AND LAW ENFORCEMENT SECTION | Councillor | James R Waymack, MD, FACEP |
| TOXICOLOGY SECTION | Councillor | Jennifer Hannum, MD, FACEP |
| | *Alternate* | Evan Schwarz, MD, FACEP |
| TRAUMA & INJURY PREVENTION SECTION | Councillor | Gregory Luke Larkin, MD, FACEP |
| | *Alternate* | Malcolm Bruce Parker, III, MD, FACEP |
| UNDERSEA & HYPERBARIC MEDICINE SECTION | Councillor | Drue Orwig, DO |
| | *Alternate* | Robert W Sanders, MD, FACEP |
| WELLNESS SECTION | Councillor | Harry W Severance, MD, FACEP |
| | *Alternate* | Andrea Austin, MD, FACEP |
| WILDERNESS MEDICINE SECTION | Councillor | Sally Peterson, MD |
| | *Alternate* | Dana R Mathew, DO, FACEP |
| YOUNG PHYSICIANS SECTION | Councillor | Sophia Spadafore, MD |
| | *Alternate* | Amanda K Irish, MD, MPH, MS, DTMH |
| | *Alternate* | Jessica Adkins Murphy, 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
How are Nominations and Elections Conducted? ..... 5
What is the Steering Committee? ..... 6

**III. COUNCIL REFERENCE COMMITTEES ..... 6**
Asynchronous Testimony ..... 6
Procedures ..... 7
Proceedings ..... 7
Reports ..... 8

**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. BASIC RULES GOVERNING MOTIONS ..... 10**

**VI. INCIDENTAL MOTIONS ..... 11**

**VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS ..... 11**
Questions ..... 11

**VIII. PARLIAMENTARY MOTIONS GUIDE ..... .12-13**

## I. COMPOSITION OF THE COUNCIL

### Introduction

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

### What is the Council?

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

The number of councillors representing a chapter in a given year is determined by the number of members in that chapter as shown by the average membership roll of the College of the preceding calendar year. The average is calculated by using the count of primary members in each chapter on the first day of the month then adding together each month's total and dividing by 12. Each chapter is represented by at least one councillor; an additional councillor is allowed for each 100 members in the chapter. EMRA is allocated eight voting councillors; AACEM, ACOEP, CORD, and SAEM, are each allocated one voting councillor; and each section of membership is allocated one voting councillor.

### What Does the Council Do?

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

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

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

## II. COUNCILLOR PREPARATION

### How Does a Councillor Prepare for the Annual Meeting?

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

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

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

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

**How Does the Council Conduct its Business?**

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

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

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

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

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

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

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

**What is a Resolution?**

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

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

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

*Amendments to Resolutions*

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

*Late Resolutions*

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

*Emergency Resolutions*

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

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

**What if I Have Questions About the Council?**

Questions about the Council can be directed to national ACEP staff in the Office of the Executive Director. They work closely with the Council officers in planning and executing the annual meeting and helping members to develop resolutions for consideration by the Council. Information about the Council, including important dates regarding the annual Council meeting, are posted on the ACEP website.

**How are Nominations and Elections Conducted?**

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

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

With the exception of the president-elect, the Board of Directors elects its own officers (chair, vice presidents,

and secretary-treasurer) each year during the first Board meeting after the Council meeting.

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

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

**What is the Steering Committee?**

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

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

## III. COUNCIL REFERENCE COMMITTEES

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

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

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

**Asynchronous Testimony**

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

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

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

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

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

**Procedures**

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

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

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

**Proceedings**

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

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

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

Following the open hearing and after all testimony is given, the Reference Committee will go into executive session to deliberate and construct its final report. Others are permitted to be in attendance only upon approval

from the chair and may not address the committee unless requested by the chair for clarification of testimony or to answer questions by committee members.

**Reports**

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

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

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

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

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

Examples of our common variants employing the procedure are:

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

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

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

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

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

Summary of Council Actions on Reference Committee Reports

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

## Definition of Council Action

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

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

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

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

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

## V. BASIC RULES GOVERNING MOTIONS

| Order of precedence[1] | Can interrupt? | Requires second? | Debatable?[2] | Amendable | Vote Required? | Applies to what other motions? | Can have what other motions applied to it?[3] | Renewable? |
|---|---|---|---|---|---|---|---|---|
| **Privileged Motions** | | | | | | | | |
| 1. Adjourn | No | Yes | No | Yes | Majority | None | Amend, close debate | Yes |
| 2. Recess | No | Yes | No | Yes | Majority | None | Amend, close debate | Yes |
| 3. Question of privilege | Yes | No | No | No | None | None | None | Yes |
| **Subsidiary Motions** | | | | | | | | |
| 4. Table | No | Yes | No | No | 2/3 | Main motion | None | No |
| 5. Close debate and vote immediately | No | Yes | No | Yes | 2/3 | Amendable, debatable motions | Amend | Yes |
| 6. Limit or extend debate | No | Yes | No | Yes | 2/3 | Amendable, debatable motions | Amend, close debate | Yes |
| 7. Postpone (to a certain time) | No | Yes | Yes | Yes | Majority[4] | Main motion with pending subsidiary motions | Amend, limit debate, close debate | Yes |
| 8. Refer to committee | No | Yes | Yes | Yes | Majority | Main motion with pending amendments | Amend, limit debate, close debate | Yes |
| 9. Amend | No | Yes | Yes[5] | Yes | Majority | Rewordable motions | Amend, limit debate close debate | Yes[6] |
| **Main Motions** | | | | | | | | |
| 10. a. The main motion | No | Yes | Yes | Yes | Majority | None | Subsidiary motions | No |
| b. Specific purpose main motions | | | | | | | | |
| Adopt in lieu of | No | Yes | Yes | Yes | Majority | Designated motions | Subsidiary motions | No |
| Amend a previous action | No | Yes | Yes | Yes | Same vote | Adopted main motion | Subsidiary motions | No |
| Ratify | No | Yes | Yes | No | Same vote | Adopted main motion | Subsidiary motions except amend | No |
| Recall from a committee | No | Yes | Yes | No | Majority | Referred main motion | Close debate, limit debate | Yes |
| Reconsider | Yes[7] | Yes | Yes | No | Majority | Main motion, some specific-purpose main motions[8] | Close debate, limit debate | No |
| Rescind | No | Yes | Yes | No | Same vote | Adopted main motion | Subsidiary motions except amend | No |

[1] Motions are in order only if no motion higher on the list is pending.
[2] Debate must always be germane to the pending motion.
[3] Note that the Motion to Withdraw can be applied to all motions.
[4] Postpone and make a special order requires 2/3 vote.
[5] Is not debatable when applied to an undebatable motion.
[6] At the discretion of the presiding officer.
[7] Can interrupt proceedings, but not a speaker.
[8] Adopt in lieu of, Amend a Previous Action, Ratify, and Rescind
[9] Only if it requires an immediate answer.

## 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 to it? | Renewable? |
|---|---|---|---|---|---|---|---|---|
| **Motions** | | | | | | | | |
| Appeal | Yes[7] | Yes | Yes | No | 2/3* | Ruling of chair | Close debate, limit debate | No |
| Suspend Rules | No | Yes | No | No | 2/3 | Procedural rules | None | Yes |
| Consider by paragraph | No | Yes | No | No | Majority | Main motion | None | Yes |
| Counted vote | Yes | Yes | No | No | Majority | Vote with an unclear outcome | None | No |
| **Requests** | | | | | | | | |
| Point of Order | Yes | No | No | No | None | Procedural error | None | No |
| Inquiries | Yes[9] | No | No | No | None | All motions | None | No |
| Withdraw a motion | Yes | No | No | No | None | All motions | None | No |
| Division of question | No | No | No | No | None | Divisible motions | None | No |
| Division of assembly | Yes | No | No | No | None | Vote with an unclear outcome | None | No |

*Per the Council Standing Rules*

[1] Motions are in order only if no motion higher on the list is pending.
[2] Debate must always be germane to the pending motion.
[3] Note that the Motion to Withdraw can be applied to all motions.
[4] Postpone and make a special order requires 2/3 vote.
[5] Is not debatable when applied to an undebatable motion.
[6] At the discretion of the presiding officer.
[7] Can interrupt proceedings, but not a speaker.
[8] Adopt in lieu of, Amend a Previous Action, Ratify, and Rescind
[9] Only if it requires an immediate answer.

## VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS

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

### Questions

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

**VIII.**

## *ACEP Parliamentary Motions Guide*

Based on *American Institute of Parliamentarians Standard Code of Parliamentary Procedure (2nd 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? |
|---|---|---|---|---|---|---|
| (173) Close meeting | I move that we **adjourn** | No | Yes | Yes | Yes | Majority |
| (171) Take break | I move to **recess** for | No | Yes | Yes | Yes | Majority |
| (167) Register complaint | I rise to a **question of personal privilege (or question of privilege affecting the assembly)** | Yes | No | No | No | None |
| (164) Kill motion without debate | I move that the main motion be **tabled** | No | Yes | No | No | 2/3 |
| (160) Close debate and vote immediately | I move to **close debate and vote immediately** | No | Yes | No | No | 2/3 |
| (157) **Limit or extend debate** | I move to limit debate to ... | No | Yes | Yes | Yes | 2/3 |
| (153) **Postpone to certain time** | I move to postpone the motion until ... | No | Yes | Limited | Yes | Majority |
| (149) **Refer** to committee | I move to refer the motion to … | No | Yes | Limited | Yes | Majority |
| (135) Modify wording of motion | I move to **amend** the motion by ... | No | Yes | Yes, unless undebatable motion | Yes | Majority |
| (115) Propose action to assembly (a **main motion**) | I move that … | No | Yes | Yes | Yes | Majority |

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

[1] As modified by the ACEP Council Standing Rules

## *ACEP Parliamentary Motions Guide*

Based on *American Institute of Parliamentarians Standard Code of Parliamentary Procedure (2nd Ed.)*[1]

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

| YOU WANT TO: | YOU SAY: | INTERRUPT? | 2ND? | DEBATE? | AMEND? | VOTE? |
|---|---|---|---|---|---|---|
| (179) Suspend rules | I move to **suspend…** | No | Yes | No | No | 2/3 |
| (183) Enforce rules | **Point of order** | Yes | No | No | No | None |
| (186) Submit matter to assembly | I **appeal** the ruling of the chair | Yes | Yes | Yes | No | 2/3 |
| (189) Parliamentary question | I rise to a **parliamentary inquiry** | Yes | No | No | No | None |
| (189) Factual inquiry | I rise to a request for information | Yes | No | No | No | None |
| (193) Request to **withdraw motion** | I withdraw my motion | Yes | No | No | No | Majority |
| (196) **Divide motion** | I request that the motion be divided … | No | No | No | No | None |
| (200) Demand rising vote | I call for a **division of the assembly** | Yes | No | No | No | None |

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

| | | | | | | |
|---|---|---|---|---|---|---|
| (121) Adopt one of several similar motions | I move the adoption of … in lieu of … | No | Yes | Yes | Yes | Majority |
| (123) **Amend a previous action** | I move to amend the motion that was … | No | Yes | Yes | Yes | Same as original |
| (125) Confirm prior action | I move to **ratify …** | No | Yes | Yes | No | Same as original |
| (127) Recall referred matter | I mot to **recall …** | No | Yes | Yes | Yes | Majority |
| (129) Reconsider main motion | I move to **reconsider** ... | No | Yes | Yes | No | Majority |
| (132) Cancel previous action | I move to **rescind** ... | No | Yes | Yes | No | Same as original |

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




# Council Standing Rules

## Revised October 2024

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Council Standing Rules

Revised October 2024

**Preamble**

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

**Alternate Councillors**

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

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

**Amendments to Council Standing Rules**

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

**Announcements**

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

**Appeals of Decisions from the Chair**

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

**Board of Directors Seating**

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

**Campaign Rules**

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

**Conflict of Interest Disclosure**

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

**Councillor Allocation for Sections of Membership**

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

**Councillor Seating**

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

**Credentialing and Proper Identification**

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

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

**Debate**

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

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

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

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

**Distribution of Printed or Other Material During the Annual Meeting**

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

**Election Procedures**

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

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

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

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

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

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

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

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

**Electronic Devices**

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

**Leadership Development Advisory Committee**

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

**Limiting Debate**

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

**Nominating Committee**

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

**Nominations**

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

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

**Parliamentary Procedure**

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

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

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

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

**Policy Review**

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

**Reference Committees**

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

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

A Reference Committee may recommend that a resolution:

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

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

C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee's motion to refer may go fully into the merits of the resolution. If the motion to refer is not adopted, the speaker shall state the original resolution.

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

**Reports**

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

**Resolutions**

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

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

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

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

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

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

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

- ***Bylaws Resolutions***

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

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

- ***Late Resolutions***

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

- ***Emergency Resolutions***

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

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

**Smoking Policy**

Smoking is not permitted in any College venue.

**Unanimous Consent Agenda**

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

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

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

**Voting Immediately**

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

**Voting on Resolutions and Motions**

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




# BYLAWS

## Revised October 2024

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 — Disciplinary Action ..... 3
Section 5 — Dues, Fees, and Assessments ..... 3
Section 6 — 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

October 2024

## 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 seek election to or serve on the national Board of Directors, may not seek election to or serve as Council Speaker or Council Vice Speaker, may not serve as a councillor or alternate councillor, and may not serve on a Council committee. With the exception of those in inactive status, international members may serve as voting members of College committees to which they are appointed but may not serve as committee chairs, may participate as voting members in sections of membership, and may serve as a section officer except for the positions of councillor and alternate councillor.

Section 3 — Agreement

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

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

Section 4 — Disciplinary Action

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

Section 5 — Dues, Fees, and Assessments

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

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

### Section 6 — Official Publications

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

## ARTICLE V — ACEP FELLOWS

### Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

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

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

### Section 2 — Fellow Status

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

## ARTICLE VI — CHAPTERS

### Section 1 — Charters

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

## Section 2 — Chapter Bylaws

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

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

## Section 3 — Qualifications

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

A member with professional and/or residential ties in multiple chapters may hold membership in these chapters, providing the member pays full chapter dues in each chapter. Such members with multiple chapter memberships shall designate which single chapter membership shall count for purposes of councillor allotment. A member of a chapter who retires from medical practice regardless of membership class and changes 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 average membership roll of the College of the preceding calendar year. The average will be calculated by using the count of primary members in each chapter on the first day of the month then adding together each month's total and dividing by 12. However, a member holding memberships simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one chapter. Councillors shall be elected or appointed from regular and candidate physician members in accordance with the governance documents or policies of their respective sponsoring bodies.

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

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

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

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

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

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

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

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

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

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

### Section 2 — Powers of the Council

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

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

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

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

### Section 3 — Meetings

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

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

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

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

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

### Section 4 — Quorum

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

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

Section 5 — Voting Rights

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

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

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

Section 6 — Resolutions

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

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

Section 7 — Nominating Committee

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

Section 8 — Board of Directors Action on Resolutions

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

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

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

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

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

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

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

## ARTICLE IX — BOARD OF DIRECTORS

### Section 1 — Authority

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

### Section 2 — Composition and Election

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

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

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

### Section 3 — Meetings

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

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

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

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

Section 4 — Removal

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

Section 5 — Vacancy

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

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

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

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

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

Section 2 — Election of Officers

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

Section 3 — Removal

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

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

Section 4 — Vacancy

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

Section 4.1 — President

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

Section 4.2 — President-Elect

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

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

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

Section 4.4 — Council Officers

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

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

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

Section 4.5 — Vacancy by Removal of a Board Officer

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

Section 4.6 — Vacancy by Removal of a Council Officer

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

Section 5 — President

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

Section 6 — Chair

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

Section 7 — Vice Presidents

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

Section 8 — President-Elect

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

Section 9 — Secretary-Treasurer

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

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

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

Section 10 — Immediate Past President

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

Section 11 — Speaker

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

Section 12 — Vice Speaker

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

Section 13 — Executive Director

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

Section 14 — Assistant Secretary-Treasurer

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

ARTICLE XI — COMMITTEES

Section 1 — General Committees

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

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

Section 2 — Executive Committee

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

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

### Section 3 — Steering Committee

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

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

### Section 4 — Bylaws Interpretation Committee

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

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

### Section 5 — Finance Committee

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

### 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 current edition of *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, except when in conflict with the Bylaws of the College or the Council Standing Rules.

### 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 the individual's official capacity and as to any action in another capacity while holding such office, and shall continue as to a person who shall have ceased to be a Director, Officer, or Employee of the College engaged in any other enterprise at the request of the College and shall inure to the benefit of the heirs, executors and administrators of such person.

Section 4 — Insurance or Other Arrangement

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

Section 5 — Exclusion of Certain Acts from Indemnification

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




# COLLEGE MANUAL

## Revised October 2020




# College Manual

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 ..... 6

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 2020

## I. Applications for Membership

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

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

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

### A. Definitions

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

### B. Complaint Received

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

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

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

**C. Executive Director**

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

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

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

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

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

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

**F. Right of Respondent to Request a Hearing**

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

**G. Hearing Procedures**

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

**H. Notice to the Board of Directors**

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

**I. Possible Disciplinary Action and Disclosure to ACEP Members**

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

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

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

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

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

2. Scope and Manner of Disclosure

a. Disclosure to ACEP Members: Any ACEP member may transmit a request for information to the Executive Director regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section I.1.

b. Disclosure to Non-Members: If a non-member makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. No further information shall be provided.

## J. Ground Rules

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

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

## III. Chartering Chapters

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

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

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

## IV. Charter Suspension-Revocation

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

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

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

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

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

## V. Filling Board Vacancies Created by Other Than Removal

### General Provisions

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

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

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

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

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

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

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

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

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

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

## VII. Amendments

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Meeting
September 27-28, 2024
Mandalay Bay Hotel and Convention Center
Las Vegas, NV

Minutes

The 53nd annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:06 am Pacific time on Friday, September 27, 2024, by Speaker Melissa W. Costello, MD, FACEP.

Seated at the table were: Melissa W. Costello, MD, FACEP, speaker; Michael McCrea, MD, FACEP, vice speaker; Sandra M. Schneider, MD, FACEP, Council secretary and interim executive director; and Jim Slaughter, JD, CPP, parliamentarian.

Dr. Costello welcomed everyone. She provided a meeting dedication and led the Council in reciting the Pledge of Allegiance and singing the National Anthem.

John Hardwick, MD, FACEP, president of the Nevada Chapter, welcomed councillors and other meeting attendees.

Douglas Char, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 329 councillors of the 422 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

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

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

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

The following members were credentialed by the Tellers, Credentials, & Elections Committee for seating at the 2024 Council meeting:

| | |
|---|---|
| ASSOCIATION OF ACADEMIC CHAIRS OF EM | Jane H Brice, MD, FACEP |
| ALABAMA CHAPTER | Paul Daniel Kivela, MD, MBA, FACEP<br>Jaron D Raper, MD, FACEP<br>Annalise Sorrentino, MD, FACEP<br>Sean Vanlandingham, MD, FACEP |
| ALASKA CHAPTER | Camilla Sulak, MD, FACEP |
| ARIZONA CHAPTER | Patricia A Bayless, MD, FACEP<br>Lawrence A DeLuca, MD, FACEP<br>Bradley A Dreifuss, MD, FACEP<br>Olga Gokova, MD, FACEP<br>Nicole R Hodgson, MD, FACEP<br>Paul Andrew Kozak, MD, FACEP<br>Wendy Ann Lucid, MD, FACEP<br>Anthony C Wong, MD, FACEP |

| | |
|---|---|
| ARKANSAS CHAPTER | Brian L Hohertz, MD, FACEP<br>Robert Thomas VanHook, MD, FACEP |
| CALIFORNIA CHAPTER | Nida F Degesys, MD, FACEP<br>Luigi Di Stefano, MD, FACEP<br>Adam P Dougherty, MD, FACEP<br>Nicole Elizabeth Exeni McAmis, MD<br>Andrew N Fenton, MD, FACEP<br>Jorge A Fernandez, MD, FACEP<br>Marc Allan Futernick, MD, FACEP<br>Michael Gertz, MD, FACEP<br>Douglas Everett Gibson, MD, FACEP<br>Alicia Mikolaycik Gonzalez, MD, FACEP<br>Hannah Gordon, MD, MPH<br>Kamara W Graham, MD, FACEP<br>Jason Greenspan, MD, FACEP<br>Vikant Gulati, MD, FACEP<br>Puneet Gupta, MD, FACEP<br>Omar Guzman, MD, FACEP<br>Michael J Kiemeney, MD, FACEP<br>Christopher Libby, MD, MPH, FACEP<br>Aimee K Moulin, MD, FACEP<br>Leslie Mukau, MD, FACEP<br>Valerie C Norton, MD, FACEP<br>Comfort Arinola Adeola Orebayo , DO<br>Bing S Pao, MD, FACEP<br>Chi Lee Perlroth, MD, FACEP<br>Kelly E Quinley, MD<br>Vivian Reyes, MD, FACEP<br>Matthew Richard, MD, FACEP<br>Ellen Marie Shank, MD<br>Susanne J Spano, MD, FACEP<br>Thomas Jerome Sugarman, MD, FACEP<br>David Terca, MD, FACEP<br>Anna L Yap, MD<br>Randall J Young, MD, FACEP |
| COLORADO CHAPTER | Jasmeet Singh Dhaliwal, MD, MPH, MBA<br>Ramnik S Dhaliwal, MD, JD<br>Laura Edgerley-Gibb, MD, FACEP<br>Anna Engeln, MD, FACEP<br>Rachelle M Klammer, MD, FACEP<br>Rebecca L Kornas, MD, FACEP |
| CONNECTICUT CHAPTER | Daniel Freess, MD, FACEP<br>Carlos Patrick Holden, MD, FACEP<br>Elizabeth Schiller, MD, FACEP<br>Gregory L Shangold, MD, FACEP<br>Kevin Joseph Sprague, II, MD<br>David E Wilcox, MD, FACEP |
| COUNCIL OF RESIDENCY DIRECOTRS IN EM | Boyd D Burns, DO, FACEP |
| DELAWARE CHAPTER | Kathryn Groner, MD, FACEP<br>John T Powell, MD, MHCDS, FACEP |
| DISTRICT OF COLUMBIA CHAPTER | Christopher T Clifford, MD<br>Rita A Manfredi-Shutler, MD, FACEP |

| | |
|---|---|
| | Natasha N Powell, MD, MPH, FACEP |
| EMERGENCY MEDICINE RESIDENTS' ASOCIATION | Jacob Mark Altholz, MD<br>Michaela Skylar Banks, MD<br>Blake Denley, MD<br>Kenneth Taeyoung Kim, MD<br>Aaron R Kuzel, DO<br>Derek Martinez, DO<br>Morgan Danielle Sweere, MD<br>David Wilson, MD |
| FLORIDA CHAPTER | Andrew I Bern, MD, FACEP<br>Ricki A Brown, MD<br>Blake Buchanan, MD, FACEP<br>Stuart James Bumgarner, MD<br>Damian E Caraballo, MD, FACEP<br>Edward A Descallar, MD, FACEP<br>Anton Gomez, DO<br>Gabriel Gomez, DO<br>Harold Gomez Acevedo, MD, FACEP<br>Kelly Gray-Eurom, MD, MMM, FACEP<br>Shayne M Gue, MD, FACEP<br>Brandy Milstead Hollingsworth, MD<br>Saundra A Jackson, MD, FACEP<br>Steven B Kailes, MD, FACEP<br>Ryan T McKenna, DO, FACEP<br>Ashley Norse, MD, FACEP<br>Jeremy K Selley, DO, FACOEP<br>Todd L Slesinger, MD, FACEP<br>Ian David Storch, MD, FACEP<br>Zachary C Terwilliger, MD<br>Stephen C Viel, MD, MBA, FACEP |
| GEORGIA CHAPTER | Matthew R Astin, MD, FACEP<br>Brett H Cannon, MD JD MBA, FACEP<br>James Joseph Dugal, MD, FACEP<br>Matthew Taylor Keadey, MD, FACEP<br>DW “Chip” Pettigrew, III, MD, FACEP<br>Alison Ruch, MD, FACEP<br>James L Smith, Jr, MD, FACEP<br>Matthew J Watson, MD, FACEP<br>Kathryn West, MD, FACEP |
| GOVT SERVICES CHAPTER | Christine A DeForest, DO, FACEP<br>Roderick Fontenette, MD, FACEP<br>Katrina N Landa, MD, FACEP<br>Linda L Lawrence, MD, CPE, FACEP<br>David S McClellan, MD, FACEP<br>Torree M McGowan, MD, FACEP<br>Katey Della Giustina Osborne, MD<br>Mike Ramirez, MD<br>Justine K Stremick, MD, FACEP<br>Sean Stuart, DO, FACEP |
| HAWAII CHAPTER | Mark Baker, MD, FACEP<br>John M Gallagher, MD, FACEP |
| IDAHO CHAPTER | Ken John Gramyk, MD, FACEP |

| | |
|---|---|
| | Darin J Lee, MD |
| | Travis Marshall, MD, FACEP |
| ILLINOIS CHAPTER | Amit D Arwindekar, MD, FACEP |
| | Kristen M Donaldson, MD, MPH, FACEP |
| | Elisabeth M Giblin, MD |
| | Cai Glushak, MD, FACEP |
| | Katarzyna Maria Gore, MD, FACEP |
| | John W Hafner, MD, FACEP |
| | Adnan Hussain, MD, FACEP |
| | Jason A Kegg, MD, FACEP |
| | Janet Lin, MD, FACEP |
| | Monika Pitzele, MD, PhD, FACEP |
| | Yanina Purim-Shem-Tov, MD, MS, FACEP |
| | Willard W Sharp, MD, FACEP |
| | Deborah E Weber, MD, FACEP |
| INDIANA CHAPTER | Michael D Bishop, MD, FACEP |
| | Sara Ann Brown, MD, FACEP |
| | Timothy A Burrell, MD, MBA, FACEP |
| | Kyle D English, MD, FACEP |
| | Emily M Fitz, MD, FACEP |
| | Eric B Yazel, MD, FACEP |
| IOWA CHAPTER | Ryan M Dowden, MD, FACEP |
| | Rachael Sokol, DO, FACEP |
| KANSAS CHAPTER | John F McMaster, MD, FACEP |
| | Matthew S Sinnwell, MD, FACEP |
| KENTUCKY CHAPTER | Christopher W Pergrem, MD, FACEP |
| | Isaac Shaw, MD |
| | Hugh W Shoff, MD MS, FACEP |
| | Beth Spurlin, MD, PhD, MBA, FAAP |
| LOUISIANA CHAPTER | Deborah D Fletcher, MD, FACEP |
| | Jamie Kuo, MD, MHLA, FACEP |
| | Phillip Luke LeBas, MD, FACEP |
| | Jordan N Vaughn, MD |
| MAINE CHAPTER | Garreth C Debiegun, MD, FACEP |
| | Brandon E Giberson, DO, FACEP |
| | James B Mullen, III, MD, FACEP |
| MARYLAND CHAPTER | Michael C Bond, MD, FACEP |
| | Timothy P Chizmar, MD, FACEP |
| | Karen Dixon, MD, FACEP |
| | Kerry Forrestal, MD, FACEP |
| | Jon Mark Hirshon, MD, MPH, PhD, FACEP |
| | Phillip David Magidson, MD, FACEP |
| | Richard Gentry Wilkerson, MD, FACEP |
| MASSACHUSETTS CHAPTER | Jamie Aron, MD |
| | Amy Costigan, MD, FACEP |
| | Stephen K Epstein, MD, MPP, FACEP |
| | Gayle Marie Galletta, MD, FACEP |
| | Joseph William Kopp, MD, FACEP |
| | Joseph Leary, DO |

| | |
|---|---|
| | Matthew B Mostofi, DO, FACEP |
| | Mark D Pearlmutter, MD, FACEP |
| | Michele Schroeder, MD, FACEP |
| | Joseph C Tennyson, MD, FACEP |
| MICHIGAN CHAPTER | Michael J Baker, MD, FACEP |
| | Abigail Brackney, MD, FACEP |
| | Sara S Chakel, MD, FACEP |
| | Pamela N Coffey, MD, FACEP |
| | Michael W Fill, DO, FACEP |
| | Gregory Gafni-Pappas, DO, FACEP |
| | Michael Vincent Gratson, MD, FACEP |
| | Antony P Hsu, MD, FACEP |
| | Robert T Malinowski, MD, FACEP |
| | Therese G Mead, DO, FACEP |
| | Emily M. Mills, MD, FACEP |
| | James C Mitchiner, MD, MPH, FACEP |
| | Diana Nordlund, DO, JD, FACEP |
| | David T Overton, MD, FACEP |
| | Luke Christopher Saski, MD, FACEP |
| | Jennifer B Stevenson, DO, FACEP |
| | Andrew Taylor, DO, FACEP |
| | Larisa May Traill, MD, FACEP |
| | Bradley J Uren, MD, FACEP |
| | Bradford L Walters, MD, FACEP |
| MINNESOTA CHAPTER | Paul C Allegra, MD, FACEP |
| | Heather Ann Heaton, MD, FACEP |
| | Matthew E Herold, MD, FACEP |
| | Donald L Lum, MD, FACEP |
| | David A Milbrandt, MD, FACEP |
| | David Nestler, MD, MS, FACEP |
| | Lisa M Roazen, MD, FACEP |
| | Andrew R Zinkel, MD, MBA, FACEP |
| MISSISSIPPI CHAPTER | Lisa M Bundy, MD, FACEP |
| | Frederick B Carlton, Jr, MD, FACEP |
| | Fred E Kency, Jr, MD, FACEP |
| MISSOURI CHAPTER | Douglas Mark Char, MD, FACEP |
| | Jonathan Heidt, MD, MHA, FACEP |
| | Dennis E Hughes, DO, FACEP |
| | Timothy J Koboldt, MD, FACEP |
| | Marc Mendelsohn, MD, MPH, FACEP |
| | Robert Francis Poirier, Jr, MD, MBA, FACEP |
| MONTANA CHAPTER | Harry Eugene Sibold, MD, FACEP |
| NEBRASKA CHAPTER | Renee Engler, MD, FACEP |
| | Julie Query, MD |
| NEVADA CHAPTER | John Dietrich Anderson, MD, FACEP |
| | Sabina A Braithwaite, MD, FACEP |
| | John Hardwick, MD, FACEP |
| | Erin Simmers Pearson, MD, FACEP |
| NEW HAMPSHIRE CHAPTER | Kathleen J Clem, MD, FACEP |
| | Scott Weston Rodi, MD, MPH, FACEP |

| | |
|---|---|
| NEW JERSEY CHAPTER | Chris Bryczkowski, MD, FACEP<br>William Basil Felegi, DO, FACEP<br>Rachelle Ann Greenman, MD, FACEP<br>Patrick Blaine Hinfey, MD, FACEP<br>Marianna Karounos, DO, MS, FACEP<br>Marjory E Langer, MD, FACEP<br>Jessica M Maye, DO, FACEP<br>J Mark Meredith, MD, FACEP<br>Scott H Pasichow, MD, MPH, FACEP<br>Chirag N Shah, MD, FACEP |
| NEW MEXICO CHAPTER | Scott Mueller, DO, FACEP<br>Tony B Salazar, MD, FACEP<br>Aaron Snyder, MD |
| NEW YORK CHAPTER | David O Andonian, MD<br>Brahim Ardolic, MD, FACEP<br>Joseph Basile, MD, FACEP<br>Nicole Berwald, MD, FACEP<br>Kirby Black, MD, FACEP<br>Erik Blutinger, MD, MSc, FACEP<br>Robert M Bramante, MD, FACEP<br>Lauren J Curato, DO, FACEP<br>Mark Curato, DO, FACEP<br>Ugo A Ezenkwele, MD, FACEP<br>Keith Grams, MD, FACEP<br>Sanjey Gupta, MD, FACEP<br>Abbas Husain, MD, FACEP<br>Laura Iavicoli, MD, FACEP<br>Marc P Kanter, MD, FACEP<br>Stuart Gary Kessler, MD, FACEP<br>Elyse Katz Lavine, MD, FACEP<br>Penelope Lema, MD, FACEP<br>Sophia D Lin, MD<br>Kurien Mathews, DO MBA, FACEP<br>Laura D Melville, MD<br>Joshua B Moskovitz, MD, MBA, MPH, FACEP<br>Nestor B Nestor, MD, FACEP<br>Norman Liang Ng, DO MBA, FACEP<br>Blake Peterson, MD<br>Jeffrey S Rabrich, DO, FACEP<br>Vinay Saggar, MD<br>Jeffrey J Thompson, MD, FACEP<br>Asa Viccellio, MD, FACEP<br>Luis Carlos Zapata, MD, FACEP |
| NORTH CAROLINA CHAPTER | Melanie R Artho, MD, FACEP<br>Jill Lynn Benson, MD, FACEP<br>Smeet R Bhimani, DO, MBA<br>Scott W Brown, MD, FACEP<br>Gregory J Cannon, MD, FACEP<br>Jennifer Casaletto, MD, FACEP<br>Thomas Lee Mason, MD, FACEP<br>Eric Evan Maur, MD, FACEP<br>Madjimbaye Charles Namde, MD, MBA, FACEP<br>Bret A Nicks, MD, MHA, FACEP<br>Stephen A Small, MD, FACEP |

| | |
|---|---|
| NORTH DAKOTA CHAPTER | K J Temple, MD, FACEP |
| OHIO CHAPTER | Eileen F Baker, MD, PhD, FACEP<br>Marina N Boushra Freiberg, MD<br>Christina Campana, DO, FACEP<br>Joshua S da Silva, DO, FACEP<br>Ruben Geeraert, MD<br>Daniel R Martin, MD, MBA, FACEP<br>Jesse A Park, DO<br>John R Queen, MD, FACEP<br>Matthew J Sanders, DO, FACEP<br>Brian Scharfenberg, DO, FACEP<br>George RJ Sontag, MD, FACEP<br>Ryan Squier, MD, FACEP<br>Joseph P Tagliaferro, III, DO, FACEP<br>K Robert Thompson, III, MD, FACEP<br>Nicole Ann Veitinger, DO, FACEP |
| OKLAHOMA CHAPTER | Cecilia Guthrie, MD, FACEP<br>James Raymond Kennedye, MD, MPH, FACEP<br>Kurtis A Mayz, JD, MD, MBA, FACEP |
| OREGON CHAPTER | Brittany N Arnold, MD, FACEP<br>Patsy Chenpanas, MD<br>Alex Kaplan, MD, FACEP<br>John C Moorhead, MD, FACEP<br>Christian Smith, MD, FACEP |
| PENNSYLVANIA CHAPTER | Lauren Altomare, DO<br>Christine Aspiotes, DO<br>Blake C Bailey, DO, FACEP<br>Christopher L Berry, MD, FACEP<br>Monisha Bindra, DO, MPH, FACEP<br>Angela Cai, MD, MBA<br>Avram Flamm, DO, FACEP<br>Richard Hamilton, MD, MBA, FACEP<br>Brian Kelly, DO<br>George Vivek Koshy, DO<br>Zeenah Mansour, MD<br>Eric M Melnychuk, DO, FACEP<br>Shawn M Quinn, DO, FACEP<br>Meaghan L Reid, DO, FACEP<br>Jennifer L Savino, DO, FACEP<br>Holly A Stankewicz, DO, FACEP<br>Theresa Ann Walls, MD, MPH<br>Elizabeth Barrall Werley, MD, FACEP |
| PUERTO RICO CHAPTER | Edwin J Garcia La Torre, MD, FACEP<br>Daniella M Santiago-Haddock, MD, FACEP |
| RHODE ISLAND CHAPTER | Achyut B Kamat, MD, FACEP<br>Charles F Pattavina, MD, FACEP<br>Jessica Smith, MD, FACEP |
| SOCIETY FOR ACADEMIC EMERGENCY MEDICINE | Ali S Raja, MD, DBA, MPH, FACEP |
| SOUTH CAROLINA CHAPTER | Matthew D Bitner, MD, FACEP |

| | |
|---|---|
| | Allison Leigh Harvey, MD, FACEP<br>Kelly M Johnson, MD, FACEP<br>Angel Alisha Lee Rochester, MD, FACEP<br>Andriana Slavica Saric, DO |
| SOUTH DAKOTA CHAPTER | Donald Neilson, MD |
| TENNESSEE CHAPTER | Stanton Elseroad, MD, MBA, FACEP<br>Sanford H Herman, MD, FACEP<br>Kito Lord, MD, MBA, CHCQM-PHYADV, FACEP<br>Thomas R Mitchell, MD, FACEP<br>Sullivan K Smith, MD, FACEP |
| TEXAS CHAPTER | Sara Andrabi, MD, FACEP<br>Jessica Ann Best, MD, FACEP<br>Angela Pettit Cornelius, MD, FACEP<br>Carrie de Moor, MD, FACEP<br>Diana L Fite, MD, FACEP<br>Andrea L Green, MD, FACEP<br>Robert D Greenberg, MD, FACEP<br>Doug Jeffrey, MD, FACEP<br>Alexander J Kirk, MD, FACEP<br>Ira R Nemeth, MD, FACEP<br>Heather S Owen, MD, FACEP<br>Anant Patel, DO, FACEP<br>Daniel Eugene Peckenpaugh, MD, FACEP<br>R Lynn Rea, MD, FACEP<br>Richard Dean Robinson, MD, FACEP<br>Marcus Lynn Sims, II, DO, FACEP<br>Theresa Tran, MD, FACEP<br>Gerad A Troutman, MD, FACEP<br>Brianna L Wapples, MD<br>James M Williams, DO, FACEP<br>Sandra Williams, DO, MPH, FACEP |
| UTAH CHAPTER | Jim V Antinori, MD, FACEP<br>Alison L Smith, MD, MPH, FACEP<br>Henry T Yeates, DO, FACEP |
| VERMONT CHAPTER | Matthew S Siket, MD, FACEP<br>Alexandra Nicole Thran, MD, FACEP |
| VIRGINIA CHAPTER | Caroline Hollis Cox, MD<br>Joshua Easter, MD<br>James R Humble, MD<br>Brooke Harris Lindborg, MD, FACEP<br>Jessica Maerz, MD, FACEP<br>Theodore J Tzavaras, MD<br>Lauren Webb, MD<br>Winston Wu, MD<br>Courtney Terry Zydron, MD, MBA |
| WASHINGTON CHAPTER | Herbert C Duber, MD, MPH, FACEP<br>Joshua R Frank, MD, FACEP<br>Sarah M Hansen, MD<br>C Ryan Keay, MD, FACEP<br>Vasisht Srinivasan, MD, FACEP<br>Jessica J Wall, MD, MPH, MSCE, FACEP |

| | |
|---|---|
| | Aine Yore, MD, FACEP |
| WEST VIRGINIA CHAPTER | Adam Thomas Crawford, DO, FACEP<br>Christopher S Goode, MD, FACEP |
| WISCONSIN CHAPTER | Michael L Becker, MD, FACEP<br>William D Falco, MD, MS, FACEP<br>Alecia M Gende, DO, CAQSM, FACEP<br>Susan E Good, MD, FACEP<br>Lisa J Maurer, MD, FACEP<br>Jamie Schneider, MD, FACEP |
| WYOMING CHAPTER | Russell Lauver, DO |
| AAWEP SECTION | Christina L Shenvi, MD, PhD, MBA, FACEP |
| AIR MEDICAL TRANSPORT SECTION | Robert Eduard Suter, DO, MHA, FACEP |
| CAREERS IN EMERGENCY MEDICINE SECTION | Constance J Doyle, MD, FACEP |
| CRITICAL CARE MEDICINE SECTION | Nicholas Johnson, MD, FACEP |
| CRUISE SHIP MEDICINE SECTION | Richard L Stennes, MD, MBA, FACEP |
| DEMOCRATIC GROUP PRACTICE SECTION | David G Hall, MD, FACEP |
| DISASTER MEDICINE SECTION | George-Thomas M Pugh, MD |
| DIVERSITY & INCLUSION SECTION | Karen V Douglass, MD, FACEP |
| DUAL TRAINING SECTION | Carissa J Tyo, MD, FACEP |
| EM PRACTICE MGMT & HEALTH POLICY SECTION | Richard Lee Austin, Jr, MD, FACEP |
| EMERGENCY MEDICAL INFORMATICS SECTION | Tricia Smith, MD, FACEP |
| EMERGENCY MEDICINE LOCUM TENENS SECTION | Jamila Goldsmith, MD, FACEP |
| EMERGENCY MEDICINE WORKFORCE SECTION | Harry W Severance, MD, FACEP |
| EMERGENCY TELEHEALTH SECTION | Aditi U Joshi, MD, MSc, FACEP |
| EMERGENCY ULTRASOUND SECTION | Gregg Helland, MD, FPD-AEMUS |
| EMS-PREHOSPITAL CARE SECTION | Ryan Winchell, MD |
| EVENT MEDICINE SECTION | Melissa D Kohn, MD, FACEP |
| EXPLORING RETIREMENT SECTION | Pamela P Bensen, MD, MS, FACEP |
| FORENSIC MEDICINE SECTION | Jessica Elizabeth Hobbs, DO, FACEP |
| FREESTANDING EMEGENCY CENTERS | William H Kranichfeld, MD |
| GERIATRIC EMERGENCY MEDICINE SECTION | Angel Li, MD |
| INTERNATIONAL EMERGENCY MEDICINE SECTION | Sean Kivlehan, MD, FACEP |

| | |
|---|---|
| MEDICAL DIRECTORS SECTION | Bruce M Lo, MD, MBA, RDMS, FACEP |
| MEDICAL HUMANITIES SECTION | Jay A Kaplan, MD, FACEP |
| OBSERVATION SERVICES SECTION | Adam J Rodos, MD, FACEP |
| PAIN MANAGEMENT SECTION | Reuben J Strayer, MD, FACEP |
| PALLIATIVE MEDICINE SECTION | Justin K Brooten, MD, FACEP |
| PEDIATRIC EMERGENCY MEDICINE SECTION | Leslie A Hueschen, MD, FACEP |
| QUALITY IMPROVEMENT & PATIENT SAFETY SECTION | Robert Sands Redwood, MD, MPH, FACEP |
| RESEARCH, SCHOLARLY ACTIVITY, & INNOVATION SECTION | Charles B Kemmler, MD, PhD, FACEP |
| RURAL EMERGENCY MEDICINE SECTION | Benjamin Knutson, MD, FACEP |
| SOCIAL EMERGENCY MEDICINE SECTION | Laura Janneck, MD, FACEP |
| SPORTS MEDICINE SECTION | Dustin M Harris, MD, FACEP |
| TACTICAL EMERGENCY MEDICINE SECTION | James R Waymack, MD, FACEP |
| TOXICOLOGY SECTION | Jennifer Hannum, MD, FACEP |
| TRAUMA & INJURY PREVENTION SECTION | Gregory Luke Larkin, MD, FACEP |
| UNDERSEA & HYPERBARIC MEDICINE SECTION | Robert W Sanders, MD, FACEP |
| WELLNESS SECTION | Kristen Nordenholz, MD, FACEP |
| WILDERNESS MEDICINE SECTION | Carlton E Heine, MD, PhD, FACEP |
| YOUNG PHYSICIANS SECTION | Laurel J Barr, MD, FACEP |

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

Past Presidents

Larry A. Bedard, MD, FACEP (CA)
Brooks F. Bock, MD, FACEP (CO)
Vidor E. Friedman, MD, FACEP (CO)
Angela F. Gardner, MD, FACEP (TX)
Michael J. Gerardi, MD, FACEP (NJ)
Nicholas J. Jouriles, MD, FACEP (OH)
Rebecca B. Parker, MD, FACEP (AZ)
Mark S. Rosenberg, DO, MBA, FACEP (NJ)
Andrew Sama, MD, FACEP (NY)
Robert W. Schafermeyer, MD, FACEP (NC)
Sandra M. Schneider, MD, FACEP (TX)

Past Speakers

Peter J. Jacoby, MD, FACEP (CT)
Gary R. Katz, MD, MBA, FACEP (OH)
Todd B. Taylor, MD, FACEP (AZ)

Past Chairs of the Board

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

**********

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

# Council Standing Rules

**Preamble**

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

**Alternate Councillors**

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

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

**Amendments to Council Standing Rules**

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

**Announcements**

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

**Appeals of Decisions from the Chair**

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

**Board of Directors Seating**

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

**Campaign Rules**

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

**Conflict of Interest Disclosure**

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

**Councillor Allocation for Sections of Membership**

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

**Councillor Seating**

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

**Credentialing and Proper Identification**

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

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

**Debate**

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

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

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

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

**Distribution of Printed or Other Material During the Annual Meeting**

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

**Election Procedures**

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

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

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

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

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

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

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

**Electronic Devices**

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

**Leadership Development Advisory Committee**

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

**Limiting Debate**

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

**Nominating Committee**

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

**Nominations**

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

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

**Parliamentary Procedure**

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

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

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

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

**Policy Review**

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

**Reference Committees**

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

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

A Reference Committee may recommend that a resolution:

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

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

**Reports**

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

**Resolutions**

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

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

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

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

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

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

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

- ***Bylaws Resolutions***

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

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

- ***Late Resolutions***

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

- ***Emergency Resolutions***

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

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

**Smoking Policy**

Smoking is not permitted in any College venue.

**Unanimous Consent Agenda**

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

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

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

**Voting Immediately**

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

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

**Voting on Resolutions and Motions**

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

**********

The councillors reviewed and accepted the minutes of the October 7-8, 2023, Council meeting and approved the actions of the Steering Committee taken at their January 25, 2024, and April 14, 2024, meetings.

Dr. Schneider, interim executive director and Council secretary, addressed the Council.

Dr. Costello called for submission of emergency resolutions. The emergency resolution "Reaffirming EMRA's Vital Relationship with ACEP" was accepted by the Council. It was numbered 70 and assigned to Reference Committee A.

Dr. Costello reported that eight late resolutions were received and reviewed by the Steering Committee. One commendation resolution and five memorial resolutions were accepted by the Steering Committee. Commendations and memorial resolutions are not assigned to a Reference Committee for testimony. One late resolution was accepted for submission to the Council. The late resolution "Updating ACEP's Position on PA and NP Supervision in the ED" was numbered 69 and assigned to Reference Committee C.

Dr. Costello presented the Nominating Committee report.

Six members were nominated for four positions on the Board of Directors: Jennifer J. Casaletto, MD, FACEP; Steven B. Kailes, MD, FACEP; C. Ryan Keay, MD, FACEP; Heidi C. Knowles, MD, FACEP; Diana B. Nordlund, DO, JD, FACEP; and Bing S. Pao, MD, FACEP. Dr. Costello called for floor nominations. There were no nominees. The nominations were then closed.

Three members were nominated for President-Elect: L. Anthony Cirillo, MD, FACEP; Jeffrey M. Goodloe, MD, FACEP; and Ryan A. Stanton, MD, FACEP. Dr. Costello called for floor nominations. There were no floor nominees. The nominations were then closed.

Dr. Costello explained the Candidate Forum procedures. The candidates then made their opening statements

to the Council.

The Diversity, Inclusion, & Health Equity Section requested to withdraw Resolution 23. There were no objections and the resolution was withdrawn.

The Council recessed at 9:48 am for the Reference Committee hearings. The resolutions considered by the 2024 Council appear below as submitted.

## 2024 Council Resolutions

***RESOLUTION 1***

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

***RESOLUTION 2***

RESOLVED, That the American College of Emergency Physicians commends and thanks J.T. Finnell, II, MD, MSc, FACMI, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of emergency medicine.

***RESOLUTION 3***

RESOLVED, That the American College of Emergency Physicians commends Mary Ellen Fletcher, CPC, CEDC, CAE, for her outstanding service and dedication to the College and the specialty of emergency medicine and extends heartfelt gratitude and appreciation for her extraordinary contributions.

***RESOLUTION 4***

RESOLVED, That the American College of Emergency Physicians commends Christopher S. Kang, MD, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

***RESOLUTION 5***

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

***RESOLUTION 6***

RESOLVED, That the American College of Emergency Physicians commends Shari Purpura for her outstanding service and commitment to the College, its chapters, and the specialty of emergency medicine.

***RESOLUTION 7***

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Neal Aulick, II, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians, the Ohio Chapter, the Pennsylvania College of Emergency Physicians, and the West Virginia College of Emergency Physicians extends to his wife Ginger of 33 years, and his daughters Afton and Harper Aulick, gratitude for his service as an emergency physician at multiple hospitals in Ohio, Pennsylvania, and West Virginia, as well as for his dedication and commitment to the specialty of emergency medicine.

***RESOLUTION 8***

RESOLVED, That the American College of Emergency Physicians and the Colorado Chapter extend to Marilyn J. Gifford, MD's son, Eric Caplan, MD, and his wife Melissa Ewer, MD, son Brian Caplan, JD, and his wife Christina, brother Steve Gifford, and his wife Mimi, her five grandchildren Connor, Carson, Alaina, Piper, and Relic, other family members, friends and colleagues, condolences and profound gratitude for her advocacy to Emergency Medical Services and her commitment to the specialty of emergency medicine.

***RESOLUTION 9***

RESOLVED, That the American College of Emergency Physicians hereby honors the memory of Veronica

Greer, MD, for her exceptional contributions to the field of emergency medicine, her inspiring leadership, and her unwavering dedication to education and patient care; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Veronica Greer, MD, acknowledging that though she may be gone, her legacy as a friend, mentor, and role model will live on in perpetuity.

***RESOLUTION 10***

RESOLVED, That the American College of Emergency Physicians honors the life and legacy of Christopher H. Linden, MD, FACEP, expressing our deepest condolences to his family and all who loved him and acknowledging his remarkable achievements and the profound impact he had on the fields of emergency medicine and medical toxicology and the lives of those fortunate enough to have known him.

***RESOLUTION 11***

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

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extend to the family of Gregory L. Walker, MD, FACEP, especially his sons Andy and Sam, his colleagues, partners, former residents, and all friends, our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Michigan, where his impact will be felt for generations to come.

***RESOLUTION 12***

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Jesse A. Weigel, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his children Karen Weigel, Kevin Weigel, and Jennifer Hudson gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

***RESOLUTION 13***

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

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

***RESOLUTION 14***

RESOLVED, That the ACEP Bylaws, Article XIV –Miscellaneous, Section 3 – Parliamentary Authority, be amended to read:

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

***RESOLUTION 15***

RESOLVED, That the ACEP Council Standing Rules, Parliamentary Procedure (paragraph one) be amended to read as follows with the proviso that the changes will become effective after the 2024 Council meeting and only upon adoption of the companion resolution College Parliamentary Authority – Bylaws Amendment:

**Parliamentary Procedure**

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

***Voting Immediately***.

***RESOLUTION 16***

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 2.4 – International Members, be amended to read:

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.~~

**International members may not seek election to or serve on the national Board of Directors, may not seek election to or serve as Council Speaker or Council Vice Speaker, may not serve as a councillor or alternate councillor, and may not serve on a Council committee. With the exception of those in inactive status, international members may serve as voting members of College committees to which they are appointed but may not serve as committee chairs, may participate as voting members in sections of membership, and may serve as a section officer except for the positions of councillor and alternate councillor**.

***RESOLUTION 17***

RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 3 – Qualifications be amended to read:

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

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

RESOLVED, That the ACEP Bylaws Article IX – Board of Directors, Section 2 – Composition and Election be amended to read:

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

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

RESOLVED, That the ACEP Bylaws Article X– Officers/Executive Director, Section 7 – Vice President be amended to read:

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

and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected"; and be it further

RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 9 – Secretary-Treasurer be amended to read:

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

RESOLVED That the ACEP Bylaws Article XI – Committees, Section 5 – Finance Committee be amended to read:

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

RESOLVED, That the ACEP Bylaws Article XV – Mandatory Indemnification, Section 3 – Non-Exclusive; Continuation) be amended to read:

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

***RESOLUTION 18***

RESOLVED, That ACEP survey the membership to obtain robust, direct member feedback on Scientific Assembly locations, including whether they would prefer a rotating or semi-permanent site, preferred and non-preferred cities, and provide input on the other factors that the College should consider when designating a conference location.

***RESOLUTION 19***

RESOLVED, That ACEP:

1. Establish, enforce, and periodically update guidelines that avoid the selection of speakers who use or promote divisive language or ideologies that conflict with ACEP's commitment to diversity, equity, and inclusion.
2. Develop a thorough vetting process for potential speakers to ensure their current language and ideologies align with ACEP's values and standards.

Provide resources and education for members and event organizers on the importance of maintaining a professional and inclusive environment emphasizing the impact of divisive language and ideologies.

***RESOLUTION 20***

RESOLVED, That ACEP collaborate with other stakeholder organizations in emergency medicine to develop a working advisory council to determine and adjudicate issues as they pertain to the direction of emergency medicine as a specialty, such as but not limited to, residency program growth.

***RESOLUTION 21***

RESOLVED, That ACEP develop a volunteer recognition certificate for ACEP physician volunteers and

leaders that can be printed and proudly displayed for interested parties.

***RESOLUTION 22***

RESOLVED, That ACEP promote, advertise, and support the best practices as defined in the "Well Workplace" policy statement; and be it further

RESOLVED, That ACEP develop and comprehensively support a system to track adherence to the "Well Workplace" policy statement in an effort to create a wellness certification mechanism or incorporate adherence to this well workplace policy into the ED Accreditation Program.

***RESOLUTION 23*** *(This resolution was withdrawn.)*

RESOLVED, That ACEP develop a statement affirming its commitment to the prioritization of diversity and inclusion, the promotion of cultural competency, the support of health equity, the promotion of transparency, and the fostering of a collaborative environment; and be it further

RESOLVED, That ACEP continue to evaluate and adapt strategies to ensure they meet the evolving needs of our diverse patient population and our commitment to excellence in emergency medicine.

***RESOLUTION 24***

RESOLVED, That the American College of Emergency Physicians prioritize advocacy to have the Medicare three-midnight rule for skilled nursing placement removed.

***RESOLUTION 25***

RESOLVED, That ACEP collaborate with relevant stakeholders including the AMA, hospital associations, nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the emergency department to hospital discharge and chronic care facility placement if necessary for all patients admitted to observation and inpatient status from the emergency department.

***RESOLUTION 26***

RESOLVED, That ACEP advocate for and support the development of policies that will ensure appropriate consideration of context of contemporaneous boarding and overcrowding during Root Cause Analysis and related patient safety processes in hospitals; and be it further

RESOLVED, That ACEP commit resources for establishing best practices and assisting hospitals with considering relevant corrective actions for medical errors committed as a result of ED overcrowding; and be it further

RESOLVED, That ACEP work with other organizations to require that Root Cause Analysis and corrective actions include hospital capacity constraints and overcrowding as benchmarks in "analysis questions" and "root cause types" when analyzing an event and organizing next steps.

***RESOLUTION 27***

RESOLVED, That ACEP collaborate with the American Medical Association to advocate that the Centers for Medicare and Medicaid Services (CMS) modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician be required to be on-site and available for care of emergency department patients at all times.

***RESOLUTION 28***

RESOLVED**,** That ACEP collect data on free standing emergency department-type facilities (FSEDs) nationally, and any state regulations specifically pertaining to them, and this may include a survey of current services and equipment offered at FSEDs in each state as well as staffing and other pertinent policies that might be helpful to ACEP chapters who may be addressing issues with these facilities.

***RESOLUTION 29***

RESOLVED, That ACEP promote and advocate that all free standing emergency departments (FSEDs) maintain the following minimum standards:

1. All facilities advertised or promoted as free standing emergency departments (FSEDs) or similar titles implying services comparable to a hospital-based emergency department should be staffed by at least one board-certified or board-eligible emergency physician 24 hours a day, 7 days a week. All FSEDs should be physician-led. Nurse practitioners and physician assistants providers may be allowed to supplement staff at FSEDs, but a physician must be present on site at all times.
2. FSEDs must have x-ray, CT, and ultrasound capabilities at all times with trained technicians dedicated to those tasks. Ultrasound technicians may be on call if they can arrive within 30 minutes when needed.

3. There should be at least two registered nurses with experience in emergency medicine services with the ability to flex up nursing staff as needed if--in the opinion of the on-duty physician-- patient census, acuity level, or length of stay requires more nursing staff for safe and optimal patient care.
4. All FSEDs must maintain on the premises during all hours of operation laboratory services capable of performing low and moderate complexity laboratory tests that can be completed in a timely manner so that results are readily available for the on-site physician to make decisions regarding appropriate patient care and disposition. This may include but not be limited to only use of point of care tests at any hour of operation. The facility must be staffed by a certified technician or dedicated staff member for laboratory services who is trained to process labs on site. Facility lab capability should include, at a minimum, tests such as CBC, CMP and BMP, troponins (preferably high sensitivity), d-dimers, pregnancy tests including a Beta-hCG quantitative level, and basic toxicology screens.
5. A trained and certified respiratory therapist (RT) should be on site at all times of operation. The RT can be trained to do additional tasks including ECGs, IV access, clerical duties, and other tasks as needed.
6. The FSED should have a trained security officer present at all hours of operation. The security guard may also be assigned clerical duties or other tasks as needed.
7. FSEDs should have at least two units of packed red blood cells on site and immediately available for emergency use at all times.

***RESOLUTION 30***

RESOLVED, That ACEP formally request that appropriate federal government agencies investigate whether health insurers and hospitals violate antitrust or other laws by requiring emergency physicians to be in-network as a condition for an emergency professional service contract.

***RESOLUTION 31***

RESOLVED, That ACEP:

1. Create expectations that NEMPAC implement measures to provide clear and detailed reports on how NEMPAC contributions are distributed, ensuring that ACEP members can easily access and understand this information.
2. Discourage NEMPAC to support candidates who discriminate or promote discrimination based on race, gender, sexual orientation, age, disability, nationality, or religion, thereby maintaining the integrity and inclusiveness of ACEP's mission.
3. Encourage NEMPAC to support policies, candidates, and initiatives that are grounded in evidence-based practices. This will be achieved through rigorous vetting processes and consultations with medical experts, devaluing non-evidence-based ideologies that could undermine the quality of emergency care.

***RESOLUTION 32***

RESOLVED, That ACEP advocate for legislation that would require health systems to file notice with regulatory agencies before completing critical transactions, to protect the integrity of health systems and maintain competitive markets.

***RESOLUTION 33***

RESOLVED, That ACEP collaborate with relevant organizations and stakeholders to look at models, such as incentivized pay structures, to recruit and maintain nursing staff in emergency medicine, in alignment with our organization's beliefs and policies, to maintain a safe standard of care for our patients.

***RESOLUTION 34***

RESOLVED, That ACEP collaborate with other stakeholders to investigate ways to establish EMS physician reimbursement pathways.

***RESOLUTION 35***

RESOLVED, That ACEP provide guidance to members on legally and operationally sound practices for sharing of protected health information; and be it further

RESOLVED, That ACEP encourage hospital systems to improve the education of relevant employees regarding the legality and appropriateness of accessing and/or sharing protected health information with emergency physicians actively engaged in patient care.

***RESOLUTION 36***

RESOLVED, That ACEP develop a legislative proposal to reform EMTALA in such a way that eliminates the

ability to deny patients who require transfer access to capable hospitals while preserving patient access to initial evaluation, stabilization, and treatment within the capability of the facility they present to regardless of ability to pay.

***RESOLUTION 37***

RESOLVED, ACEP develop a policy statement that delineates:

- EMTALA applies to all emergency medical conditions and there should be no exceptions to EMTALA for any specific emergency medical condition or the evidence-based treatment that would be used to stabilize a patient.
- ACEP supports that the decision to provide any procedure in the course of patient care to satisfy EMTALA requirements, including, but not limited to, abortion care and/or pregnancy termination, be made between the patient and the emergency clinician, and that laws and regulations should not inhibit or obstruct the patient-physician relationship.
- ACEP reinforces the need for emergency physicians to be able to provide care at the standard required by medical best practices and that no procedure or treatment be removed from those treatment options in the care of emergency patients served under federal EMTALA protections.

***RESOLUTION 38***

RESOLVED, That ACEP work with the appropriate governmental entities at the federal level and assist chapters in working with state governmental entities, as well as work with other relevant stakeholders, to ensure that termination of pregnancy of a non-living fetus be legally permissible; and be it further

RESOLVED, That ACEP work with the appropriate governmental entities at the federal level and assist chapters in working with state governmental entities, as well as work with other relevant stakeholders, to ensure that termination of pregnancy of a fetus with no hope of survival be legally permissible; and be it further

RESOLVED, That ACEP work with the appropriate governmental entities at the federal level and assist chapters in working with state governmental entities, as well as work with other relevant stakeholders, to ensure that, when medically indicated to protect the health or life of a pregnant woman, termination of pregnancy or induction of labor be legally permissible.

***RESOLUTION 39***

RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing what resources are or are not available at a given time; and be it further

RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

***RESOLUTION 40***

RESOLVED, ACEP affirms that physicians providing telehealth emergency medicine or telehealth urgent care services be board certified or board eligible in emergency medicine.

***RESOLUTION 41***

RESOLVED, That ACEP both advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations; and be it further

RESOLVED, That ACEP create a mechanism for tracking workplace violence reports such that the scope of the problem can be identified.

***RESOLUTION 42***

RESOLVED, That ACEP advocate for all emergency departments to preserve and protect the accurate reporting of each workplace violence incident while preserving employee confidentiality without repercussion for employment purposes; and be it further

RESOLVED, That ACEP officially work with the Occupational Safety and Health Administration, the Department of Justice, and other relevant stakeholders to advocate for national legislation that standardizes the prevention and the response to harmful acts of violence on health care workers in emergency departments.

***RESOLUTION 43***

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to:

1. Explore delaying implementation of the new oral board examination format to allow for adequate preparation by emergency medicine residency programs and graduating residents;

2. Relocate the primary testing site to a more central U.S. location or add an additional testing site in the western half of the U.S. to reduce travel costs and minimize time zone impacts for candidates;
3. Implement an income-based fee structure for the new oral board examination to improve affordability and accessibility for all candidates, including differentiating between early career attendings and fellows;
4. Ensure oral board candidates will not bear undue financial burdens related to the newly proposed ABEM Oral Boards Update for 2026;
5. Provide a 5-year period after implementation during which the cost of retaking the new oral boards will be waived for those who do not pass;
6. Develop and implement a comprehensive, candidate facing, evaluation process for the new oral board examination format to ensure that it equitably assesses communication, procedural skills, patient management, high-stakes communication, difficult conversations, patient communications beyond diagnosis, procedural skills, clinical decision making/shared decision making, team management, leadership, troubleshooting, task switching, prioritization, and continues to bring value to the public and diplomates;
7. Establish accommodations and alternative arrangements for candidates with health, safety, or legal concerns, who may face risks or challenges in traveling to the examination site.

***RESOLUTION 44***

RESOLVED, That ACEP continue to advocate for additional critical access hospital funding to cover the full salary, housing, and travel costs of emergency medicine resident rotations at rural Critical Access Hospitals; and be it further

RESOLVED, That ACEP collaborate with the Council of Residency Directors in Emergency Medicine to create clear pathways that enable rural Critical Access Hospitals and residency programs to use the existing partial Centers for Medicare & Medicaid Services funding for training residents to promote rural clinical experiences including using critical access hospitals as non-provider sites, building rural residency tracks, and expanding rural elective opportunities; and be it further

RESOLVED, That ACEP support the Rural Emergency Medicine Section in maintaining a central "Rural Rotation List" to be managed by the ACEP Rural Emergency Medicine Section and shared with the Council of Residency Directors in Emergency Medicine; and be it further

RESOLVED, That ACEP request that the Accreditation Council for Graduate Medical Education require all emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

***RESOLUTION 45***

RESOLVED, That ACEP wholeheartedly encourage and support comprehensive research efforts on the health effects of climate change and the pivotal role of emergency medicine in mitigating and responding to these effects; and be it further

RESOLVED, That ACEP call for and promote initiatives to facilitate data collection on climate-related health emergencies, such as heat-related illnesses, vector-borne diseases, and extreme weather events, to inform evidence-based interventions, strengthen disaster preparedness, and enhance the capacity to respond effectively to climate change-induced health challenges; and be it further

RESOLVED, That ACEP support the introduction of curricula that address climate change in medical schools and residency programs.

***RESOLUTION 46***

RESOLVED, That ACEP work with the American Board of Emergency Medicine to incorporate education on human trafficking into *The Model of the Clinical Practice for Emergency Medicine* to ensure inclusion in all emergency medicine residency training; and be it further

RESOLVED, That ACEP develop a standardized training presentation for human trafficking that can be used at all institutions; and be it further

RESOLVED, That ACEP include education on human trafficking as part of the annual ACEP Scientific Assembly.

***RESOLUTION 47***

RESOLVED, That ACEP declare human trafficking is a public health crisis in the United States.

***RESOLUTION 48***

RESOLVED, That ACEP support further research into evidence-based solutions to alarm fatigue in the emergency department setting, with topics including indications for cardiac monitor use in the emergency department for both cardiac and undifferentiated ED patients, appropriate silencing of clinical alarms including when latching (silencing the alarm after the initial alert) is appropriate, indications to discontinue cardiac monitoring; and be it further

RESOLVED, That ACEP identify a workgroup to facilitate collaboration between clinicians, computer scientists, industry vendors, and regulatory agencies to develop evidence-based best-practices to reduce clinically inactionable alarms and alarm fatigue that can result in patient harm and avoidable deaths to build a culture of safety around the use of cardiac monitors.

***RESOLUTION 49***

RESOLVED, That ACEP create a policy advocating for the establishment of a centralized repository of verified primary source documents, work history, case logs, certificates of insurance, and other materials; and be it further

RESOLVED, That ACEP work with the American Medical Association, the American Osteopathic Association, the Federation of State Medical Boards, The Joint Commission, American Hospital Association, state agencies, and other interested parties to establish a recognized centralized repository of verified credentialing documents that can be used by all hospitals in the process of credentialing and privileging physicians at their facility that requires a minimum amount of additional submissions by physicians applying for privileges.

***RESOLUTION 50***

RESOLVED, That ACEP gather information to quantify the extent of the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression of which they and their families were not educated by the physicians responsible for doing so; and be it further

RESOLVED, That information quantifying the extent of the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression be used to develop feedback and a behavioral modification campaign to physicians through both general and specialty societies; and be it further

RESOLVED, That ACEP take action to advocate that appropriate payer incentives and disincentives be developed to require physicians caring for patients with end stage or terminal diseases to educate them on prognosis and to make timely decisions about advance directives, hospice, and other palliative care.

***RESOLUTION 51***

RESOLVED, That ACEP gather information to quantify the extent of poor communication and/or untimely feedback from consultants and/or hospitalists concerning emergency department patients and its impact on our mutual patients; and be it further

RESOLVED, That ACEP, in coordination with other stakeholders and specialty societies, develop a campaign to improve communication and feedback to emergency physicians from consultants and/or hospitalists concerning emergency department patients.

***RESOLUTION 52***

RESOLVED, That ACEP revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department"[6] policy statement to include that:

1. Emergency physicians should retain primary responsibility for performing critical care activities within emergency departments to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care scenarios effectively; and
2. Credentialing processes must prioritize patient safety and quality of care, ensuring that physicians and non-physician practitioners are granted privileges to manage patients commensurate with their training; and
3. The scope of practice for nurse practitioners and physician assistants in emergency departments should be clearly defined, focusing on roles where their training and expertise can complement but not substitute for the specialized skills of emergency physicians in critical care.

***RESOLUTION 53***

RESOLVED, That ACEP collaborate with relevant organizations to amend and include requirements for emergency nursing within the tiered levels of the ACEP ED accreditation pathway.

***RESOLUTION 54***

RESOLVED, That ACEP work with relevant stakeholders, including departments of health, to prioritize the acute care and evaluation of emergent patients and not require routine unrelated screenings in the emergency department; and be it further

RESOLVED, That ACEP develop a policy statement noting that mandating the emergency department to offer public health disease screening and behavioral health screening outside of the reason for the acute visit in the emergency department may have unintended consequences on workflow and care of emergency department patients.

***RESOLUTION 55***

RESOLVED, That ACEP work with relevant stakeholders to change reporting for ED patient experience scores to be based on mean score rather than percentile score; and be it further

RESOVLED, That ACEP revise the "Patient Experience of Care Surveys" policy statement to advocate for mean score to be the reporting metric rather than percentile scores.

***RESOLUTION 56***

RESOLVED, That ACEP develop and adopt a universal code of conduct for patients and visitors in the emergency department.

***RESOLUTION 57***

RESOLVED, That ACEP create a task force, ideally in conjunction with the American College of Radiology and other stakeholders, to develop a policy statement or other resource information on the rational communication of imaging hazards to emergency patients; and be it further

RESOLVED, That information be transmitted to hospital imaging departments and Chief Medical Officers for the purpose of updating their imaging and patient communication and consent policies to be consistent with the findings in a policy statement or other resource information developed by ACEP, the American College of Radiology, and other stakeholders.

***RESOLUTION 58***

RESOLVED, That ACEP wholeheartedly encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and be it further

RESOLVED, That ACEP work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste; and be it further

RESOLVED, That ACEP work to support research to decrease waste in the health care sector.

***RESOLUTION 59***

RESOLVED, That ACEP advocate to transition to hospital tap water in the United States for wound irrigation to decrease the carbon footprint of emergency departments contributing to global efforts to combat climate change; and be further

RESOLVED, That ACEP emphasize the importance of research and education within the emergency medicine community, and to raise awareness of the financial and environmental benefits of tap water for wound irrigation in the United States highlighting its safety, efficacy, and potential for cost savings; and it further

RESOLVED, That ACEP urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

***RESOLUTION 60***

RESOLVED, That ACEP develop resources for ACEP members to provide evidence-based firearm-related lethal means safety counseling to at risk youth; and be it further

RESOLVED, That ACEP work with other organizations to develop training for health care providers in firearm-related lethal means safety training.

***RESOLUTION 61***

RESOLVED, That ACEP create education to raise awareness that secure gun storage, storing guns locked, unloaded and separate from ammunition, can prevent theft and access by children, unauthorized users, and anyone who may pose a danger to themselves or others, and that secure gun storage can save children's lives; and be it further

RESOLVED, That ACEP collaborate with Doctors for America and take the pledge to become a credible messenger to advocate for and promote gun safety and help reduce firearm related injuries; and be it further

RESOLVED, That ACEP encourage emergency physicians to function as messengers to their patients, adopting messages from established, credible organizations such as Gun Violence Prevention Experts, the White House Office of Gun Violence Prevention, the National Organization of Black Law Enforcement Executives (NOBLE), and Everytown for Gun Safety.

***RESOLUTION 62***

RESOLVED, That ACEP provide education and encourage emergency physicians' awareness of the "Stop the Bleed" initiative; and be it further

RESOLVED, That ACEP promote activities that foster awareness and empowerment among at-risk youth via collaboration with such entities as Community Violence Intervention Program (CVIP) to take proactive measures in teaching "Stop the Bleed" techniques to youth.

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

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

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

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

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Amy H. Kaji MD, PhD, MPH, 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 Amy H. Kaji, MD, PhD, MPH, her friends, and her colleagues our condolences and gratitude for her tremendous service to the specialty of emergency medicine, and to the patients and physicians of California and the United States.

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

RESOLVED, That the American College of Emergency Physicians honors the memory of Joseph Sabato, Jr., MD, FACEP, and extends its deepest sympathies to his family, friends, and colleagues and acknowledges that his legacy will continue to inspire and guide the emergency medicine community.

***RESOLUTION 66*** *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Dawn E. Beemer Karns, their three children Nathan Christopher, Carter Alexander, and Alaina Grace, his parents John and Cynthia Karns, and the rest of his family gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.

***RESOLUTION 67*** *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians and the California Chapter extend their heartfelt gratitude to the family of Madeline "Maddie" Giegold, MD, for sharing her extraordinary life with us; and be it further

RESOLVED, That the memory of Madeline "Maddie" Giegold, MD, will be cherished and her impact on emergency medicine will be felt for years to come.

***RESOLUTION 68*** *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians honors the memory of Jeffery Scott Shafer, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Illinois College of Emergency Physicians extends to his wife of 19 years Jamie; their two children Seth and Allison; his mother, Bonnie (John) Howard; his father Clyde (Trish) Shafer; his father-in-law and mother-in-law, Gary and Vicki Ellis; his brother Jeremy (Staci) Shafer; step-brothers, Patrick (Tana) Howard and Steve (Angela) Benard; brother-in-law Jeremy Ellis; maternal grandmother Dorothy Farris; and cherished family members gratitude for his service to the pre-hospital community and his dedication to the specialty of emergency medicine.

***RESOLUTION 69*** *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP amend by deletion its "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to read:

~~"ACEP Acknowledges that there are currently workforce limitations in specific CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "Offsite" by telehealth means as follows:~~

- ~~Critical Access Hospitals (CAHs)~~
- ~~Rural Emergency Hospitals (REHs)"~~

***RESOLUTION 70*** *(This emergency resolution was accepted by the Council.)*

RESOLVED, That our American College of Emergency Physicians formally recognize the Emergency Medicine Residents' Association as our official partner representing the voice of emergency medicine physicians-in-training.

**********

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

Resolutions 13-23 and 70 were assigned to Reference Committee A. Larisa M. Traill, MD, FACEP, chaired Reference Committee A and other members were: Laurel Barr, MD, FACEP; Amanda Irish, MD, MPH; Catherine A. Marco, MD, FACEP; Emily Mills, MD, FACEP; Aine Yore, MD, FACEP; Amanda Pairitz-Campo; and Laura Lang, JD.

Resolutions 24-42 were assigned to Reference Committee B. Torree McGowan, MD, FACEP, chaired Reference Committee B and other members were: Blake Bailey, DO, MBA, FACEP; Lisa M. Bundy, MD, FACEP; Joshua R. Frank, MD, FACEP; George RJ Sontag, MD, FACEP; James C. Mitchiner, MD, MPH, FACEP; Erin Grossmann; and Ryan McBride, MPP.

Resolutions 43-62 and 69 were assigned to Reference Committee C. Kurtis Mayz, JD, MD, MBA, FACEP, chaired Reference Committee C and other members were: Sara Ann Brown, MD, FACEP; Angela P. Cornelius, MD, FACEP; Joshua S. da Silva, DO, FACEP; Dan Freess, MD, FACEP; Carol Wright Becker, MD, FACEP; Jonathan Fisher, MD, FACEP; Travis Schulz, MLS, AHIP; and George Solomon, MHS, FP-C, CCP-C, TP-C.

A Town Hall Meeting was convened at 1:15 pm The topic was "A Peak Behind the Curtain: The 2025 RAND Report – Strategies to Sustain Emergency Care in the United States." Michael J. McCrea, MD, FACEP, served as the moderator and the discussants were: Mahshid Abir, MD, MSc; DW "Chip" Pettigrew, MD, FACEP; Thomas J. Sugarman, MD, FACEP; and Laura Wooster, MPH.

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

At 4:45 pm Dr. Costello addressed the Council and then reviewed the procedure for the adoption of the 2024 memorial resolutions. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. Costello then read the resolveds of the memorial resolutions for: Neal F. Aulick, II, MD, FACEP; Madeline Giegold, MD; Marilyn J. Gifford, MD; Veronica Greer, MD; Amy H. Kaji, MD, PhD, MPH; Christopher J. Karns, DO; Christopher H. Linden, MD, FACEP; Joseph Sabato, Jr., MD, FACEP; Jeffery Scott Shafer, MD, FACEP; Gregory L. Walker, MD, FACEP; and Jesse A. Weigel, MD, FACEP. The Council honored the memory of those who passed away since the last Council meeting and adopted the memorial resolutions by observing a moment of silence.

Blake Denley, MD, president of the Emergency Medicine Residents' Association, addressed the Council.

Diane Gorgas, MD, president of the American Board of Emergency Medicine, addressed the Council.

Stephen Epstein, MD, FACEP, chair of the American Medical Association Section Council on Emergency Medicine, and Marilyn Heine, MD, FACEP, member of the American Medical Association's Board of Trustees, addressed the Council.

Kristin McCabe-Kline, MD, FACEP, presented the secretary-treasurer's report.

ACEP President Aisha Terry, MD, FACEP, addressed the Council. She reflected on the past year as ACEP president and highlighted the successes of the College.

The Council recessed at 6:30 pm for the candidate reception and reconvened at 8:07 am on Saturday, September 28, 2024.

Dr. Char reported that 407 councillors of the 422 eligible for seating had been credentialed.

James M. Williams, DO, FACEP, addressed the Council regarding the activities of the Emergency Medicine Foundation.

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

Dr. Costello reviewed the procedure for submitting resolution amendments electronically.

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

## REFERENCE COMMITTEE B

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

The committee recommended the following resolutions by unanimous consent:

**For adoption:** Resolution 24, Resolution 25, Resolution 30, Resolution 34, Resolution 35, Resolution 37 and Resolution 39.

**For adoption as amended or substituted:** Amended Resolution 26, Amended Resolution 27, Substitute Resolution 29, Amended Resolution 32, Amended Resolution 33, Substitute Resolution 38, Amended Resolution 40, and Amended Resolution 41.

**Not for adoption:** Resolution 31, and Resolution 36.

**For referral to the Board of Directors:** Resolution 28.

Amended Resolution 27, Amended Resolution 33, Resolution 36, Amended Resolution 38, and Amended Resolution 40, Amended Resolution 41 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

*AMENDED RESOLUTION 26*

RESOLVED, THAT ACEP ADVOCATE FOR AND SUPPORT THE DEVELOPMENT OF POLICIES THAT WILL ENSURE APPROPRIATE CONSIDERATION OF CONTEXT OF CONTEMPORANEOUS BOARDING AND OVERCROWDING DURING ROOT CAUSE ANALYSIS AND RELATED PATIENT SAFETY PROCESSES IN HOSPITALS; AND BE IT FURTHER

RESOLVED, THAT ACEP COMMIT RESOURCES FOR ESTABLISHING BEST PRACTICES AND ASSISTING HOSPITALS WITH CONSIDERING RELEVANT CORRECTIVE ACTIONS FOR MEDICAL ERRORS COMMITTED AS A RESULT OF ED OVERCROWDING; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~WORK WITH OTHER ORGANIZATIONS REQUIRE THAT ROOT CAUSE ANALYSIS AND CORRECTIVE ACTIONS~~ **PROVIDE A WRITTEN PROPOSAL TO THE JOINT COMMISSION AND OTHER RELEVANT ACCREDITING ORGANIZATIONS SUGGESTING A REVISION TO THE FRAMEWORK FOR ROOT CAUSE ANALYSIS AND CORRECTIVE ACTIONS THAT** INCLUDE**S EMERGENCY DEPARTMENT AND** HOSPITAL CAPACITY CONSTRAINTS AND OVERCROWDING AS ~~BENCHMARKS IN "ANALYSIS QUESTIONS" AND "ROOT CAUSE TYPES" WHEN ANALYZING AN EVENT AND ORGANIZING NEXT STEPS~~ **A "ROOT CAUSE TYPE" AND "CAUSAL FACTOR" AS PART OF THE ROOT CAUSE ANALYSIS**.

*SUBSTITUTE RESOLUTION 29*

**RESOLVED, THAT ACEP PROMOTE THE MAINTENANCE OF MORE SPECIFIC MINIMUM STANDARDS FOR FREESTANDING EMERGENCY DEPARTMENTS (FSEDS) PERTAINING TO APPROPRIATE STAFFING, LAB, SECURITY, SERVICE AVAILABILITY, AND IMAGING CAPABILITIES, AND UPDATE THE FSED POLICY STATEMENT ACCORDINGLY.**

*AMENDED RESOLUTION 32*

RESOLVED, THAT ACEP ADVOCATE FOR LEGISLATION THAT WOULD REQUIRE HEALTH SYSTEMS TO FILE NOTICE WITH REGULATORY AGENCIES BEFORE COMPLETING CRITICAL TRANSACTIONS~~,~~ **– INCLUDING BUT NOT LIMITED TO SALE-LEASEBACK AGREEMENTS, PURCHASES OR SALES OF HEALTH SYSTEM FACILITIES OR REAL ESTATE, DIVIDEND RECAPITALIZATION, PRIVATE PRACTICE ROLLUPS, AND CHANGES IN MAJORITY OWNER EQUITY STAKES –** TO PROTECT THE INTEGRITY OF HEALTH SYSTEMS AND MAINTAIN COMPETITIVE MARKETS.

The committee recommended that Amended Resolution 27 be adopted.

It was moved THAT AMENDED RESOLUTION 27 BE ADOPTED:

RESOLVED, THAT ACEP COLLABORATE WITH THE AMERICAN MEDICAL ASSOCIATION TO ADVOCATE THAT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) MODIFY THE "STAFF AND STAFFING RESPONSIBILITIES" CONDITIONS OF PARTICIPATION FOR CRITICAL ACCESS AND RURAL EMERGENCY HOSPITALS SUCH THAT A QUALIFIED, STATE-LICENSED (MD/DO/MBBS) PHYSICIAN BE ~~REQUIRED TO BE~~ **IMMEDIATELY AVAILABLE FOR** ON-SITE ~~AND AVAILABLE FOR~~ CARE OF EMERGENCY DEPARTMENT PATIENTS AT ALL TIMES.

It was moved THAT DISCUSSION OF AMENDED RESOLUTION 27 BE POSTPONED UNTIL AFTER DISCUSSION OF RESOLUTION 69 OR AFTER THE DISCUSSION OF REFERENCE COMMITTEE C REPORT IF RESOLUTION 69 IS NOT EXTRACTED FROM THE UNANIMOUS CONSENT AGENDA FOR REFERRAL TO THE BOARD.

The motion was adopted.

The committee recommended that Amended Resolution 33 be adopted.

It was moved THAT AMENDED RESOLUTION 33 BE ADOPTED:

RESOLVED, THAT ACEP COLLABORATE WITH RELEVANT ORGANIZATIONS AND STAKEHOLDERS TO LOOK AT MODELS, ~~SUCH AS,~~ **INCLUDING, BUT NOT LIMITED TO,** INCENTIVIZED PAY STRUCTURES, TO RECRUIT AND MAINTAIN NURSING STAFF IN EMERGENCY MEDICINE, IN ALIGNMENT WITH OUR ORGANIZATION'S BELIEFS AND POLICIES, TO MAINTAIN A SAFE STANDARD OF CARE FOR OUR PATIENTS. The motion was adopted.

The committee recommended that Substitute Resolution 38 be adopted.

It was moved THAT SUBSTITUTE RESOLUTION 38 BE ADOPTED:

**RESOLVED, THAT ACEP WILL WORK WITH THE FEDERAL GOVERNMENT AND SUPPORT CHAPTERS IN WORKING WITH THEIR STATE GOVERNMENT ENTITIES, ALONG WITH OTHER RELEVANT STAKEHOLDERS, TO ENSURE ALL PATIENTS HAVE ACCESS TO THE FULL SPECTRUM OF EVIDENCE-BASED PRENATAL, PERIPARTUM, AND POSTPARTUM PHYSICAL AND MENTAL HEALTH CARE, INCLUDING BUT NOT LIMITED TO TERMINATION OF PREGNANCY OF A NON-LIVING FETUS, A FETUS WITH NO HOPE OF SURVIVAL, OR TO PROTECT THE HEALTH OR LIFE OF A PREGNANT PERSON.**

It was moved THAT THE WORDS “FROM THE TIME OF INITIAL PRESENTATION TO THE EMERGENCY DEPARTMENT” BE INSERTED AT THE END OF THE SENTENCE AFTER THE WORD “PERSON.”

The motion was not adopted.

It was moved THAT THE WORD “PHYSICAL” BE INSERTED BEFORE THE WORDS “HEALTH OR LIFE.” The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 40 be adopted.

It was moved THAT AMENDED RESOLUTION 40 BE ADOPTED:

RESOLVED, THAT ACEP AFFIRM THAT PHYSICIANS PROVIDING TELEHEALTH EMERGENCY MEDICINE ~~OR TELEHEALTH URGENT CARE SERVICES~~ BE BOARD CERTIFIED OR BOARD ELIGIBLE IN EMERGENCY MEDICINE**, IN CONGRUENCE WITH EXISTING ACEP POLICY ON TELEHEALTH.**

It was moved AMENDED RESOLUTION 40 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP AFFIRM THAT EMERGENCY CARE SERVICES PROVIDED BY TELEHEALTH BE LED BY BOARD CERTIFIED/BOARD ELIGIBLE EMERGENCY PHYSICIANS AS IT IS FOR IN PERSON EMERGENCY CARE IN ALIGNMENT WITH EXISTING POLICY. The motion was not adopted.

It was moved THAT AMENDED RESOLUTION 40 BE REFERRED TO THE BOARD OF DIRETORS. The motion was adopted.

The committee recommended that Amended Resolution 41 be adopted in lieu of Resolution 41 and Resolution 42.

It was moved THAT AMENDED RESOLUTION 41 BE ADOPTED IN LIEU OF RESOLUTION 41 AND RESOLTUION 42:

~~RESOLVED, THAT ACEP BOTH ADVOCATE FOR AND SUPPORT THE ABILITY OF VICTIMS AND WITNESSES TO REPORT WORKPLACE VIOLENCE EVENTS WITHOUT REPERCUSSION AND RECRIMINATIONS; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP CREATE A MECHANISM FOR TRACKING WORKPLACE VIOLENCE REPORTS SUCH THAT THE SCOPE OF THE PROBLEM CAN BE IDENTIFIED.~~

RESOLVED, THAT ACEP ADVOCATE FOR ALL EMERGENCY DEPARTMENTS TO PRESERVE AND PROTECT THE ACCURATE REPORTING OF EACH WORKPLACE VIOLENCE INCIDENT WHILE PRESERVING EMPLOYEE CONFIDENTIALITY WITHOUT REPERCUSSION **OR RECRIMINATION** FOR EMPLOYMENT PURPOSES; AND BE IT FURTHER

RESOLVED, THAT ACEP OFFICIALLY WORK WITH THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, THE DEPARTMENT OF JUSTICE, AND OTHER RELEVANT STAKEHOLDERS TO ADVOCATE FOR NATIONAL LEGISLATION THAT STANDARDIZES THE PREVENTION AND THE RESPONSE TO HARMFUL ACTS OF VIOLENCE ON HEALTH CARE WORKERS IN EMERGENCY DEPARTMENTS.

The motion was adopted.

The committee recommended that Resolution 36 not be adopted.

It was moved THAT RESOLUTION 36 BE ADOPTED.

It was moved THAT RESOLUTION 36 BE REFERRED TO THE BOARD OF DIRETORS. The motion was not adopted.

It was moved THAT RESOLUTION 36 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP COLLABORATE WITH THE ARIZONA AND CONNECTICUT CHAPTERS AND OTHERS TO DEVELOP MODEL STATE POLICY, REGULATION, AND LEGISLATION, THAT REQUIRES REPORTING OF ED/HOSPITAL CROWDING AND INTERHOSPITAL TRANSFER DATA TO A RELEVANT STATE ENTITY (E.G. STATE DEPARTMENT OF HEALTH) AND DEVELOP A STATE-WIDE SYSTEM TO FACILITATE INTERFACILITY TRANSFERS. The motion was adopted.

It was moved THAT RESOLUTION 36 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

## REFERENCE COMMITTEE A

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

The committee recommended the following resolutions by unanimous consent:

**For adoption:** Resolution 16, Resolution 17, and Resolution 70.

**For adoption as amended or substituted:** Amended Resolution 13, Amended Resolution 14, and Amended Resolution 15.

**For adoption and not for adoption:** Resolution 22.

**Not for adoption:** Resolution 19 and Resolution 20.

**For referral to the Board of Directors:** Resolution 18 and Resolution 21.

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

*AMENDED RESOLUTION 14*

RESOLVED, THAT THE ACEP BYLAWS, ARTICLE XIV –MISCELLANEOUS, SECTION 3 – PARLIAMENTARY AUTHORITY, BE AMENDED TO READ:

THE PARLIAMENTARY AUTHORITY FOR MEETINGS OF THE COLLEGE SHALL BE **THE ~~MOST RECENT~~ CURRENT EDITION** OF ***~~THE STANDARD CODE OF PARLIAMENTARY PROCEDURE (STURGIS)~~ THE AMERICAN INSTITUTE OF PARLIAMENTARIANS STANDARD CODE OF PARLIAMENTARY PROCEDURE***, EXCEPT WHEN IN CONFLICT WITH THE BYLAWS OF THE COLLEGE OR THE COUNCIL STANDING RULES.

*AMENDED RESOLUTION 15*

RESOLVED, THAT THE ACEP COUNCIL STANDING RULES, PARLIAMENTARY PROCEDURE (PARAGRAPH ONE) BE AMENDED TO READ AS FOLLOWS WITH THE PROVISO THAT THE CHANGES WILL BECOME EFFECTIVE AFTER THE 2024 COUNCIL MEETING AND ONLY UPON ADOPTION OF THE COMPANION RESOLUTION COLLEGE PARLIAMENTARY AUTHORITY – BYLAWS AMENDMENT:

**PARLIAMENTARY PROCEDURE**

THE **~~MOST RECENT~~ CURRENT** EDITION OF ***~~STURGIS, STANDARD CODE OF~~***

~~*PARLIAMENTARY PROCEDURE*~~ ***THE AMERICAN INSTITUTE OF PARLIAMENTARIANS STANDARD CODE OF PARLIAMENTARY PROCEDURE***-WILL GOVERN THE COUNCIL, EXCEPT WHERE SUPERSEDED BY THESE COUNCIL STANDING RULES, THE COLLEGE MANUAL, AND/OR THE BYLAWS. ***SEE ALSO LIMITING DEBATE AND VOTING IMMEDIATELY***.

The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 13 BE ADOPTED:

RESOLVED, THAT THE ACEP BYLAWS ARTICLE VIII – COUNCIL, SECTION 1 – COMPOSITION OF THE COUNCIL, PARAGRAPH ONE, BE AMENDED TO READ:

EACH CHARTERED CHAPTER SHALL HAVE A MINIMUM OF ONE COUNCILLOR AS REPRESENTATIVE OF ALL OF THE MEMBERS OF SUCH CHARTERED CHAPTER. THERE SHALL BE ALLOWED ONE ADDITIONAL COUNCILLOR FOR EACH 100 MEMBERS OF THE COLLEGE IN THAT CHAPTER AS SHOWN BY THE **AVERAGE** MEMBERSHIP ROLL~~S~~ OF THE COLLEGE ~~ON DECEMBER 31~~ **OF THE PRECEDING** ~~**DURING**~~ ~~**THE**~~ **CALENDAR YEAR**. **THE AVERAGE WILL BE CALCULATED BY USING THE COUNT OF PRIMARY MEMBERS IN EACH CHAPTER** ~~**AT MIDNIGHT**~~ **ON THE FIRST DAY OF THE MONTH THEN ADDING TOGETHER EACH MONTH'S TOTAL AND DIVIDING BY 12.** 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.

It was moved THAT THE WORDS "ENDING JUNE 30" BE ADDED AFTER THE WORD "YEAR" AT THE END OF THE SECOND SENTENCE. The motion was not adopted.

It was moved THAT THE WORD "AVERAGE" BE REPLACED WITH THE WORD "MEDIAN." The motion was not adopted.

It was moved THAT THE RESOLUTION BE AMENDED BY DELETING THE WORD "AVERAGE" AND DELETING THE THIRD SENTENCE THAT READS: "THE AVERAGE WILL BE CALCULATED BY USING THE COUNT OF PRIMARY MEMBERS IN EACH CHAPTER ON THE FIRST DAY OF THE MONTH THEN ADDING TOGETHER EACH MONTH'S TOTAL AND DIVIDING BY 12." The motion was not adopted.

The main motion was then voted on and adopted.

## REFERENCE COMMITTEE C

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

The committee recommended the following resolutions by unanimous consent:

**For adoption:** Resolution 59

**For adoption as Amended or Substituted:** Amended Resolution 44, Amended Resolution 45, Amended Resolution 46, Amended Resolution 47, Amended Resolution 48, Amended Resolution 49, and Amended Resolution 50, Amended Resolution 54, Substitute Resolution 56, Amended Resolution 57, Amended Resolution 58, Amended Resolution 60, and Amended Resolution 61.

**Not for adoption:** Resolution 51, Resolution 55, and Resolution 62.

**For referral to the Board of Directors:** Resolution 52, Resolution 53, and Resolution 69.

**For substitution and referral to the Board of Directors:** Substitute Resolution 43.

Amended Resolution 49, Amended Resolution 50, Resolution 51, Amended Resolution 54, Resolution 55, Amended Resolution 60, Resolution 62, were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

*SUBSTITUTE RESOLUTION 43*

RECOMMENDATION PART A (FOR ADOPTION):

**RESOLVED, THAT ACEP CONTINUE THEIR ENGAGEMENT WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE TO EXPLORE ADDITIONAL TESTING SITES TO REDUCE TRAVEL COSTS AND MINIMIZE TIME ZONE IMPACTS FOR CANDIDATES; AND BE IT FURTHER**

**RESOLVED, THAT ACEP CONTINUE THEIR ENGAGEMENT WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE TO IMPLEMENT A FEE STRUCTURE FOR THE NEW ORAL BOARD EXAMINATION TO IMPROVE AFFORDABILITY AND ACCESSIBILITY FOR ALL CANDIDATES, INCLUDING DIFFERENTIATING BETWEEN EARLY CAREER ATTENDINGS AND FELLOWS; AND BE IT FURHTER**

**RESOLVED, THAT ACEP CONTINUE THEIR ENGAGEMENT WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE TO ENSURE ORAL BOARD CANDIDATES WILL NOT BEAR UNDUE FINANCIAL BURDENS RELATED TO THE NEWLY PROPOSED ABEM ORAL BOARDS UPDATE FOR 2026;**

RECOMMENDATION PART B (FOR REFERRAL):

**RESOLVED, THAT ACEP CONTINUE THEIR ENGAGEMENT WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE TO EXPLORE DELAYING IMPLEMENTATION OF THE NEW ORAL BOARD EXAMINATION FORMAT TO ALLOW FOR ADEQUATE PREPARATION BY EMERGENCY MEDICINE RESIDENCY PROGRAMS AND GRADUATING RESIDENTS; AND BE IT FURTHER**

**RESOLVED, THAT ACEP CONTINUE THEIR ENGAGEMENT WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE TO PROVIDE A 5-YEAR PERIOD AFTER IMPLEMENTATION DURING WHICH THE COST OF RETAKING THE NEW ORAL BOARDS WILL BE WAIVED FOR THOSE WHO DO NOT PASS; AND BE FURTHER**

**RESOLVED, THAT ACEP CONTINUE THEIR ENGAGEMENT WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE TO DEVELOP AND IMPLEMENT A COMPREHENSIVE, CANDIDATE FACING, EVALUATION PROCESS FOR THE NEW ORAL BOARD EXAMINATION FORMAT TO ENSURE THAT IT EQUITABLY ASSESSES COMMUNICATION, PROCEDURAL SKILLS, PATIENT MANAGEMENT, HIGH-STAKES COMMUNICATION, DIFFICULT CONVERSATIONS, PATIENT COMMUNICATIONS BEYOND DIAGNOSIS, PROCEDURAL SKILLS, CLINICAL DECISION MAKING/SHARED DECISION MAKING, TEAM MANAGEMENT, LEADERSHIP, TROUBLESHOOTING, TASK SWITCHING, PRIORITIZATION, AND CONTINUES TO BRING VALUE TO THE PUBLIC AND DIPLOMATES; AND BE IT FURTHER**

**RESOLVED, THAT ACEP CONTINUE THEIR ENGAGEMENT WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE TO ESTABLISH ACCOMMODATIONS AND ALTERNATIVE ARRANGEMENTS FOR CANDIDATES WITH HEALTH, SAFETY, OR LEGAL CONCERNS, WHO MAY FACE RISKS OR CHALLENGES IN TRAVELING TO THE EXAMINATION SITE.**

*AMENDED RESOLUTION 44*

RESOLVED, THAT ACEP CONTINUE TO ADVOCATE FOR ADDITIONAL CRITICAL ACCESS HOSPITAL FUNDING TO HELP COVER THE ~~FULL~~ SALARY, HOUSING, AND TRAVEL COSTS OF EMERGENCY MEDICINE RESIDENT ROTATIONS AT RURAL CRITICAL ACCESS HOSPITALS; AND BE IT FURTHER

~~RESOLVED, THAT ACEP COLLABORATE WITH THE COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE TO CREATE CLEAR PATHWAYS THAT ENABLE RURAL CRITICAL ACCESS HOSPITALS AND RESIDENCY PROGRAMS TO USE THE EXISTING PARTIAL CENTERS FOR MEDICARE & MEDICAID SERVICES FUNDING~~

~~FOR TRAINING RESIDENTS TO PROMOTE RURAL CLINICAL EXPERIENCES INCLUDING USING CRITICAL ACCESS HOSPITALS AS NON-PROVIDER SITES, BUILDING RURAL RESIDENCY TRACKS, AND EXPANDING RURAL ELECTIVE OPPORTUNITIES; AND BE IT FURTHER~~

RESOLVED, THAT ACEP SUPPORT THE RURAL EMERGENCY MEDICINE SECTION IN MAINTAINING A CENTRAL "RURAL ROTATION LIST" TO BE MANAGED BY THE ACEP RURAL EMERGENCY MEDICINE SECTION AND SHARED WITH THE COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE; AND BE IT FURTHER

RESOLVED, THAT ACEP REQUEST THAT THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION ~~REQUIRE~~ **ENCOURAGE** ALL EMERGENCY MEDICINE RESIDENCIES TO OFFER AT LEAST ONE RURAL EMERGENCY MEDICINE CLINICAL ELECTIVE.

*AMENDED RESOLUTION 45*

RESOLVED, THAT ACEP ~~WHOLEHEARTEDLY~~ ENCOURAGE AND SUPPORT COMPREHENSIVE RESEARCH EFFORTS ON THE HEALTH EFFECTS OF CLIMATE CHANGE AND THE PIVOTAL ROLE OF EMERGENCY MEDICINE IN MITIGATING AND RESPONDING TO THESE EFFECTS; AND BE IT FURTHER

RESOLVED, THAT ACEP CALL FOR AND PROMOTE INITIATIVES TO FACILITATE DATA COLLECTION ON CLIMATE-RELATED HEALTH EMERGENCIES, SUCH AS HEAT-RELATED ILLNESSES, VECTOR-BORNE DISEASES, AND EXTREME WEATHER EVENTS, TO INFORM EVIDENCE-BASED INTERVENTIONS, STRENGTHEN DISASTER PREPAREDNESS, AND ENHANCE THE CAPACITY TO RESPOND EFFECTIVELY TO CLIMATE CHANGE-INDUCED HEALTH CHALLENGES; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT THE INTRODUCTION OF CURRICULA THAT ADDRESS CLIMATE CHANGE IN MEDICAL SCHOOLS AND RESIDENCY PROGRAMS.

*AMENDED RESOLUTION 46*

~~RESOLVED, THAT ACEP WORK WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE TO INCORPORATE EDUCATION ON HUMAN TRAFFICKING INTO *THE MODEL OF THE CLINICAL PRACTICE FOR EMERGENCY MEDICINE* TO ENSURE INCLUSION IN ALL EMERGENCY MEDICINE RESIDENCY TRAINING; AND BE IT FURTHER~~

RESOLVED, THAT ACEP DEVELOP ~~STANDARDIZED~~ TRAINING PRESENTATIONS **AND RESOURCES** FOR **IDENTIFICATION OF** HUMAN TRAFFICKING THAT CAN BE USED AT ALL INSTITUTIONS~~; AND BE IT FURTHER~~ **AND INCLUDED AT SCIENTIFIC ASSEMBLY.**

~~RESOLVED, THAT ACEP INCLUDE EDUCATION ON HUMAN TRAFFICKING AS PART OF THE ANNUAL ACEP SCIENTIFIC ASSEMBLY.~~

*AMENDED RESOLUTION 47*

RESOLVED, THAT ACEP DECLARE HUMAN TRAFFICKING ~~IS~~ A PUBLIC HEALTH CRISIS IN THE UNITED STATES **AND REVISE ACEP'S POLICY STATEMENT ON HUMAN TRAFFICKING**.

*AMENDED RESOLUTION 48*

RESOLVED, THAT ACEP ~~SUPPORT FURTHER RESEARCH INTO~~ **COLLABORATE WITH STAKEHOLDERS TO IDENTIFY** EVIDENCE-BASED SOLUTIONS TO **ADDRESS** ALARM FATIGUE IN THE EMERGENCY DEPARTMENT SETTING, WITH TOPICS INCLUDING INDICATIONS FOR CARDIAC INITIATION AND DISCONTINUATION OF **CLINICAL** MONITORING **DEVICES** IN THE EMERGENCY DEPARTMENT ~~FOR BOTH CARDIAC AND UNDIFFERENTIATED ED PATIENTS,~~ **AND** APPROPRIATE SILENCING OF CLINICAL ALARMS INCLUDING WHEN LATCHING (SILENCING THE ALARM AFTER THE INITIAL ALERT) IS APPROPRIATE~~, INDICATIONS TO DISCONTINUE CLINICAL MONITORING DEVICES CARDIAC MONITORING.; AND BE IT FURTHER~~**.**

~~RESOLVED, THAT ACEP IDENTIFY A WORKGROUP TO FACILITATE~~

~~COLLABORATION BETWEEN CLINICIANS, COMPUTER SCIENTISTS, INDUSTRY VENDORS, AND REGULATORY AGENCIES TO DEVELOP EVIDENCE BASED BEST PRACTICES TO REDUCE CLINICALLY INACTIONABLE ALARMS AND ALARM FATIGUE THAT CAN RESULT IN PATIENT HARM AND AVOIDABLE DEATHS TO BUILD A CULTURE OF SAFETY AROUND THE USE OF CARDIAC MONITORS.~~

*SUBSTITUTE RESOLUTION 56*

~~RESOLVED, THAT ACEP DEVELOP AND ADOPT A UNIVERSAL CODE OF CONDUCT FOR PATIENTS AND VISITORS IN THE EMERGENCY DEPARTMENT.~~

**RESOLVED, THAT ACEP CREATE AND IMPLEMENT A CONCISE, UNIVRSAL CODE OF PATIENT AND VISITOR CONDUCT FOR EMERGENCY DEPARTMENTS, FEATURRING PROMINENTLY DISPLAYED SIGNAGE THAT CLEARLY DEFINES ACCEPTABLE BEHAVIOR AND STATES THAT NON-MEDICAL AGGRESSION MAY RESULT IN IMMEDATE REMOVAL.**

*AMENDED RESOLUTION 57*

RESOLVED, THAT ACEP **WORK WITH** ~~CREATE A TASK FORCE, IDEALLY IN CONJUNCTION WITH~~ THE AMERICAN COLLEGE OF RADIOLOGY AND OTHER STAKEHOLDERS, TO DEVELOP A POLICY STATEMENT OR OTHER RESOURCE INFORMATION ON THE RATIONAL COMMUNICATION OF IMAGING HAZARDS TO EMERGENCY PATIENTS~~; AND BE IT FURTHER~~**.**

~~RESOLVED, THAT INFORMATION BE TRANSMITTED TO HOSPITAL IMAGING DEPARTMENTS AND CHIEF MEDICAL OFFICERS FOR THE PURPOSE OF UPDATING THEIR IMAGING AND PATIENT COMMUNICATION AND CONSENT POLICIES TO BE CONSISTENT WITH THE FINDINGS IN A POLICY STATEMENT OR OTHER RESOURCE INFORMATION DEVELOPED BY ACEP, THE AMERICAN COLLEGE OF RADIOLOGY, AND OTHER STAKEHOLDERS.~~

*AMENDED RESOLUTION 58*

RESOLVED, THAT ACEP ~~WHOLEHEARTEDLY~~ ENCOURAGE AND SUPPORT COMPREHENSIVE RESEARCH EFFORTS TO FACILITATE DATA COLLECTION OF THE MEASUREMENTS OF EMERGENCY DEPARTMENT WASTE AND ENERGY CONSUMPTION; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH STAKEHOLDERS, SUCH AS HOSPITAL ADMINISTRATIONS, TO DECREASE ENERGY CONSUMPTION AND DECREASE THE AMOUNT OF HOSPITAL WASTE SUCH AS GENERAL TRASH, UNUSED DISPOSABLES, TRUE PLASTICS, MICRO PLASTICS, AND NON-RECYCLED GLASS, AS WELL AS BIOHAZARD/MEDICAL WASTE.~~; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP WORK TO SUPPORT RESEARCH TO DECREASE WASTE IN THE HEALTH CARE SECTOR.~~

*AMENDED RESOLUTION 61*

RESOLVED, THAT ACEP CREATE EDUCATION TO RAISE AWARENESS THAT SECURE GUN STORAGE, (STORING GUNS LOCKED, UNLOADED AND SEPARATE FROM AMMUNITION)~~,~~ **CAN SAVE LIVES,** CAN PREVENT THEFT, AND **CAN PREVENT** ACCESS BY ~~CHILDREN,~~ UNAUTHORIZED USERS~~, AND ANYONE~~ WHO MAY POSE A DANGER TO THEMSELVES OR OTHERS~~, AND THAT SECURE GUN STORAGE CAN SAVE CHILDREN'S LIVES~~; AND BE IT FURTHER

~~RESOLVED, THAT ACEP COLLABORATE WITH DOCTORS FOR AMERICA AND TAKE THE PLEDGE TO BECOME A CREDIBLE MESSENGER TO ADVOCATE FOR AND PROMOTE GUN SAFETY AND HELP REDUCE FIREARM RELATED INJURIES; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ENCOURAGE EMERGENCY PHYSICIANS **AND/OR DEPARTMENTS** TO FUNCTION AS MESSENGERS TO THEIR PATIENTS **ABOUT SAFE GUN STORAGE**, ~~ADOPTING MESSAGES FROM ESTABLISHED, CREDIBLE ORGANIZATIONS SUCH AS GUN VIOLENCE PREVENTION EXPERTS, THE WHITE HOUSE OFFICE OF GUN VIOLENCE PREVENTION, THE NATIONAL ORGANIZATION OF BLACK LAW ENFORCEMENT EXECUTIVES (NOBLE), AND EVERYTOWN FOR GUN~~

~~SAFETY.~~

The committee recommended that Amended Resolution 49 be adopted:

It was moved THAT AMENDED RESOLUTION 49 BE ADOPTED:

RESOLVED, THAT ACEP ~~CREATE A POLICY ADVOCATING~~ **ADVOCATE** FOR THE ESTABLISHMENT OF A CENTRALIZED REPOSITORY OF VERIFIED PRIMARY SOURCE DOCUMENTS, WORK HISTORY, CASE LOGS, CERTIFICATES OF INSURANCE, AND OTHER MATERIALS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN OSTEOPATHIC ASSOCIATION, THE FEDERATION OF STATE MEDICAL BOARDS, THE JOINT COMMISSION, AMERICAN HOSPITAL ASSOCIATION, STATE AGENCIES, AND OTHER INTERESTED PARTIES TO ESTABLISH A RECOGNIZED CENTRALIZED REPOSITORY OF VERIFIED CREDENTIALING DOCUMENTS THAT CAN BE USED BY ALL HOSPITALS IN THE PROCESS OF CREDENTIALING AND PRIVILEGING PHYSICIANS AT THEIR FACILITY THAT REQUIRES A MINIMUM AMOUNT OF ADDITIONAL SUBMISSIONS BY PHYSICIANS APPLYING FOR PRIVILEGES.

The motion was adopted.

The committee recommended that Amended Resolution 50 be adopted:

It was moved THAT AMENDED RESOLUTION 50 BE ADOPTED.

RESOLVED, THAT ACEP ~~GATHER INFORMATION TO QUANTIFY THE EXTENT OF~~ **WORK WITH THE AMA, AHA AND OTHER STAKEHOLDERS TO DEVELOP A STRATEGY TO ADDRESS** THE PROBLEM OF PATIENTS WITH TERMINAL OR END STAGE DISEASES BEING REFERRED TO THE ED FOR EDUCATION AND DISPOSITION OF EXPECTED PROGNOSIS AND DISEASE PROGRESSION OF WHICH THEY AND THEIR FAMILIES WERE NOT EDUCATED BY THE PHYSICIANS RESPONSIBLE FOR DOING SO~~; AND BE IT FURTHER~~**.**

~~RESOLVED, THAT INFORMATION QUANTIFYING THE EXTENT OF THE PROBLEM OF PATIENTS WITH TERMINAL OR END STAGE DISEASES BEING REFERRED TO THE ED FOR EDUCATION AND DISPOSITION OF EXPECTED PROGNOSIS AND DISEASE PROGRESSION BE USED TO DEVELOP FEEDBACK AND A BEHAVIORAL MODIFICATION CAMPAIGN TO PHYSICIANS THROUGH BOTH GENERAL AND SPECIALTY SOCIETIES; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP TAKE ACTION TO ADVOCATE THAT APPROPRIATE PAYER INCENTIVES AND DISINCENTIVES BE DEVELOPED TO REQUIRE PHYSICIANS CARING FOR PATIENTS WITH END STAGE OR TERMINAL DISEASES TO EDUCATE THEM ON PROGNOSIS AND TO MAKE TIMELY DECISIONS ABOUT ADVANCE DIRECTIVES, HOSPICE, AND OTHER PALLIATIVE CARE.~~

It was moved THAT "THE AMA, AHA, AND" BE DELETED. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 54 be adopted.

It was moved THAT AMENDED RESOLUTION 54 BE ADOPTED.

RESOLVED, THAT ACEP WORK WITH RELEVANT STAKEHOLDERS, INCLUDING **BUT NOT LIMITED TO** DEPARTMENTS OF HEALTH, **ACCREDITATION BODIES, AND HOSPITAL SYSTEMS,** TO PRIORITIZE THE ACUTE CARE AND EVALUATION OF EMERGENT PATIENTS AND NOT REQUIRE ROUTINE UNRELATED SCREENINGS IN THE EMERGENCY DEPARTMENT **WITHOUT ADEQUATE RESOURCES, FUNDING AND**

**SUPPORTS**; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT NOTING THAT MANDATING THE EMERGENCY DEPARTMENT TO OFFER PUBLIC HEALTH DISEASE SCREENING AND BEHAVIORAL HEALTH SCREENING OUTSIDE OF THE REASON FOR THE ACUTE VISIT IN THE EMERGENCY DEPARTMENT, **WITHOUT ADEQUATE RESOURCES, FUNDING AND SUPPORTS,** ~~MAY HAVE~~ **HAS** UNINTENDED CONSEQUENCES ON WORKFLOW AND CARE OF EMERGENCY DEPARTMENT PATIENTS.

It was moved THAT THE FIRST RESOLVED BE AMENDED BY REPLACING THE WORDS "NOT REQUIRE" WITH THE WORDS "IF REQUIRING," REPLACING THE WORD "WITHOUT" WITH THE WORD 'THAT," INSERTING THE WORDS "BE PROVIDED" AFTER THE WORD "SUPPORTS," AND DELETING THE SECOND RESOLVED. The motion was not adopted.

The main motion was then voted on and adopted.

The Council recessed at 11:59 am for the awards luncheon and reconvened at 1:40 pm on Saturday, September 28, 2024.

The Council then resumed discussion of the report of Reference Committee C.

The committee recommended that Amended Resolution 60 be adopted.

It was moved THAT AMENDED RESOLUTION 60 BE ADOPTED.

RESOLVED, THAT ACEP DEVELOP RESOURCES FOR ACEP MEMBERS TO PROVIDE EVIDENCE-BASED ~~FIREARM-RELATED~~ LETHAL MEANS SAFETY COUNSELING TO AT RISK YOUTH; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH OTHER ORGANIZATIONS TO DEVELOP TRAINING FOR HEALTH CARE PROVIDERS IN ~~FIREARM-RELATED~~ LETHAL MEANS SAFETY TRAINING. The motion was adopted.

The committee recommended that Resolution 51 not be adopted.

It was moved THAT RESOLUTION 51 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 55 not be adopted.

It was moved THAT RESOLUTION 55 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 62 not be adopted.

It was moved THAT RESOLUTION 62 BE ADOPTED.

It was moved THAT RESOLUTION 62 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP PROMOTE ACTIVITIES THAT FOSTER EDUCATION AND AWARENESS OF BLEEDING CONTROL TECHNIQUES WITHIN HIGH-RISK COMMUNITIES INCLUDING AT RISK YOUTH. The motion was adopted.

The amended main motion was then voted on and adopted.

The Council then resumed discussion of Amended Resolution 27.

It was moved THAT AMENDED RESOLUTION 27 BE ADOPTED:

RESOLVED, THAT ACEP COLLABORATE WITH THE AMERICAN MEDICAL

ASSOCIATION TO ADVOCATE THAT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) MODIFY THE "STAFF AND STAFFING RESPONSIBILITIES" CONDITIONS OF PARTICIPATION FOR CRITICAL ACCESS AND RURAL EMERGENCY HOSPITALS SUCH THAT A QUALIFIED, STATE-LICENSED (MD/DO/MBBS) PHYSICIAN BE ~~REQUIRED TO BE~~ **IMMEDIATELY AVAILABLE FOR** ON-SITE ~~AND AVAILABLE FOR~~ CARE OF EMERGENCY DEPARTMENT PATIENTS AT ALL TIMES.

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

It was moved THAT AMENDED RESOLUTION 36 BE RECONSIDERED. The motion was adopted.

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

It was moved THAT RESOLUTION 51 BE RECONSIDERED. The motion was not adopted.

**********

ACEP President-Elect Alison J. Haddock, MD, FACEP, addressed the Council.

Dr. Char reported that 421 councillors of the 422 eligible for seating had been credentialed.

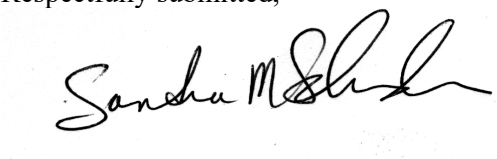
The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Casaletto, Dr. Keay, and Dr. Nordlund were elected to a three-year term. Dr. Knowles was re-elected to a three-year term.

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

There being no further business, Dr. Costello adjourned the 2024 Council meeting at 4:01 pm on Saturday, September 28, 2024.

The next meeting of the ACEP Council is scheduled for September 7-8, 2025, at the Hyatt Salt Lake City, in Salt Lake City, UT.

Respectfully submitted,



Sandra M. Schneider, MD, FACEP
Council Secretary and Interim Executive Director

Approved by,



Melissa W. Costello, MD, FACEP
Council Speaker

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Meeting
January 21, 2025
Omni Champions Gate
Orlando, FL
Minutes

Speaker Melissa Costello, MD, FACEP, called to order a meeting of the Council Steering Committee of the American College of Emergency Physicians at 10:05 am Eastern time on Tuesday, January 21, 2025.

Steering Committee members present for all or portions of the meeting were Jacob Altholz, MD; Sara Ann Brown, MD, FACEP; Melissa Costello, MD, FACEP, speaker; Joshua da Silva, DO, FACEP; Emily Fitz, MD, FACEP; Deborah Fletcher, MD, FACEP; Puneet Gupta, MD, FACEP; Robert Hancock, DO, FACEP; Jolie Holschen, MD, FACEP; Antony Hsu, MD, FACEP; Amanda Irish, MD, MPH; Greg A. Juhl, MD, FACEP; Michael McCrea, MD, FACEP, vice speaker; David Nestler, MD, MS, FACEP; Christopher Sampson, MD, FACEP; Scott Pasichow, MD, MPH, FACEP; William Weber, MD, FACEP; and Randall Young, MD, FACEP/

Other members and guests present for all or portions of the meeting were: Jennifer J. Casaletto, MD, FACEP; L. Anthony Cirillo, MD, FACEP, president-elect; Jeffrey Goodloe, MD, FACEP, vice president – communications; Alison J. Haddock, MD, FACEP, president; Steven Kailes, MD, FACEP; Heidi C. Knowles, MD, FACEP; Abhi Mehrotra, MD, MBA, FACEP; Henry Z. Pitzele, MD, FACEP; James L. Shoemaker, Jr., MD, FACEP; and Aisha Terry, MD, FACEP, immediate past president.

Staff present for all or portions of the meeting were: Jonathan Fisher, MD, FACEP; Mary Ellen Fletcher, CPC, CEDC, CAE; Robert Heard, MBA, CAE; Keith Gentry, MS, CAE; Sonja Montgomery, CAE; Mollie Pillman, MS, MBA, CAE; Sandra Schneider, MD, FACEP; and Julie Wassom.

**Officer and Staff Reports**
**Speaker**

Dr. Costello welcomed everyone and thanked them for their participation and commitment to the College. She reported on the Board retreat that was held in December and invited everyone to attend the Board meeting January 22-23. She provided a brief overview of the Steering Committee meeting agenda.

**Vice Speaker**

Dr. McCrea reported on his role as a member of the Finance Committee as the speaker's designee. He also reported on the recent budget modifications that have been approved and other actions that have been taken by the Finance Committee and approved by the Board.

**President**

Dr. Haddock gave a brief report about membership, planning for ACEP25 in Salt Lake City, the ACEP Anytime education product, the AI and Urgent Care task forces. and the Strategic Collaboration Agreement signed with the Emergency Medicine Residents' Association (EMRA).

**President-Elect**

Dr. Cirillo reported on planning for the upcoming Leadership & Advocacy Conference (LAC), the Emergency Behavioral Health Workgroup, and his attendance at the recent EMRA Board of Directors retreat.

**Interim Executive Director**

Dr. Schneider reported on key activities of the College. She thanked the Steering Committee members for their service and support of her as the Interim Executive Director. She also acknowledged the work of staff and their support.

**Steering Committee Expectations**

Dr. Costello reminded the Steering Committee of their expectation to attend the April 27, 2025, Steering Committee meeting and the Leadership & Advocacy Conference April 27-30. 2025, in Washington, DC. The Steering Committee will also meet at 6:00 pm on Thursday, September 4, 2025, in Salt Lake City, UT the evening prior to the Council meeting. It is expected that Steering Committee members will be serving as councillors or alternate councillors at the annual Council meeting.

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

Dr. Costello reviewed the Tellers, Credentials, & Elections Committee report from the 2024 Council meeting. There were 422 councillors allocated and 421 were credentialed. The UT chapter was underrepresented by one councillor. Multiple attempts were made to identify a member to fill this underrepresented councillor position.

Electronic voting was conducted using online voting software from www.associationvoting.com. The electronic voting software was programmed with the unique membership numbers of councillors prior to the Council meeting. The voting software was updated onsite to accommodate any last minute changes to delegations. There were no problems identified regarding the electronic voting system.

Six survey questions were prepared for the Council meeting including a question about voting in the U.S. presidential election. The survey results were distributed to the Steering Committee. Concerns were expressed about including a question regarding voting for presidential candidates in future years and suggested that survey questions should focus on issues other than politics. Dr. Costello explained the presidential election question was intended to be fun and interesting and not to influence or guide advocacy decisions. It was suggested that the Council meeting survey include some of the recent member survey questions and compare the responses from the Council to the responses from the membership. The Annual Meeting Subcommittee will discuss the survey questions and provide a recommendation to the Steering Committee for discussion at the April 27 meeting.

Dr. Costello discussed the potential need to prepare guidelines for "emergency credentialing" that could be used in the event that entire delegations or a certain threshold of the Council is not able to attend the meeting in person because of a natural disaster or other emergency. The guidelines would allow those councillors to participate in certain aspects of the Council meeting virtually, such as the Candidate Forum, and the ability to vote remotely. She will work with Dr. McCrea to prepare a draft for the Steering Committee to review at the April 27, 2025, meeting.

**Councillor Allocation**

Dr. Costello reported that the total councillor allocation for the 2025 Council meeting is 436 based on the average total membership as of December 31, 2024. This is 14 additional councillors than were allocated for the 2024 meeting. The average membership was used for the calculation based on the adoption of Amended Resolution 13(24) Allocation of Councillors. The following chapters gained one councillor this year: Arkansas, California, Colorado, Florida, Government Services, Kansas, Missouri, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Virginia, and West Virginia. No chapter lost any councillors based on the average membership calculation.

Under the prior allocation method, based on the total membership of the chapter as of December 31, the total councillor allocation would have been 430. The following chapters would have gained one councillor: Alaska, Arkansas, California, Florida, Kansas, New Jersey, North Carolina, Ohio, Oklahoma, and West Virginia. The Government Services Chapter would have gained 2 councillors. The following chapters would have lost one councillor: Connecticut, Idaho, Illinois, and Maryland.

All sections met the minimum membership requirement of 100 members and will have a councillor for the 2025 Council meeting.

**2024 Council Meeting**

Dr. Costello and Dr. McCrea discussed various aspects of the 2024 Council meeting and requested suggestions for potential changes for the 2025 meeting.

There was consensus to continue allowing asynchronous testimony on resolutions submitted for the 2025 Council meeting and to develop preliminary Reference Committee reports with any suggestions for amended or substituted language in the summary of the asynchronous testimony. The basis for the live Reference Committee hearings will be the resolutions as submitted.

The Town Hall meeting topic was "A Peak Behind the Curtain: The 2025 RAND Report – Strategies to Sustain Emergency Care in the United States." It was suggested that the ACGME program requirements for emergency medicine residencies be considered as a topic for the 2025 Town Hall meeting. The Council officers will determine the topic during the summer. The Steering Committee supported reducing the Town Hall meeting to 45 minutes and extending the Reference Committee hearings or the break time by 15 minutes. The Annual Meeting Subcommittee will also discuss the format of the Town Hall meeting, identify potential meeting topics for the 2025 Town Hall meeting, and provide their suggestions at the April 27 Steering Committee meeting. The Council officers will determine the topic during the summer.

Dr. Costello reminded everyone that continental breakfast on both days of the Council meeting and the traditional Council Awards Luncheon were provided. Continental breakfast and the awards luncheon will again be proposed to be included in the FY 2025-26 budget

The second day of the Council meeting was live streamed to allow members who were unable to attend because of the hurricane and for any members who would like to observe the Council meeting. Remote participants did not have privileges to speak during the meeting and the chat function was disabled. Special temporary rules to allow for voting on resolutions and during the elections were not needed since all delegations, including Florida, were represented at the meeting. Staff are currently investigating the cost to live stream the second day of the 2025 Council meeting.

The 2025 Council meeting will be held at the Hyatt Regency Salt Lake City. The hotel is connected to the convention center and is a short walk to the meeting rooms unlike the last year in Las Vegas and the prior year in Philadelphia. Meetings that occur the evening prior to the Council meeting will also be held at the Hyatt Regency Salt Lake City. These meetings include: Candidate Forum Subcommittee; Council Steering Committee; Tellers, Credentials, & Elections Committee; Reference Committee briefing; and Councillor Orientation.

**2025 Council Meeting Agenda**

The Steering Committee reviewed the draft 2025 Council meeting agenda and discussed potential changes. There was support for continuing the executive director's report on the first day of the Council meeting before recessing to the Reference Committee hearings and the EMF and NEMPAC reports the second morning before discussion of the Reference Committee reports. The Annual Meeting Subcommittee will review the Council meeting agenda and provide their suggestions at the April 14 Steering Committee meeting.

**Electronic Voting**

Dr. Costello reviewed the electronic voting system. The Steering Committee did not identify any issues or concerns about continuing to use the Association Voting platform for electronic voting during the 2025 Council meeting.

**Elections Process**

The Steering Committee discussed the format of the Candidate Forum and did not identify any potential changes. Dr. Costello shared that a few candidates mentioned the challenges with participating in the myriad of virtual meetings with chapters and the meetings that are held in person the evening prior to the Council meeting and both mornings during the Council meeting. The Candidate Forum Subcommittee will discuss the potential of if there should be guidelines or limitations when the chapter meetings are held provide and provide their recommendations for discussion at the April 27 Steering Committee meeting.

**Board Action on Three Resolutions**

Dr. Costello informed the Steering Committee about three resolutions that the Board of Directors will discuss at their January 22-23, 2025, meeting.

1. Resolution 37(22) Enhance Patient Safety and Physician Wellness – The first resolved was assigned to the Medical-Legal Committee to develop a policy statement. The committee developed the draft policy statement "Legal Protection of Participation in Peer Review.
2. Resolution 40(22) Support for Medicaid Expansion – The resolution was assigned to the State Legislative/Regulatory Committee to develop a policy statement and a toolkit. The committee developed the draft policy statement "Medicaid Expansion" and the toolkit and will release it after the policy statement is approved.
3. Amended Resolution 48(23) Medical Malpractice Certificate of Merit – The resolution was assigned to the Medical-Legal Committee to review ACEP's policy statement "Anonymous Affidavits of Merit" and determine if revisions should be made or whether a new policy statement should be developed. The committee revised the policy statement.

**Action on Resolutions**

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2024, 2023, and 2022 Council meetings were provided for review. The reports were assigned to the Annual Meeting Subcommittee for further review.

**Resolution Submission Requirements**

Dr. Costello led a discussion regarding the resolution requirements that allow any two members to submit a resolution. She also asked the Steering Committee for their thoughts about the ability for the Speaker to disallow a resolution that is not pertinent to the current Strategic Plan or initiatives of the College. There were mixed reactions from the Steering Committee about changing the resolution requirements and extending the authority of the Council officers to disallow a resolution. The Bylaws & Council Standing Rules Subcommittee will discuss these issues further and provide their recommendations to the Steering Committee for discussion at the April 27, 2025, meeting.

**Subcommittee Volunteers and Appointments**

Dr. Costello announced that three subcommittees will be appointed: Annual Meeting Subcommittee, Bylaws & Council Standing Rules Subcommittee, and Candidate Forum Subcommittee. All Steering Committee members should plan to serve on at least two subcommittees. All second year Steering Committee members are typically appointed to the Candidate Forum Subcommittee unless planning to seek nomination to the Board of Directors or as a Council officer or if they are planning to assist a candidate in their campaign. Ms. Montgomery will distribute the subcommittee objectives and deadlines and ask for volunteers to serve on each subcommittee. The subcommittee reports will be discussed at the April 27, 2025, Steering Committee meeting.

**Next Meeting**

The next meeting of the Council Steering Committee is scheduled for Sunday, April 27, 2025, during the Leadership & Advocacy Conference in Washington, DC.

With no further business, the meeting was adjourned at 2:57 pm Eastern time on Tuesday, January 21, 2025.

Respectfully submitted,



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



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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Meeting
April 27, 2025
Grand Hyatt Hotel
Washington, DC
Minutes

Speaker Melissa Costello, MD, FACEP, called to order a meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:07 am Eastern time on Sunday, April 27, 2025.

Steering Committee members present for all or portions of the meeting were Jacob Altholz, MD; Sara Ann Brown, MD, FACEP; Melissa Costello, MD, FACEP, speaker; Joshua da Silva, DO, FACEP; Deborah Fletcher, MD, FACEP; Puneet Gupta, MD, FACEP; Robert Hancock, DO, FACEP; Jolie Holschen, MD, FACEP; Antony Hsu, MD, FACEP; Greg A. Juhl, MD, FACEP; Michael McCrea, MD, FACEP, vice speaker; David Nestler, MD, MS, FACEP; Scott Pasichow, MD, MPH, FACEP; Christopher Sampson, MD, FACEP; and William Weber, MD, FACEP

Other members and guests present for all or portions of the meeting were: Pamela Bensen, MD, FACEP; L. Anthony Cirillo, MD, FACEP, president-elect; Christine DeForest, DO, FACEP; Frank Duncan, III, MD, FACEP; Joshua Frank, MD, FACEP; Daniel Freess, MD, FACEP; Kelly Gray-Eurom, MD, MMM, FACEP; Alison J. Haddock, MD, FACEP, president; Priyash Hafiz; Elizabeth Jacobs, MD; Steven Kailes, MD, FACEP; Gabor D. Kelen, MD, FACEP; C. Ryan Keay, MD, FACEP; Kurtis Mayz, JD, MD, MBA, FACEP; Abhi Mehrotra, MD, MBA, FACEP; Alycia Montgomery, MD; Bing Pao, MD, FACEP; Henry Z. Pitzele, MD, FACEP; Larisa M. Traill, MD, FACEP; and Aine Yore, MD, FACEP.

Staff present for all or portions of the meeting were: Jonathan Fisher, MD, FACEP; Mary Ellen Fletcher, CPC, CEDC, CAE; Sonja Montgomery, CAE; and Sandra Schneider, MD, FACEP.

**Officer and Staff Reports**
**Speaker**

Dr. Costello welcomed everyone and thanked them for their participation and commitment to the College. She announced the candidates for election at the 2025 Council meeting:

**President-Elect**
Jeffrey M. Goodloe, MD, FACEP
Gabor D. Kelen, MD FACEP

**Board of Directors Candidates (4 positions to be filled)**
Daniel Freess, MD, FACEP – CT
Robert Hancock, DO, FACEP – TX
Steven B. Kailes, MD, MPH, FACEP – FL
Kristin B. McCabe-Kline, MD, FACEP – FL (incumbent)
Bing S. Pao, MD, FACEP – CA

**Speaker**
Michael J. McCrea, MD, FACEP – OH (unopposed)

**Vice Speaker**
Kurtis A. Mayz, JD, MD, MBA, FACEP – OK
Larisa M. Traill, MD, FACEP – MI
Aine Yore, MD, FACEP – WA

She reported the Council Awards Committee has selected the 2025 award recipients and she is in the process of notifying the recipients. She congratulated Dr. da Silva as a recipient of the Council Horizon Award.

**Vice Speaker**

Dr. McCrea reported on his role as a member of the Finance Committee and his participation in the Leadership & Advocacy Conference (LAC) Planning Committee.

**President**

Dr. Haddock reported the Executive Director Search Committee has completed the first round of interviews for the new executive director. The goal is to have a new executive director in place by ACEP25. She gave a brief overview of the RAND report and the AHRQ report on boarding. She also discussed planning for ACEP25 in Salt Lake City, the ACEP Anytime education product, and several workgroups she has appointed. She encouraged everyone to submit comments to the Accreditation Council on Graduate Medical Education (ACGME) by the May 1, 2025, deadline regarding the proposed emergency medicine residency program requirements.

**President-Elect**

Dr. Cirillo reported on the work of the LAC Planning Committee and reminded everyone of the May 6, 2025, deadline to submit committee interest for the 2025-26 committee year. Current committee members should complete the committee evaluation to express their interest in being reappointed. He encouraged members to contact him, any Board member, or staff about ideas they have instead of waiting to submit a Council resolution.

**Interim Executive Director**

Dr. Schneider reported that registration for LAC this year is the highest since pre-COVID. She reported on other on key activities of the College and budget planning for FY 2025-26. She thanked the Steering Committee members for their service and support of her as the Interim Executive Director. She also acknowledged the work of staff and their support.

**Annual Meeting Subcommittee**

Dr. Brown 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 2025 Town Hall meeting topic. The subcommittee supports the current format of the Town Hall meeting that may include a pro/con debate of various aspects of an issue by high-level speakers/content experts followed by a period of Q & A. The subcommittee suggested the following topics for consideration:

- Changes to ACGME emergency medicine program requirements –how programs will need to adapt and other implementation challenges (i.e., What will happen in the transition year when there are no graduates?)
- Use of AI in the ED
- Drug Shortages
- Impact of Executive Orders on emergency medicine practice
- Workforce/Unfilled Residency Slots
- Assessing the Response to the Opioid Crisis
- RAND Report (follow up to last year's discussion)
- ED Accreditation

Another topic suggested during the Steering Committee meeting was interactions with U.S. Immigration and Customs Enforcement in the ED. The Council officers will make the final determination about the format, topic, and speakers for this year's Town Hall meeting this summer.

The subcommittee reviewed the implementation actions on 2022, 2023, and 2024 resolutions and concurred that the actions taken are consistent with the Council's expectations. No concerns were identified regarding implementation actions. Updates to the implementation action on the resolutions can be accessed on the ACEP website by all members.

The subcommittee provided suggestions for questions that should be considered to use as survey questions during the Council meeting. There was consensus from the subcommittee to discontinue including questions about political affiliation or voting in the U.S. presidential election in future years. The Council officers will determine the final survey questions this summer.

The subcommittee reviewed the draft 2025 Council meeting agenda and supports reducing the Town Hall meeting to 45 minutes and ending the Council meeting 15 minutes earlier instead of extending the break time. The Council officers will finalize the Council meeting agenda in early summer.

**Bylaws & Council Standing Rules Subcommittee**

Dr. Costello presented the subcommittee's report on behalf of Emily Fitz, MD, FACEP, subcommittee chair, who was not able to attend the meeting. The subcommittee reviewed the language in the Bylaws Article VIII – Council, Section 1 – Composition of the Council (paragraph 8) and the Council Standing Rules (CSR), Councillor Allocation for Sections of Membership. The subcommittee supported simplifying the language in the CSR to reflect that a section must have 100 dues-paying members as defined in the Bylaws and believes this is a housekeeping change and should not require extensive discussion by the Council. A draft CSR amendment was submitted for consideration by the Steering Committee.

> It was moved THAT THE STEERING COMMITTEE SUBMIT THE COUNCIL STANDING RULES AMENDMENT REGARDING COUNCILLOR ALLOCATIONS FOR SECTIONS OF MEMBERSHIP TO THE 2025 COUNCIL FOR CONSIDERATION. The motion was adopted.

The subcommittee discussed the resolution requirements allowing any two members to submit a resolution and whether the Council officers should have the ability to disallow a resolution. The subcommittee decided to not propose any changes to the resolution requirements in the Bylaws and the CSR at this time. The subcommittee also discussed potentially including the Council Steering Committee in the resolution review process before the resolutions are distributed to the Council, although it was noted this could increase the timeframe needed to process resolutions and could potentially delay the preparation of background information. Dr. Costello explained that the Speaker technically has the authority to determine when a resolution is out of order or inappropriate for submission to the Council per ACEP's parliamentary authority. The parliamentary authority also describes a process that could be used for the Council to reject the consideration of a resolution. The subcommittee discussed whether it is necessary to clarify in the CSR a process for the Council to discuss any resolutions that were overruled by the Speaker and determined that the mechanism in the CSR to appeal the decision of the chair is sufficient.

The Steering Committee discussed the possibility of resolutions being submitted to the Council asking the College to engage in activities that are in opposition to executive orders. It was noted that ACEP's General Counsel will need to advise the Council officers and the Council in such matters.

The subcommittee also discussed ACEP's Policy Compendium and the Policy Sunset Review Process for reviewing policy statements every 5 years from their approval date. The Council has the opportunity to guide policy development and policy revisions through resolutions.

**Emergency Credentialing Procedures**

The Steering Committee discussed the potential need to formalize a process for "emergency credentialing" to participate in certain aspects of the Council meeting, such as the Candidate Forum, and the ability to vote remotely in the event that a certain threshold of the Council, for example 10%, is not able to attend the meeting in person. There was agreement that there should be an explainable event that prevents in person attendance at the Council meeting, such as a hurricane or other disaster. Dr. Costello stated that emergency credentialing procedures exist in the parliamentary authority if needed.

**Candidate Forum Subcommittee**

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

The subcommittee discussed the candidates' meetings with chapters and whether there should be limitations regarding when the meetings are held. Several of last year's candidates provided feedback to the Council officers about the number of virtual meetings they were invited to attend and the challenges with their availability. Some candidates expressed concerns about potentially creating a negative perception if they cannot attend the meetings. The subcommittee acknowledged that candidate wellness is important. Candidates have the ability to schedule their own virtual meetings and invite councillors and others to attend. The subcommittee determined that changes to the Campaign Rules with guidance regarding chapter meetings will not be proposed this year since many or most chapters have likely already scheduled their meetings. It was suggested to survey candidates to gain a better understanding about the scope of the problem.

The subcommittee discussed the ability for candidates to submit campaign videos and the lack of submissions from most candidates for the past few years. The subcommittee questioned the usefulness of the videos and whether the videos achieve the intended goal of providing additional information to assist with making an informed decision about the candidates. The subcommittee submitted proposed changes to the Candidate Campaign Rules to discontinue posting the videos on the Council engagED community and ACEP's social media sites and continuing to allow candidates to distribute their campaign video on their personal social media sites.

> It was moved THAT THE STEERING COMMITTEE APPROVE THE PROPOSED CHANGES TO #9 OF THE CANDIDATE CAMPAIGN RULES REGARDING CAMPAIGN VIDEOS. The motion was adopted.

The remainder of the subcommittee's objectives will be completed this summer and during the 2025 Council meeting. The subcommittee will meet immediately following the April 27, 2025, Steering Committee meeting to finalize the candidate written questions and to review the assignments for moderators, coordinators, and door monitors. The subcommittee will meet 4:30 – 6:00 pm in Salt Lake City on Thursday, September 5, 2025, to review the format for the Candidate Forum, finalize questions for the Candidate Forum, and meet with the candidates.

**Board Action on Resolutions**

Dr. Costello informed the Steering Committee about actions on resolutions the Board of Directors will discuss at their April 30, 2025, meeting.

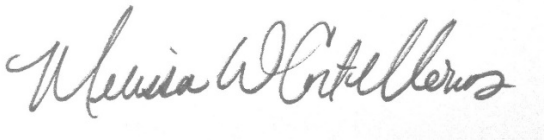
1. Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine"
   - Unsupervised Emergency Department Care – new policy statement (focuses on non-physicians)
   - Providers of Unsupervised Emergency Department Care – revised policy statement with new title "Resident Moonlighting in the Emergency Department"
2. Amended Resolution 53(23) Treating Physician Determines Patient Stability
   - Protection of Emergency Physicians from Coercion in Patient Transfers – new policy statement
   - Treating Physician Determines Patient Stability – new policy statement
3. Amended Resolution 61(23) ACEP Financial Decision Transparency
   - Chapter Credit Card Fees

**Next Meeting**

The next meeting of the Council Steering Committee is scheduled for Thursday, September 4, at the Hyatt Regency Salt Lake City in Salt Lake City, UT.

With no further business, the meeting was adjourned at 11:04 am Eastern time on Sunday, April 27, 2025.

Respectfully submitted,



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



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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# DEFINITION OF COUNCIL ACTIONS

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 Council Meeting
# Reference Committees

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

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

Amanda Pairitz-Campo
Laura Lang, JD

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

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

Brianna Hanson, MPH
Ryan McBride, MPP

**Reference Committee C – Emergency Medicine Practice**
Resolutions 61-80

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# INTRODUCTION

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

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

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

Asynchronous testimony will open on Thursday, August 7 for all resolutions assigned to a Reference Committee. An announcement with the link to the 2025 resolutions will be posted on the Council engagED when asynchronous testimony opens. After clicking on the link provided:

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

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

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

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

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

**Asynchronous testimony will close at 12:00 noon Central time on Monday, August 25.** Comments from the online testimony will be used to develop the preliminary Reference Committee reports. The preliminary reports will be distributed to the Council on Friday, August 29 and will be the starting point for the live Reference Committee hearings during the Council meeting in Salt Lake City on Friday, September 5.

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

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

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

Your Council Officers,

Melissa W. Costello, MD, FACEP
Speaker

Michael J. McCrea, MD, FACEP
Vice Speaker

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

**2025 Council Resolutions**

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 1(25)

SUBMITTED BY: Alabama Chapter

SUBJECT: Commendation for Melissa Wysong Costello, MD, FACEP

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 2(25)

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 3(25)

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

SUBJECT: Commendation for Gene Scruggs

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 4(25)

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 5(25)

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

SUBJECT: Commendation for Shelly Lyford and West Health

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 6(25)

SUBMITTED BY: District of Columbia Chapter

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 7(25)

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 8(25)

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

SUBJECT: In Memory of James B. Broselow, MD

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 9(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Vinod K. Chettur, MD

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 10(25)

SUBMITTED BY: Alaska Chapter

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 11(25)

SUBMITTED BY: Michigan College of Emergency Physicians

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 12(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 13(25)

SUBMITTED BY: Massachusetts College of Emergency Physicians

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 14(25)

SUBMITTED BY: North Carolina College of Emergency Physicians

SUBJECT: In Memory of Roger B. Lim, MD

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 15(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Lidio W. Medina, MD

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 16(25)

SUBMITTED BY: Ohio Chapter

SUBJECT: In Memory of Joseph Moellman, MD

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 17(25)

SUBMITTED BY: Ohio Chapter

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 18(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 19(25)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 20(25)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 Council Meeting
# Reference Committee Members

## Reference Committee A – Governance, Membership, & Academic Affairs

Resolutions 21-40

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

Amanda Pairitz-Campo
Laura Lang, JD

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

**Bylaws Amendment**

RESOLUTION: 21(25)

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

SUBJECT: Distinguished ACEP Fellow Recognition

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

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

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

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

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

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

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

ARTICLE V — ACEP FELLOWS

Section 1 – Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician, regular, or international members for three continuous years immediately prior to election.
2. Be certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics.

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

**Distinguished Fellows of the College shall meet the following criteria:**

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

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

Section 2 – Fellow Status

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

**Background**

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

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

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

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

**ACEP Strategic Plan Reference**

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

**Fiscal Impact**

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

**Prior Council Action**

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

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

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

**Prior Board Action**

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

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

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

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

Sonja Montgomery
Governance Operations Director

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

**Bylaws Amendment**

RESOLUTION: 22(25)

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

SUBJECT: International ACEP Fellow Recognition

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

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

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

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

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

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

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

Section 1 – Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician, **or** regular~~, or international~~ members for three continuous years immediately prior to election.
2. Be certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
   B. Satisfaction of at least three of the following individual criteria during their professional career:
      1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;

2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
4. active involvement in emergency medicine administration or departmental affairs;
5. active involvement in an emergency medical services system;
6. research in emergency medicine;
7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

**International Fellows of the College shall meet the following criteria:**

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

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

Section 2 – Fellow Status

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

**Background**

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

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

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

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

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

**ACEP Strategic Plan Reference**

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

**Fiscal Impact**

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

**Prior Council Action**

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

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

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

**Prior Board Action**

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

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

requirements for fellowship in the Bylaws.

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

Sonja Montgomery
Governance Operations Director

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

**Council Standing Rules Amendment**

RESOLUTION: 23(25)

SUBMITTED BY: Council Steering Committee

SUBJECT: Councillor Allocation for Sections of Membership Housekeeping Change

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

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

WHEREAS, The Bylaws – Article VIII – Council, Section 1 – Composition of the Council (paragraph 8) specifies that sections are entitled to one councillor "if the number of section dues-paying and complimentary candidate members meets the minimum number established by the Board of Directors for the charter of that section based on the membership rolls of the College on December 31 of the preceding year.; and

WHEREAS, The Council Standing Rules, Councillor Allocation for Sections of Membership, specifies "a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting;" and

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

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

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

**Background**

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

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

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

**ACEP Strategic Plan Reference**

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

**Fiscal Impact**

Budgeted staff resources to update the Council Standing Rules.

**Prior Council Action**

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

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

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

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

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

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

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

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

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

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

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

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

**Prior Board Action**

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

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

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

**Background Information Prepared by:** Sonja Montgomery
Governance Operations Director

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

**College Manual Amendment**

RESOLUTION: 24(25)

SUBMITTED BY: Ethics Committee
Board of Directors

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

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

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

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

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

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

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

## Procedures for Addressing Charges of Ethical Violations and Other Misconduct

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

### A. Definitions

1. ACEP means the American College of Emergency Physicians.
2. *Code of Ethics* means the *Code of Ethics for Emergency Physicians.*
3. *Procedures* means the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct.*
4. Ethics Complaint Review Panel consists of three (3) members of the Ethics Committee and two (2) members of the Medical-Legal Committee **with no conflicts of interest in each pending matter** – in matters requiring the expertise of a different committee, the President may appoint two (2) members of the relevant committee to replace the standing members of the Medical-Legal Committee.
5. Bylaws Committee refers to the Bylaws Committee or appointed subcommittee.
6. Board Hearing Panel conducts all hearings and consists of ~~the~~ **an** ACEP Vice President, Chair of the Board, and Board Liaison to the Ethics Committee.
7. ACEP review bodies are the Ethics Complaint Review Panel, the Bylaws Committee, the Board Hearing Panel and the ACEP Board of Directors.

### B. Complaint Received

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

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

**C. Executive Director**

1. a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.
   b. If all elements of the complaint have been met, sends a written acknowledgement to the complainant confirming complainant's intent to file a complaint. Includes a copy of ACEP's *Procedures* providing guidelines and timetables that will be followed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the *Procedures*.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the *Procedures.*
3. Notifies the ACEP President and the Chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
4. **Determines, in consultation with the ACEP President and the Chair of the Ethics Committee or the Bylaws Committee, along with other committee designee(s) as appropriate given the subject matter of the complaint, that:**
   a. ~~Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, the Bylaws Committee, or other committee designee, that t~~**T**he **charges and conduct set forth in the** complaint**, as alleged by the complainant,** ~~is frivolous, inconsequential, or~~ do~~es~~ not allege an actionable violation of a policy or principle included in the *Code of Ethics* or ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination~~.~~**;** or
   b. ~~Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, or other committee designee, that t~~**T**he complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics*, and if so, forwards the complaint and the response together, after both are received, to each member of the Ethics Complaint Review Panel **after membership on the Ethics Complaint Review Panel has been confirmed;** or
   c. ~~Determines, in consultation with the ACEP President and the Chair of the Bylaws Committee, or other committee designee, that t~~**T**he complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, after both are received, to each member of the Bylaws Committee, or at the discretion of the Chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose **and that has been screened for conflicts of interest;** or
   d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the

matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues~~, the complaint will not be considered. T~~the Ethics Complaint Review Panel or the Bylaws Committee**, as appropriate,** will review the President's ~~action~~ **recommendation to reject the complaint**. The President's action can be overturned by a majority vote of the applicable ACEP review body **or adopted by the body**.

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

**D. Ethics Complaint Review Process. ~~[w~~Within sixty (60) days of the forwarding of the complaint /response specified in Section C.4.b. above, the Ethics Complaint Review Panel:~~]~~**

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

**E. Bylaws Complaint Review Process~~[w~~Within sixty (60) days of the forwarding of the complaint /response specified in Section C.4.b. above, the Bylaws Committee:**

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws as it existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference **or web conference** call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.

4. Considers whether:
   a. Applicable version of the ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. ~~Bylaws Committee r~~**R**enders a decision to impose disciplinary action, based solely on the written record.
6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee's determination and the option of:
   a. A hearing; or
   b. The imposition of the Bylaws Committee's decision based solely on the written record.
7. If the respondent chooses the option described in Section E.6.b., that is, a Bylaws Committee decision based solely on the written record, the Bylaws Committee will implement its decision to impose disciplinary action based on the written record.

**F. Right of Respondent to Request a Hearing**

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

**G. Hearing Procedures**

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by USPS Certified Mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board Hearing Panel intends to call in the hearing.
2. The Executive Director will send a notification by USPS Certified Mail of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing.
3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel ~~or any other person of their choice~~. Each party will bear the expense of his or her own counsel.
5. The parties have the right to have a record made of the proceedings by transcript, audio~~tape~~, **recording,** or video~~tape~~ **recording** at the expense of the requesting party. **A copy of any such record must be provided to the Executive Director.**
6. The hearing will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person, except in circumstances in which it is ~~impossible or commercially impracticable~~ **impractical** for the parties and the Board Hearing Panel to hold an in-person hearing, at which time the Board Hearing Panel may choose to hold a virtual hearing.
7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. **Any documents or materials to be provided or presented during the hearing not already in the record, including written documents, handouts, or slide presentations, must be provided to the presiding officer 14 days prior to the hearing to assess if the material and information contained therein are relevant to the proceedings.** Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.
8. The Board Hearing Panel will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the filing of any written briefs, conclude the hearing.

9. The decision of the Board Hearing Panel will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the Board Hearing Panel's decision will be sent by USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board Hearing Panel's decision and a statement of the basis for that decision.

**H. Notice to the Board of Directors**

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

**I. Possible Disciplinary Action and Disclosure to ACEP Members**

1. Nature of Disciplinary Action
   a. Censure
      i. Private Censure: a private letter of censure informs a member that his or her conduct does not conform with the College's ethical standards; it may detail the manner in which ACEP expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. Upon written request by a member of ACEP, ACEP may confirm the censure; however, contents of the letter will not be provided.

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

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

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

   b. Suspension from ACEP membership shall be for a period of twelve (12) months; the dates of commencement and completion of the suspension shall be determined by the-ACEP President. At the end of the twelve (12) month period of suspension, the suspended member may request reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues). The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action**, disclosure of which shall be subject to the discretion of the Executive Director**. ACEP is also

required to report the suspension from membership and a description of the conduct that led to the suspension to the Board of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

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

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

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

2. Scope and Manner of Disclosure
   a. Disclosure to ACEP Members: Any ACEP member may transmit a request for information to the Executive Director regarding disciplinary actions taken by the College. ~~Such~~ **The** letter shall specify the name of the member or former member who is the subject of the request. The Executive Director ~~shall~~ **may** disclose, in writing, the relevant information as described in Section I.1.
   b. Disclosure to Non-Members: If a non-member makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. No further information shall be provided. **If a non-member makes a request for information about disciplinary actions against a member who has received private censure, the Executive Director shall inform the individual that no published announcement of disciplinary action is available but shall not indicate or confirm that a private censure has been imposed.**

**J. Ground Rules**

1. All proceedings are confidential until a final decision on the complaint is rendered by the applicable ACEP review body, at which time the decision will be available upon request by ACEP members, to the extent specified in Section I. Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel, may request further written documentation from either party to the complaint; a time to satisfy any request

will be specified in the notice of such request, and these times will not count against the ACEP review body's overall time to complete its task.

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

**Background**

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

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

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

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

**ACEP Strategic Plan Reference**

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

**Fiscal Impact**

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

**Prior Council Action**

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

Resolution 14(20) Ethics Procedures – Bylaws Amendment adopted. Amended the Bylaws to permit a designated body appointed by the Board of Directors to render a decision regarding disciplinary action as stated in the College Manual.

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. Amended by substitution the ethics procedures in the College Manual. The changes addressed the timeliness of filing allegations, clarifications of aspects of the process, ensuring that deadlines are reasonable in light of process and review requirements, a respondent's membership status during the pendency of an ethics complaint, and clarifications of the scope and disclosure of disciplinary actions.

Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to deadlines and provided mechanisms in the event that the number of Board recusals impacts the Board's ability to act on ethics complaints.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to due process and the hearing procedures.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes related to the categories of sanctions and clarifying when disclosure of such sanctions may be appropriate or necessary.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes included enhancements related to communications, responsibilities, timelines, and voting.

Resolution 5(99) College Manual adopted and included the "Procedures for Addressing Ethics and Other Disciplinary Charges." The resolution established the College Manual and defined the method for amending it.

Amended Resolution 4(99) Streamlining Bylaws adopted. The resolution simplified the Bylaws by placing procedural provisions in either the Council Standing Rules or a College Manual.

Amended Resolution 1(97) Code of Ethics for Emergency Physicians Bylaws amendment adopted. The resolution codified ACEP's Code of Ethics for Emergency Physicians in the Bylaws.

**Prior Board Action**

April 2025, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting the College Manual resolution to the 2025 Council.

Resolution 15(20) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

Resolution 14(20) Ethics Procedures – Bylaws Amendment adopted.

June 2020, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting Bylaws and College Manual resolutions to the 2020 Council.

June 2019, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting a College Manual resolution to the 2019 Council. (The resolution was subsequently withdrawn based on comments received from the Bylaws Committee.)

December 2018, discussed revising the Procedures for Addressing Charges of Ethical Violations and Other Misconduct" to create a more efficient review process.

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

June 2013, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting a College Manual resolution to the 2013 Council.

Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct College Manual resolution adopted.

April 2010, reviewed the proposed changes to the "Procedures for Addressing Ethics and Other Disciplinary Charges" and approved submitting a College Manual resolution to the 2010 Council.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

June 2007, reviewed the proposed changes to the "Procedures for Addressing Ethics and Other Disciplinary Charges" and requested additional changes to be reviewed and approved by the Board. Approved submitting a College Manual resolution to the 2007 Council.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.

Resolution 5(99) College Manual adopted.

Amended Resolution 4(99) Streamlining Bylaws adopted.

August 1998, approved the Procedures for Addressing Ethics Charges.

Amended Resolution 1(97) Code of Ethics for Emergency Physicians Bylaws amendment adopted.

July 1997, approved submitting the "Code of Ethics for Emergency Physicians" Bylaws amendment to the 1997 Council.

June 1997, approved the "Code of Ethics for Emergency Physicians."

**Background Information Prepared by:** Laura Lang, JD
General Counsel

Sonja Montgomery
Governance Operations Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 25(25)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Young Physicians Section

SUBJECT: Protecting Section Integrity and Member Engagement in ACEP

PURPOSE: Amend the "Policy on Sections of Membership" to require that a charter for any section of membership may only be suspended or revoked by a two-thirds vote of the Board of Directors

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Sections within ACEP are essential for fostering community, professional development, and focused advocacy among emergency physicians with shared interests and identities; and

WHEREAS, Section dissolution should be undertaken only with substantial justification and transparency, in order to preserve the diversity and engagement of ACEP's membership; and

WHEREAS, In the current politically volatile environment, ACEP must safeguard against external political pressures that could unduly influence internal decisions, including the potential dissolution of sections; and

WHEREAS, The perception or reality of politically motivated section closures may significantly diminish trust in ACEP governance and decrease member participation; therefore be it

RESOLVED, That the Board of Directors amend the "Policy on Sections of Membership" to require that a charter for any section of membership may only be suspended or revoked by a two-thirds vote of the Board of Directors.

**Background**

This resolution seeks to raise the threshold for the Board of Directors to suspend or revoke a section charter from a majority vote to a two-thirds vote.

There are currently 40 sections of membership with approximately 24,000 unique members and total section membership of more than 33,000 members (some members belong to more than one section). Sections provide an opportunity for members to network with other members who share common areas of interest in the diverse areas of emergency medicine or life stages. Section members have the opportunity to cultivate ideas and develop programs to improve the care of emergency patients worldwide.

ACEP's "Policy on Sections of Membership" provides guidance on many issues pertaining to sections, including establishing a section, maintenance of a section, and section charter probation, suspension, and revocation. The policy stipulates that a 2/3 vote of the Board is required to establish a section; however, only a majority vote of the Board is required to suspend or revoke a charter based on the following criteria:

1. The actions of the section are deemed to be in conflict with the Bylaws or the Policy on Sections of Membership.
2. The section fails to comply with all the requirements of the Bylaws, the Policy on Sections of Membership, the individual Section's Operational Guidelines, the online communities Terms of Use, or with any other requirement of the College.

3. The actions of the section are determined not to be in accordance with the goals, objectives, or in the best interest of the College.

**ACEP Strategic Plan Reference**

Member Engagement and Trust: Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

**Fiscal Impact**

Budgeted staff resources.

**Prior Council Action**

Resolution 9(09) Bylaws Housekeeping Changes adopted. This resolution made several editorial revisions to the Bylaws for consistency with the Texas Business Organizations Code and included a revision to the language pertaining to section councillors.

Resolution 10(07) Complimentary Members in Section Councillor Allocation adopted. This Bylaws amendment clarified that complimentary section memberships are to be included when determining section eligibility for a councillor and limited this allocation to candidate members only.

Amended Resolution 30(05) Standing Rules Housekeeping Changes adopted. This Council Standing Rules resolution made comprehensive housekeeping changes throughout the document including non-substantive updated language to the Councillor Allocation for Sections of Membership.

Amended Resolution 6(99) Council Standing Rules adopted. This resolution revised the Council Standing Rules based on the streamlined Bylaws and stipulated that future changes to the Council Standing Rules can only be made through submission of resolutions to the Council. *Note: Changes to the Council Standing Rules prior to 2000 were proposed by the Council Steering Committee and approved by the Council at the next annual meeting.*

Amended Resolution 4(99) Streamlining Bylaws adopted. This Bylaws amendment simplified the Bylaws by placing procedural provisions in either the Council Standing Rules or a College manual.

October 1997, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of December 31 each year.

Amended Resolution 3(96) Councillor Allocations for Sections of Membership adopted. This Bylaws amendment specified that sections must have 100 dues-paying members as of December 31 of the preceding year.

September 1992, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 1(90) Voting Privilege for Section Councillors adopted. This Bylaws amendment granted voting privileges to section councillors.

September 1990, approved the Council Standing Rules with the addition of one non-voting councillor for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 11(89) Councillor Allotment for Sections of Membership adopted. This resolution allocated one councillor per section without the right to vote.

Substitute Resolution 13(88) Sections of Membership adopted. This resolution established sections of membership.

**Prior Board Action**

June 2024, approved the revised "Policy on Sections of Membership;" revised and approved June 2022, June 2017, April 2008, June 2002, July 2001, June 1996, October 1993, June 1992, January 1992, and May 1990; originally approved January 1989.

*Note:* Prior to 1993 the Board of Directors did not take action on Bylaws amendments adopted by the Council.

**Background Information Prepared by:** Sonja Montgomery
Governance Operations Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 26(25)

SUBMITTED BY: Christopher L. Smith, MD, FACEP
Jessica J. Wall, MD, MPH, MSCE, FACEP
Aine Yore, MD, FACEP
California Chapter
District of Columbia Chapter
Washington Chapter
Access, Belonging, & Community Section

SUBJECT: Affirmation of ACEP's Support for Diversity, Equity, and Inclusion in Emergency Medicine

PURPOSE: Reaffirm ACEP's commitment to the core principles of DEI by reaffirming the previous policy statement supporting DEI.

FISCAL IMPACT: No additional funding is required for ACEP to reaffirm its current policy statement.

WHEREAS, The American College of Emergency Physicians (ACEP) has a longstanding history of supporting diversity, equity, and inclusion (DEI) initiatives [1, 2, 3, 4, 5, 6] as integral to the mission of advancing the highest quality of emergency care; and

WHEREAS, The College approved a policy statement supporting the principles inherent within DEI in September 2024; and

WHEREAS, The principles of DEI are essential to ensuring equitable access to emergency care, addressing health disparities, and supporting the well-being and professional development of a diverse emergency medicine workforce; and

WHEREAS, ACEPs Access, Belonging, and Community (ABC) Section (formerly the Diversity, Inclusion, and Health Equity Section) and the Access, Belonging, and Community (ABC) Committee (formerly the Diversity, Equity, and Inclusion Committee) have demonstrated exemplary leadership in advancing DEI initiatives, developing resources, and promoting awareness throughout the College and the broader emergency medicine community; and

WHEREAS, Recent actions at the federal and state levels threaten to undermine DEI initiatives critical to fostering inclusive, equitable, and culturally competent health care environments; therefore be it

RESOLVED, That ACEP reaffirm its commitment to the core principles of diversity, equity, and inclusion, recognizing their fundamental role in promoting patient-centered care, health equity, and a thriving, representative workforce by reaffirming its previous policy statement supporting diversity, equity, and inclusion as essential to the College's mission and the practice of emergency medicine.

**Resolution References**


[1]2021 ACEP Policy Statement: Cultural Awareness and Emergency Care
[2]2023 ACEP Policy Statement: Workforce Diversity in Health Care Settings
[3]2021 ACEP Policy Statement: Non-Discrimination and Harassment
[4]2021 ACEP Policy Statement: Implicit Bias and Awareness Training
[5]2022 ACEP Policy Statement: Caring for Transgender and Gender Diverse Patients in the Emergency Department
[6]2023 ACEP Policy Statement: Appropriate Use of Race in Research

## Background

This resolution calls for ACEP to reaffirm its commitment to the core principles of diversity, equity, and inclusion by reaffirming the previous policy statement "Diversity, Equity, and Inclusion" approved by the Board of Directors in September 2024.

ACEP has a longstanding commitment to the principles of diversity, equity, and inclusion (DEI) as integral to its mission and to advancing emergency medicine. ACEP has demonstrated consistent support for DEI through Council and Board actions, policy statements, and national leadership in multi-organization efforts such as the All-EM DEI Vision Statement. Recent developments at the state and federal level have introduced new challenges that may hinder the continuation of DEI initiatives in health care and academic settings.

Internally, ACEP's work on DEI initiatives have been championed by the Access, Belonging, & Community (formerly DEI) Committee and the Access, Belonging, & Community (formerly DIHE) Section. The committee and section have worked to raise awareness, develop tools and resources, and guide integration of DEI principles across the College's strategies. Recognizing the deep importance of intentional language, ACEP's recent updates to its committee and section nomenclature reflect a broader shift away from the term "DEI" toward a more inclusive and active framing – Access, Belonging, & Community (ABC) – emphasizing inclusion as a lived experience rather than a topic of discussion. The scope of their efforts often extends beyond traditional definitions and addresses health disparities and equal access to care across all communities and reflects a holistic approach to achieving health equity in emergency medicine. Reaffirming DEI principles aligns with ACEP's values. The principles of diversity, equity, and inclusion are foundational to ensuring equitable access to care, supporting a thriving emergency medicine workforce, and addressing health disparities that affect patient outcomes.

**Background References**

1. Cohen, A. J., Sheldon, L. K., Van Decker, W. A., et al. (2022). *Perceptions of Diversity, Equity, and Inclusion in an Urban Emergency Department Patient Population*. **Journal of Patient Experience**, 9, 23743735221130807.
2. Estrellado, M., Shah, M. M., Thomas, A., et al. (2021). *An Intensive Approach to Improving Diversity, Equity, and Inclusion in an Academic Emergency Department*. **Western Journal of Emergency Medicine**, 22(6), 1325–1333.
3. *ACEP Now Why Diversity, Equity, and Inclusion Matter in Medical Education* August 2024
4. ACEP *Statement on a Diverse Emergency Physician Workforce* April 2024

## ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Member Engagement and Trust: Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

## Fiscal Impact

No additional funding is required for ACEP to reaffirm its current policy statement.

## Prior Council Action

Amended Resolution 51(22) Implementation of Social Determinants of Health Evaluation in the ED adopted. Directed ACEP to support and encourage evaluation for social determinants of health and advocate for national, state, and local resources and responses to be paired with the evaluation for social determinants of health.

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted. Directed ACEP to seek to improve the recognition of, and attention to, social determinants of health by supporting research of evidence-based SDH screening and interventions in the ED; advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

Amended Resolution 56(21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted. Directed ACEP to issue a statement to the membership denouncing the validity of the use of race-based science and its detrimental impact in the care of diverse populations, commit to educating ACEP members by denouncing the use of race-based calculators in clinical policies, and commit to not support research studies that utilize race-based calculations that are not supported by sound scientific evidence.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted. Directed ACEP to: 1) Promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED; 2) compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the ED; 3) encourage hospitals to provide adequate and appropriate education, training, and resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients; and 4) encourage EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted. Directed ACEP to survey speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Resolution 21(21) Diversity, Equity, and Inclusion adopted. Directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion within the next year; create a road map to promote diversity, equity, and inclusion; embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and report to the 2022 Council the outcome of the summit and have a roadmap created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted. The resolution directed ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism as it pertains to emergency care; continue to explore models of health care that would make equitable health care accessible to all; and continue to use its voice as an organization and support its members who seek to reform discriminatory systems and advocate for policies promoting the social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

Amended Resolution 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted. Directed ACEP to create or select a framework to assess the future work of the College (position statements, adopted resolutions, task forces) through the lens of health equity and provide a biennial assessment of the work of the College pertaining to health equity.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members.

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

**Prior Board Action**

September 2024, approved the policy statement "Diversity, Equity, and Inclusion"

July 2024, reviewed the "Implicit Bias Awareness and Training" Policy Resource & Education Paper (PREP).

June 2023, approved the policy statement "Appropriate Use of Race in Research."

June 2023, approved the revised policy statement "Workforce Diversity in Health Care Settings;" revised and approved November 2017; reaffirmed June 2013 and October 2007; originally approved October 2001.

April 2023, reviewed the Policy Resource & Education Paper "A Guide to Caring for Patients Who Identify as Transgender and Gender Diverse in the Emergency Department."

Amended Resolution 51(22) Implementation of Social Determinants of Health Evaluation in the ED adopted.

June 2022, approved the policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department."

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted.

Amended Resolution 56(21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; revised and approved April 2008 with current title; originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with current title; originally approved October 2005 titled "Non-Discrimination."

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

Amended Resolution 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

October 2017, reviewed the information paper "Disparities in Emergency Care."

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted.

**Background Information Prepared by:** Tony Vellucci, CNE, CDE
Associate Executive Director, Emergency Medicine Foundation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 27(25)

SUBMITTED BY: Michael J. Bresler, MD, FACEP
Gus M. Garmel, MD, FACEP
Nicole E. Exeni McAmis, MD
Colorado Chapter
Montana Chapter

SUBJECT: Upholding Equal Access to Care in Emergency Medicine Amidst Political Challenges

PURPOSE: 1) Reaffirm commitment to promoting and maintaining equal access to care in the ED, ensuring that all patients and staff are treated with respect, dignity, and fairness; 2) Advocate for implementation of policies and practices in the ED that address unconscious bias and cultural competence, and support equitable health care delivery for all, regardless of the political environment; 3) Support continued development and integration of implicit bias training into emergency medicine residency programs, continuing medical education courses, and ongoing professional development to equip emergency providers with the tools necessary to maintain inclusive and equitable care for all regardless of political and societal challenges; 4) Support efforts to incorporate education on culturally and religiously sensitive care into emergency medicine training and continuing education programs, including awareness of variations in patient preferences and beliefs regarding gender concordance in care, expressions of pain, and attitudes toward different medical systems; and 5) Call for active collaboration with other health care organizations, advocacy groups, and community leaders to ensure that culturally sensitive equal access to care for all remains a central focus in emergency medicine practice and policy, particularly in the context of current political dynamics.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Diversity, equity, and inclusion (DEI) are fundamental to providing high-quality, patient-centered care in the emergency department (ED), ensuring that all individuals, regardless of their race, ethnicity, gender, sexual orientation, or socioeconomic background, receive respectful, equitable, and culturally competent care[1]; and

WHEREAS, The current political climate has led to increased polarization and challenges to DEI initiatives in healthcare, which may undermine efforts to promote inclusive environments and equitable access to care in the ED[2]; and

WHEREAS, Emergency medicine physicians and staff are often the first point of contact for patients who face significant health disparities, and it is critical that these providers uphold the principles of DEI to foster trust, reduce health inequities, and ensure that marginalized communities are not further disadvantaged[3]; and

WHEREAS, Maintaining DEI in the ED requires ongoing education, training, and policy development to address unconscious bias, discrimination, and barriers to care that may arise, especially in a politically charged environment[4]; and

WHEREAS, Emergency physicians frequently care for patients from diverse cultural, religious, and ethnic backgrounds, and must be aware of variations in attitudes toward health, illness, pain expression, gender concordance in examinations, and preferences for traditional versus Western medical practices; and

WHEREAS, ACEP has long championed diversity, equity, and inclusion in health care, and it is essential for the organization to continue advocating for the protection of these principles within the ED, especially in light of evolving political landscapes[5]; therefore be it

RESOLVED, That ACEP reaffirm its commitment to promoting and maintaining equal access to care in the emergency department, ensuring that all patients and staff are treated with respect, dignity, and fairness; and be it further

RESOLVED, That ACEP advocate for the implementation of policies and practices in the ED that address unconscious bias and cultural competence, and support equitable health care delivery for all, regardless of the political environment; and be it further

RESOLVED, That ACEP support the continued development and integration of implicit bias training into emergency medicine residency programs, continuing medical education courses, and ongoing professional development to equip emergency providers with the tools necessary to maintain inclusive and equitable care for all regardless of political and societal challenges; and be it further

RESOLVED, That ACEP support efforts to incorporate education on culturally and religiously sensitive care into emergency medicine training and continuing education programs, including awareness of variations in patient preferences and beliefs regarding gender concordance in care, expressions of pain, and attitudes toward different medical systems; and be it further

RESOLVED, That ACEP call for active collaboration with other health care organizations, advocacy groups, and community leaders to ensure that culturally sensitive equal access to care for all remains a central focus in emergency medicine practice and policy, particularly in the context of current political dynamics.

**Resolution References**

1. Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Available at: https://www.ncbi.nlm.nih.gov/books/NBK220358/. Accessed 2/18/25.
2. American Civil Liberties Union. The Impact of Politics on Healthcare Equity. Available at: https://www.aclu.org/issues/health-care. Accessed 2/18/25.
3. American College of Emergency Physicians. Diversity and Inclusion in Emergency Medicine. Available at: https://www.acep.org/diversity. Accessed 2/18/25.
4. National Institutes of Health. Addressing Unconscious Bias in Healthcare. Available at: https://www.nih.gov/about-nih/what-we-do/nih-almanac/addressing-unconscious-bias. Accessed 2/18/25.
5. American Medical Association. Promoting Diversity, Equity, and Inclusion in Healthcare. Available at: https://www.ama-assn.org/delivering-care/public-health/diversity-equity-and-inclusion. Accessed 2/18/25.
6. American Hospital Association. Achieving Health Equity: A Guide for Healthcare Organizations. Available at: https://www.aha.org/achieving-health-equity. Accessed 2/18/25.
7. Accreditation Council for Graduate Medical Education. Diversity, Equity, and Inclusion in Medical Education. Available at: https://www.acgme.org/What-We-Do/Accreditation/Diversity-Equity-and-Inclusion. Accessed 2/18/25.
8. National Public Health Institute. Health Equity in a Divided Society. Available at: https://www.nphii.org/equity-advocacy. Accessed 2/18/25.

## Background

*Note:* Components of this resolution are similar to Resolution 26(25) Affirmation of ACEP's Support for Diversity, Equity, and Inclusion in Emergency Medicine and Resolution 40(25) Support Ongoing Education on Implicit Bias and Structural Inequity. Much of the background information from these resolutions are included in the background for this resolution.

This resolution calls for ACEP to: 1) Reaffirm commitment to promoting and maintaining equal access to care in the ED, ensuring that all patients and staff are treated with respect, dignity, and fairness; 2) Advocate for implementation of policies and practices in the ED that address unconscious bias and cultural competence, and support equitable health care delivery for all, regardless of the political environment; 3) Support continued development and integration of implicit bias training into emergency medicine residency programs, continuing medical education courses, and ongoing professional development to equip emergency providers with the tools necessary to maintain inclusive and equitable care for all regardless of political and societal challenges; 4) Support efforts to incorporate education on culturally and religiously sensitive care into emergency medicine training and continuing education programs, including awareness of variations in patient preferences and beliefs regarding gender concordance in care, expressions of pain, and attitudes toward different medical systems; and 5) Call for active collaboration with other health care organizations, advocacy groups, and community leaders to ensure that culturally sensitive equal access to care for all remains a central focus in emergency medicine practice and policy, particularly in the context of current political dynamics.

Ensuring patient-centered and equitable care in the emergency department are foundational principles in emergency medicine. Emergency physicians caring for individuals from highly diverse racial, ethnic, socioeconomic, gender, and cultural backgrounds and often in moments of critical need. Upholding equal access to care values in emergency medicine is essential for improving health outcomes, fostering patient trust, and addressing longstanding health disparities. These values are increasingly under scrutiny with legislative proposals in several states potentially undermining the ability of emergency departments to maintain inclusive and culturally competent care. Emergency physicians and health care staff must be prepared to navigate these tensions while continuing to serve all patients with dignity and respect.

ACEP has a longstanding commitment to the principles of equal access to care as integral to its mission and to advancing emergency medicine. ACEP has demonstrated consistent support through adoption of Council and Board actions, policy statements, and national leadership in multi-organization efforts such as the All-EM DEI Vision Statement. Recent developments at the state and federal level have introduced new challenges that may hinder the continuation of DEI initiatives in health care and academic settings.

ACEP's policy statement "Diversity, Equity, and Inclusion" states (in part):

> "ACEP is committed to fostering an inclusive and equitable health care environment for all individuals. We recognize that diversity within our organization is crucial to reflecting the diverse backgrounds and experiences of the patients we serve. This diversity enhances our cultural competence and improves the effectiveness of our care."

Internally, ACEP's work on DEI initiatives have been championed by the Access, Belonging, & Community (formerly DEI) Committee and the Access, Belonging, & Community (formerly DIHE) Section. The committee and section have worked to raise awareness, develop tools and resources, and guide integration of DEI principles across the College's strategies. Recognizing the deep importance of intentional language, ACEP's recent updates to its committee and section nomenclature reflect a broader shift away from the term "DEI" toward a more inclusive and active framing – Access, Belonging, & Community (ABC) – emphasizing inclusion as a lived experience rather than a topic of discussion. The scope of their efforts often extends beyond traditional definitions and addresses health disparities and equal access to care across all communities and reflects a holistic approach to achieving health equity in emergency medicine. Reaffirming DEI principles aligns with ACEP's values. The principles of diversity, equity, and inclusion are foundational to ensuring equitable access to care, supporting a thriving emergency medicine workforce, and addressing health disparities that affect patient outcomes.

Implicit biases – unconscious attitudes or stereotypes – can have negative influences on clinical decision-making, communication between patients and physicians or other health care professionals, and perpetuate health disparities, particularly for marginalized groups. These biases can lead to inequitable care, reduced patient trust, and poorer health outcomes.[1-5] Education that addresses implicit bias increases awareness of self-biases, provides strategies to mitigate their impact, and fosters critical reflection, which are essential for delivering equitable care. Without such education, biases may remain unrecognized and unaddressed, contributing to ongoing disparities in health care delivery and outcomes. Integrating implicit bias education is a critical step toward advancing health equity and professionalism in medicine[1-5]

ACEP has taken several steps to address implicit bias within emergency medicine. These actions include developing and promoting educational resources, supporting policy changes, and encouraging open dialogue about bias.[6-8] Amended Resolution 14(19) Implicit Bias Awareness and Training called for developing and publicizing a policy statement that promotes implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles; and continue to create and advertise free, CME- eligible, online training related to implicit bias. The policy statement "Implicit Bias Awareness and Training" was developed in response to Amended Resolution 14(19). Additionally, a Policy Resource & Education Paper (PREP) was developed by the Academic Affairs Committee as an adjunct to the policy statement. (The PREP is pending journal publication. It will be available on the ACEP website as soon as available.)

ACEP currently offers a wide range of educational content and resources to address implicit bias. The following educational sessions have been presented at previous ACEP annual meetings and are available in ACEP Anytime:

Racism and Bias in the ED Environment (2024) – Jenice Baker, MD, FACEP
How to Talk About Race and Medicine With Patients (2024) – Jenice Baker, MD, FACEP
Belonging: The Intersection of Diversity, Equity and Inclusion and Physician Well-Being (2024)
- Al'ai Alvarez, MD, FACEP
Belonging: The Intersection of Diversity, Equity, and Inclusion, and Physician Well-Being (2023) – Al'ai Alvarez, MD, FACEP
Unlearning Implicit Bias 2023 – Al'ai Alvarez, MD, FACEP
Unlearning Implicit Bias 2022 – Bernard Lopez, MD, FACEP

ACEP Anytime will be updated to include additional courses as they are developed.

Recently, several states have enacted laws restricting or banning certain types of implicit bias training, particularly in educational and health care settings. Florida, North Dakota, Tennessee, and Texas have passed legislation restricting the use of state or federal funds for diversity, equity, and inclusion (DEI) programs, including mandatory implicit bias training. Tennessee has gone further by prohibiting public institutions from mandating implicit bias training for educators and employees, according to Tennessee State Government (.gov). These laws often focus on prohibiting mandatory training that promotes what they consider "divisive concepts" or "identity politics." Other states such as California, Delaware, Maryland, Massachusetts, Michigan, New Jersey, and Washington have enacted legislation requiring implicit bias training, especially for health care providers. Illinois and Minnesota also have such requirements for health care professionals.[9] It is important to note that the legal landscape regarding implicit bias training is complex and constantly evolving. Some laws prohibiting bias training have faced legal challenges. Additionally, some states or organizations may still implement such training without a specific state mandate, or even if they face restrictions, they may adapt their training programs to be compliant with current laws and regulations.

Both the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) have recently taken steps to suspend enforcement of certain "diversity" requirements. This action follows concerns about potential conflicts between these requirements and state laws, as well as criticism from some regarding the emphasis on DEI in medical education.[10,11]

ACEP's Legislative and Regulatory Priorities for the First Session of the 119th Congress include:

- Promote legislative options and solutions to identify and eliminate health disparities and implement broad, systemic solutions to address social determinants of health that create disparities, address structural racism, and improve health equity in the health care system.

**Background References**

1. Twelve Tips for Teaching Implicit Bias Recognition and Management. Gonzalez CM, Lypson ML, Sukhera J. Medical Teacher. 2021;43(12):1368-1373. doi:10.1080/0142159X.2021.1879378.
2. The Time Is Now: Addressing Implicit Bias in Obstetrics and Gynecology Education. Royce CS, Morgan HK, Baecher-Lind L, et al. American Journal of Obstetrics and Gynecology. 2023;228(4):369-381. doi:10.1016/j.ajog.2022.12.016.
3. Educational Strategies in the Health Professions to Mitigate Cognitive and Implicit Bias Impact on Decision Making: A Scoping Review. Thompson J, Bujalka H, McKeever S, et al. BMC Medical Education. 2023;23(1):455. doi:10.1186/s12909-023-04371-5.
4. Implicit Bias in Health Professions: From Recognition to Transformation. Sukhera J, Watling CJ, Gonzalez CM. Academic Medicine : Journal of the Association of American Medical Colleges. 2020;95(5):717-723. doi:10.1097/ACM.0000000000003173.
5. Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs. Vela MB, Erondu AI, Smith NA, et al. Annual Review of Public Health. 2022;43:477-501. doi:10.1146/annurev-publhealth-052620-103528.
6. https://www.acep.org/news/acep-newsroom-articles/change-is-happening-fast-acep-is-your-voice-in-washington-when-it-matters-most
7. https://www.acepnow.com/article/addressing-bias-racism-and-disparities-in-the-emergency-department/
8. https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/implicit-bias-and-cultural-sensitivity---effects-on-clinical-and-practice-management.pdf
9. https://www.asha.org/advocacy/state/state-mandates-around-diversity-equity-and-inclusion/states-with-restrictions-on-diversity-equity-and-inclusion-concepts-in-higher-education/
10. https://www.acgme.org/newsroom/2025/5/acgme-board-executive-committee-action/#:~:text=The%20ACGME%20has%20heard%20significant,for%20approval%20of%20accreditation%20requirements.
11. https://lcme.org/announcement-may-19-2025/#:~:text=On%20May%2019%2C%202025%2C%20the,information%20related%20to%20Element%203.3.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Member Engagement and Trust: Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Amended Resolution 51(22) Implementation of Social Determinants of Health Evaluation in the ED adopted. Directed ACEP to support and encourage evaluation for social determinants of health and advocate for national, state, and local resources and responses to be paired with the evaluation for social determinants of health.

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted. Directed ACEP to seek to improve the recognition of, and attention to, social determinants of health by supporting research of evidence-based SDH screening and interventions in the ED; advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

Amended Resolution 56(21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted. Directed ACEP to issue a statement to the membership denouncing the validity of the use of race-based science and its detrimental impact in the care of diverse populations, commit to educating ACEP members by denouncing the use of race-based calculators in clinical policies, and commit to not support research studies that utilize race-based calculations that are not supported by sound scientific evidence.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted. Directed ACEP to: 1) Promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED; 2) compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the ED; 3) encourage hospitals to provide adequate and appropriate education, training, and resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients; and 4) encourage EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted. Directed ACEP to survey speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Resolution 21(21) Diversity, Equity, and Inclusion adopted. Directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion within the next year; create a road map to promote diversity, equity, and inclusion; embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and report to the 2022 Council the outcome of the summit and

have a roadmap created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted. The resolution directed ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism as it pertains to emergency care; continue to explore models of health care that would make equitable health care accessible to all; and continue to use its voice as an organization and support its members who seek to reform discriminatory systems and advocate for policies promoting the social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

Amended Resolution 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted. Directed ACEP to create or select a framework to assess the future work of the College (position statements, adopted resolutions, task forces) through the lens of health equity and provide a biennial assessment of the work of the College pertaining to health equity.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members.

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

**Prior Board Action**

January 2025, approved the Legislative and Regulatory Priorities for the First Session of the 119th Congress.

September 2024, approved the policy statement "Diversity, Equity, and Inclusion."

July 2024, reviewed the "Implicit Bias Awareness and Training" Policy Resource & Education Paper (PREP).

June 2023, approved the policy statement "Appropriate Use of Race in Research."

June 2023, approved the revised policy statement "Workforce Diversity in Health Care Settings;" revised and approved November 2017; reaffirmed June 2013 and October 2007; originally approved October 2001.

April 2023, reviewed the Policy Resource & Education Paper "A Guide to Caring for Patients Who Identify as Transgender and Gender Diverse in the Emergency Department."

Amended Resolution 51(22) Implementation of Social Determinants of Health Evaluation in the ED adopted.

June 2022, approved the policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department."

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted.

Amended Resolution 56(21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; revised and approved April 2008 with current title; originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with current title; originally approved October 2005 titled "Non-Discrimination."

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

Amended Resolution 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

October 2017, reviewed the information paper "Disparities in Emergency Care."

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted.

**Background Information Prepared by:** Tony Vellucci, CNE, CDE
Associate Executive Director, EMF

Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 28(25)

SUBMITTED BY: Access, Belonging, & Community Section

SUBJECT: Establish a College-Wide Mentorship Program

PURPOSE: Create and implement a comprehensive mentorship program accessible to all members and include resources to support the mentorship of members from marginalized and underrepresented communities in medicine.

FISCAL IMPACT: Budgeted committee and staff resources to develop the framework for the program. Additional unbudgeted estimated minimum cost of $25,000 annually to support platform costs, staffing, and program coordination. Outside funding from a supporting partner or sponsor could help defray expenses.

WHEREAS, Mentorship plays a critical role in the professional development, retention, and satisfaction of emergency physicians at all stages of their careers; and

WHEREAS, Members from historically marginalized communities, including those underrepresented in medicine, continue to face unique challenges in accessing mentorship opportunities and career advancement; therefore be it

RESOLVED, That ACEP create and implement a comprehensive mentorship program accessible to all members; and be it further

RESOLVED, That ACEP's mentorship program include resources to support the mentorship of members from marginalized and underrepresented communities in medicine.

**Background**

This resolution requests ACEP to create and implement a comprehensive mentorship program accessible to all members and include resources to support the mentorship of members from marginalized and underrepresented communities in medicine.

Mentorship has long been recognized as a key factor in the growth, resilience, and satisfaction of emergency physicians at every stage of their professional journey. While ACEP has historically supported mentorship efforts, the most recent structured program was the Diversity Mentoring Initiative, which operated from 2019 through 2020 with exclusive support from Vituity. This initiative, developed in partnership with ACEP's Diversity, Inclusion & Health Equity (DIHE) Section (now the Access, Belonging, & Community Section) and the EMRA Diversity & Inclusion Committee, sought to foster leadership and career development across the spectrum of emergency medicine professionals to include medical students, residents, and attending emergency physicians. The program focused particularly on building diversity and equity within the specialty and helping address long-standing disparities in mentorship access for members of historically marginalized and underrepresented communities in medicine.

Vituity supported the development and implementation of the mentorship platform with a $50,000 commitment over two years, and partnered with ACEP to shape its strategy, visibility, and growth. The platform offered participants the opportunity to engage in valuable mentor-mentee relationships with a focus on career planning, research development, leadership pathways, and cultural competency. The program was not sustained beyond 2020 despite the program's impact and its alignment with ACEP's mission and values.

Re-establishing a comprehensive and accessible mentorship program for all members managed by ACEP would need to build on the prior success of the program sponsored by Vituity and expand its reach to all members. ACEP's

Access, Belonging, & Community Committee has an objective for the FY 2025-26 committee year to "Develop guidance and recommendations for consideration by the Board for the development of a personal mentorship and support program for all members based upon each member's unique and personal professional journey in emergency medicine."

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Member Engagement and Trust: Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency medicine.

**Fiscal Impact**

Budgeted committee and staff resources to develop the framework for the program. Additional unbudgeted estimated minimum cost of $25,000 annually to support platform costs, staffing, and program coordination. Outside funding from a supporting partner or sponsor could help defray expenses.

**Prior Council Action**

Substitute Resolution 20(23) Emergency Medicine Research Mentorship Network adopted. Directed ACEP to foster collaborations with Society for Academic Emergency Medicine, Council of Residency Directors in Emergency Medicine, and Emergency Medicine Foundation, and other stakeholders to support robust research mentorship opportunities.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted. Directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members.

**Prior Board Action**

September 2024, approved the policy statement "Diversity, Equity, and Inclusion"

Substitute Resolution 20(23) Emergency Medicine Research Mentorship Network adopted.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted.

**Background Information Prepared by:** Tony Vellucci, CNE, CDE
Associate Executive Director, Emergency Medicine Foundation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 29(25)

SUBMITTED BY: Access, Belonging, & Community Section

SUBJECT: Promote Equal Access in Leadership

PURPOSE: Develop strategies and report annually on efforts to provide equal access to leadership for all members regardless of background.

FISCAL IMPACT: Budgeted committee, section, and staff resources to continue current initiatives to promote access to leadership opportunities.

WHEREAS, The American College of Emergency Physicians (ACEP) recognizes the importance of representative leadership in shaping inclusive policies, guiding organizational culture, and advancing health equity; and

WHEREAS, Diverse leadership improves organizational performance, fosters innovation, and better reflects the populations served by emergency physicians; therefore be it

RESOLVED, That ACEP develop strategies and report annually on efforts to provide equal access to leadership for all members regardless of background.

**Background**

This resolution calls for ACEP to develop strategies and report annually on efforts to provide equal access to leadership for all members regardless of background.

ACEP has long acknowledged that diverse leadership is essential to creating inclusive policies, shaping organizational culture, and ensuring equal access to emergency care. Leadership reflecting the diversity of the emergency medicine workforce and the patients served contributes to stronger decision-making, improved innovation, and greater trust among communities. ACEP's policy statement "Diversity, Equity, and Inclusion" reinforces that "diversity within our organization is crucial to reflecting the diverse backgrounds and experiences of the patients we serve." The "Workforce Diversity in Health Care Settings" policy statement affirms the importance of recruiting, retaining, and promoting individuals from historically underrepresented groups.

There are several strategies in place within chapters and national ACEP to promote leadership development and availability of volunteer leadership positions. These leadership development initiatives strive to ensure that opportunities are open to all members. The Leadership Development Advisory Committee (LDAC), as codified in the Council Standing Rules, is a Council Committee charged with identifying and mentoring diverse College members to serve in leadership roles. The LDAC provides information and guidance to members interested in College leadership opportunities and, when applicable, how to obtain and submit materials necessary for consideration by the Nominating Committee if interested in seeking nomination for the Board of Directors or as a Council officer. The role of the Nominating Committee is limited to vetting candidates submitted by component bodies or self-nominations for leadership positions elected by the Council, which include the Board of Directors, President-Elect, Speaker, and Vice Speaker. No potential candidates have ever been excluded from nomination because of gender identity, ethnicity, political or religious beliefs, or sexual orientation.

The Access, Belonging, & Community Committee (formerly the Diversity, Equity, & Inclusion Committee) has an objective for the FY 2025-26 committee year to "Develop guidance and recommendations for consideration by the Board for the development of a personal mentorship and support program for all members based upon each member's unique and personal professional journey in emergency medicine."

ACEP has taken significant steps over the past several years to address health disparities, social determinants of health, and systemic inequities within emergency medicine. Initiatives to expand leadership opportunities within ACEP's volunteer leadership structure, including sections, committees, task forces, work groups, education faculty, the Council, Board of Directors, etc., are ongoing so that future leaders reflect the full breadth and strength of the communities they serve.

Amended Resolution 12(19) ACEP Composition Annual Report directed that the Council be provided with an annual report on the demographics of councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment. A demographics report is provided to the Council annually and will continue to be provided since an end date is not specified.

ACEP will continue to promote the availability of leadership positions by publicizing national ACEP committee interest, Council committee interest, Board and Council officer nominations, etc. through promotion on the ACEP website in addition to articles in *ACEP Now,* the *EM Today* electronic newsletter, and other communication vehicles.

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Member Engagement and Trust: Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

- Build up the leadership pipeline within ACEP and throughout emergency medicine spheres of influence.
- Measure and showcase the diversity and character of ACEP leaders and members.

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

**Fiscal Impact**

Budgeted committee, section, and staff resources to continue current initiatives to promote access to leadership opportunities

**Prior Council Action**

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted. Directed ACEP to survey speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Resolution 21(21) Diversity, Equity, and Inclusion adopted. The resolution directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion and create a road map to promote diversity, equity, and inclusion. The resolution also directed ACEP to embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP and provide a report to the 2022 Council regarding the outcome of the summit.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members

Amended Resolution 12(19) ACEP Composition Annual Report adopted. Directed that the Council be provided with an annual report on the demographics of councillors and alternate councillors on a chapter-by-chapter basis, as well as

the demographics of ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted. Directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members.

Resolution 11(17) Diversity of ACEP Councillors – Bylaws Amendment not adopted. The resolution sought to amend the Bylaws to encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of membership, including candidate physician and young physician members.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to work with component bodies of the Council to develop strategies to increase diversity within the Council and its leadership.

**Prior Board Action**

The Board of Directors approves the Strategic Plan annually.

September 2024, approved the policy statement "Diversity, Equity, and Inclusion"

June 2023, approved the revised policy statement "Workforce Diversity in Health Care Settings;" revised and approved November 2017; reaffirmed June 2013 and October 2007; originally approved October 2001.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; revised and approved April 2008 with current title; originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with current title; originally approved October 2005 titled "Non-Discrimination."

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

Amended Resolution 12(19) ACEP Composition Annual Report adopted.

January 2019, accepted the final report of the Leadership Diversity Task Force.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted.

September 2018, accepted the final report of the Diversity & Inclusion Task Force.

May 2018, approved recommendations from the Leadership Diversity Task Force to collect demographic data. including the proportion of underrepresented populations within ACEP's overall membership and leadership and review the diversity data every three years and presenting the findings to the ACEP Council.

April 2017, approved the Diversity & Inclusion Task Force's recommendation to distribute a survey to the membership on diversity and inclusion to be administered by the American Association of Medical Colleges.

April 2017, approved the revised Strategic Plan objective "Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine."

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted.

April 2016, approved adding the objective "Promote and facilitate diversity and cultural sensitivity within ACEP" to ACEP's Strategic Plan.

**Background Information Prepared by:** Tony Vellucci, CNE, CDE
Associate Executive Director, EMF

Sonja Montgomery
Governance Operations Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 30(25)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Development of Research Grant Funding Opportunities Exclusively for ACEP Members as a Membership Benefit

PURPOSE: Work with EMF to develop research grant opportunities that require applicants to be ACEP members.

FISCAL IMPACT: Budgeted ACEP and EMF staff resources.

WHEREAS, ACEP founded the Emergency Medicine Foundation (EMF) in 1972 to promote research in emergency medicine; and

WHEREAS, The ACEP Council is the largest contributor to EMF annually; and

WHEREAS, The EMF is an independent organization and does not require ACEP membership to apply for or receive an EMF award; and

WHEREAS, ACEP currently lacks exclusive research grant funding opportunities for its members as a benefit of membership unlike organizations such as the Society for Academic Emergency Medicine (SAEM) and the Council of Residency Directors (CORD); and

WHEREAS, Both SAEM and CORD continue to accelerate growth of emergency medicine members by offering exclusive membership benefits including access to member only research grants, therefore be it

RESOLVED, That ACEP work with the Emergency Medicine Foundation to develop research grant opportunities that require applicants to be ACEP members.

**Background**

This resolution calls for ACEP to work with EMF to develop research grant opportunities that require applicants to be ACEP members.

EMF awards research grants to improve emergency medicine patient care. While most of the applicants are emergency physicians, EMF has awarded grants to other emergency care professionals, such as pharmacists and epidemiologists, depending on the research topic.

EMF currently partners with the Emergency Medicine Residents' Association (EMRA) and the Society for Academic Medicine Foundation (SAEMF) to award research grants to residents and medical students. The EMF partnered grants with SAEMF and EMRA do not have requirements that applicants must be members of EMRA, SAEM or ACEP.

EMF will have two grants this cycle that are not partnered grants – Pilot Studies and Early Career. The EMF Board of Trustees recently held a strategic planning meeting. One of the tasks was to develop research priorities for the next five years. The priorities the EMF Board suggested include health policy, infrastructure, health care delivery changes, and workforce. These topics may not fall under the research expertise of emergency physicians and may be better studied by non-emergency physicians. If this resolution is approved, ACEP and EMF leaders will need to determine the research priorities that can be studied solely by ACEP's emergency physician members. This may limit EMF's ability to fund certain research if ACEP members do not have expertise in certain topics.

While SAEM may require membership to apply for and be awarded a SAEMF grant, the SAEM has membership categories that are not limited to emergency physicians. Membership includes those professionals who are PhD, DSc, or equivalent who hold a university appointment or are actively involved in emergency medicine. Also, SAEM accepts physician assistant, nurse practitioner, and nurse research coordinators/project managers, lay public, and government officials as members in addition to emergency medicine pharmacists, residents, and medical students. SAEM has an emergency department administrative and business function level of membership that includes primary administration of an emergency medicine residency programs. ACEP membership is limited to emergency physicians, residents, and medical students. Providing EMF grants that require the applicant to be an ACEP member may or may not be a member benefit that increases membership.

**ACEP Strategic Plan Reference**

Practice Innovations: Develop an institutional framework that will support the creation of innovative models going forward.

**Fiscal Impact**

Budgeted ACEP and EMF staff resources.

**Prior Council Action**

None

**Prior Board Action**

None

**Background Information Prepared by:** Cynthia A. Singh, MS
Director of Grant Development
EMF Deputy Executive Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 31(25)

SUBMITTED BY: Joshua J. Davis, MD
Kenneth Frumkin, MD, PhD, FACEP

SUBJECT: Evaluate the Quality and Member Support for ACEP's Association with an Open Access Journal

PURPOSE: 1) conduct an internal review of the quality and impact of articles published in *Annals of Emergency Medicine* and *JACEP Open*; 2) survey members to assess perceptions about the *JACEP Open* publication fees; and 3) provide a report to the Council regarding the results of the quality assessment and member survey results within 12 months including any recommendations for future editorial direction or affiliation.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. Estimated cost for an outside vendor to develop and administer a survey is approximately $15,000. Loss of revenue of approximately $250,000 per year plus any fees to break the contract with the publisher, if the College determined to no longer support an open access journal.

WHEREAS, ACEP holds a central role in promoting high standards of scientific publishing and clinical excellence in emergency medicine; and

WHEREAS, ACEP is currently affiliated with both *Annals of Emergency Medicine* (a traditional subscription journal) and *JACEP Open* (an open access journal published online only); and

WHEREAS, Open access publishing models have benefits in improving access to research, but also present concerns regarding article processing charges, peer review quality, and academic prestige; and

WHEREAS, There has been increasing scrutiny across academic medicine regarding the rigor, impact, and sustainability of open access journals, and their alignment with the mission and values of professional societies; and

WHEREAS, The current article processing charge for authors hoping to publish their scientific work in JACEP Open is $2,600; and

WHEREAS, Shifting costs of publishing to researchers is unfair, especially towards researchers in resource-poor environments and disciplines; and

WHEREAS, Experts have noted that the open access model to publishing perversely incentivizes journal proliferation, but not quality of content; and

WHEREAS, It is essential to ensure that ACEP's official publications uphold the highest standards of quality, transparency, and member trust; therefore be it

RESOLVED, That ACEP initiate an internal review of the quality and impact of articles published in both its official journals, *Annals of Emergency Medicine* and *JACEP Open*; and be it further

RESOLVED, That ACEP survey its membership to assess perceptions regarding ACEP's affiliation with an open access journal with publication charges; and be it further

RESOLVED, That the findings from both a journal quality assessment and a member survey of membership perceptions regarding an open access journal be reported to the ACEP Council within 12 months of resolution adoption, along with any recommendations for future editorial direction or affiliation.

**Background**

This resolution asks ACEP to conduct an internal review of the quality and impact of articles published in *Annals of Emergency Medicine* and *JACEP Open*, survey members to assess perceptions about the *JACEP Open* publication fees, and provide a report to the Council regarding the results of the quality assessment and member survey results within 12 months including any recommendations for future editorial direction or affiliation.

Open access publication has grown steadily over the last few years; approximately 50% of scientific articles are now published open access.[1] While *Annals of Emergency Medicine* does provide a "hybrid" model for both subscription and open access (authors who want to publish their articles open access can pay the article publication charge; more information can be found here: https://www.annemergmed.com/open-access-information), the creation of a purely open access journal, i.e., *JACEP Open*, allows ACEP to retain and publish high quality articles, many of which are not accepted for publication in *Annals* because of methodological or scope concerns, that currently are submitted and published by competitor journals. Note that as of July 8, 2025, there have been 3,819 articles submitted to *JACEP Open* and of these, 2,193 (57%) were transfers from *Annals of Emergency Medicine* with 895 (41%) transferred articles accepted for publication.

*JACEP Open* provides a citable, searchable, and easily discoverable journal venue for ACEP-generated papers and educational materials, including works submitted by committees, sections, and chapters. ACEP pays the publication fees for any submissions from committees that were developed based on an objective assigned to the committee. *JACEP Open* has an impact factor of 1.9 and ranks #25 out of 56 emergency medicine journals and the journal helps position the College as a leader in the free open access medical education arena by providing high quality, open access educational materials to its members and the emergency medicine specialty as a whole.

*JACEP Open* launched in 2019 with Wiley as its publisher, with the first issue being published in January/February 2020. It quickly passed the scientific quality evaluation phase of the PubMed Central application (October 2020) and became indexed in PubMed Central. The journal was accepted into Web of Science in 2021 for coverage in the Emerging Sources Citation Index (ESCI), was accepted to Scopus in January 2022 and received its first impact factor in June 2023. Additionally, in April 2020, it was the first emergency medicine journal to publish a COVID-19 paper.

These accomplishments speak to the scientific rigor and integrity of the journal's editorial board. Editor Emeritus Henry E. Wang, MD, MS, FACEP. spearheaded the launch of the journal and its continued growth for the first five years of its existence. His dedication and energy in creating a journal from scratch, building an editorial board of recognized experts in the field of emergency medicine, including content experts in EMS, pediatrics, infectious disease, practice management, and more, were integral for the early success of the journal. Marianne Gausche-Hill, MD, FACEP, an internationally known leader in emergency medicine, recently became the second editor in chief and continues the successful growth of the journal. The journal received almost 750 manuscripts in 2024, a 20% increase over 2023. The journal's acceptance rate for scientific works in 2024 was 35%. *JACEP Open* has published 34 issues on www.jacepopen.com. The 2024 annual report can be found at https://www.jacepopen.com/article/S2688-1152(25)00034-7/fulltext.

The journal has also surpassed all financial estimates for the College. Optimistic calculations in 2020 suggested a potential return of $25,000 to the College and the actual results were double. The 2020-2024 royalty chart below displays the actual royalties *JACEP Open* received per its former contract with Wiley (25% of all revenues collected, including article publication charges, advertising, permission fees, etc.).

| JACEP Open Royalty 2020-2024 | |
|---|---|
| 2020 | $51,626 |
| 2021 | $60,273 |
| 2022 | $79,229 |
| 2023 | $52,453 |
| 2024 | $75,384 |

ACEP signed a contract with Elsevier to become the new publisher for *JACEP Open*, effective January 1, 2025.

Elsevier, in consultation with journal staff, sets the article publication charges. Elsevier's pricing models ensure attractive price/value positioning to authors and funders and a strong financial return for *JACEP Open,* both now and in the future. The pricing proposals are created by reviewing the journal's quality and competition within its specific field, including field and author community, and then proposing a model that is a competitive price/quality ratio within this group of competitors. *JACEP Open's* article publication charges are in line or less than other emergency medicine journals in Elsevier's collection. Elsevier offers discounts of 20% for papers transferred from *Annals* or if any of the authors are ACEP members.

ELSEVIER

**Article Publishing Charge (APC) price list**

**Emergency Medicine Journals**

All prices excluding taxes. Prices as of date: 09-May-2025

| ISSN | Title | Business model | List price * | | | |
|---|---|---|---|---|---|---|
| | | | USO | EUR | GBP | JPY |
| 2211-419X | African Journal of Emergency Medicine | Open access | 2,140 | 2,000 | 1,710 | 265,420 |
| 0735-6757 | The American Journal of Emergency Medicine | Hybrid | 3,980 | 3,720 | 3,190 | 493,640 |
| 0196-0644 | Annals of Emergency Medicine | Hybrid | 3,850 | 3,600 | 3,080 | 477,520 |
| 2588-994X | Australasian Emergency Care | Hybrid | 2,160 | 2,020 | 1,730 | 267,900 |
| 2688-1152 | JACEP Open | Open access | 2,600 | 2,430 | 2,080 | 322,480 |
| 0099-1767 | Journal of Emergency Nursing | Hybrid | 2,500 | 2,340 | 2,000 | 310,080 |
| 0736-4679 | The Journal of Emergency Medicine | Hybrid | 3,390 | 3,170 | 2,710 | 420,460 |
| 2405-4690 | Visual Journal of Emergency Medicine | Hybrid | 1,640 | 1,530 | 1,310 | 203,410 |

**Background Reference**

[1]Directory of Open Access Journals (DOAJ). Accessed June 30, 2025.https://doaj.org/

## ACEP Strategic Plan Reference

Member Engagement and Trust: Enhance ACEP's branded positioning and communication strategies.

## Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. The estimated cost for utilizing an outside vendor to develop and administer the survey is in the range of $15,000. Additionally, loss of revenue of approximately $250,000 per year plus any fees to break the contract with the publisher, if the College determined to no longer support an open access journal.

## Prior Council Action

None

## Prior Board Action

October 2016, approved proceeding with development of a second peer-reviewed, open access, online-only journal for ACEP.

**Background Information Prepared by:** Tracy Napper
Editorial Director, Scientific Journals

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 32(25)

SUBMITTED BY: California Chapter

SUBJECT: Transparency in Vendor and Speaker Communication Restrictions at Scientific Assembly

PURPOSE: 1) Release the current guidelines on restricted or censored topics; 2) Refrain from restricting or censoring vendors or speakers at Scientific Assembly unless such restriction is necessary to uphold legal or safety standards; 3) , Any restriction of vendors or speakers at Scientific Assembly be subject to review and approval by the Council.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS**,** ACEP's Scientific Assembly is the organization's largest educational meeting, intended to promote education, exchange of ideas, and advancement of emergency medicine practice; and

WHEREAS**,** The exhibition hall serves as a venue for attendees to engage with organizations and explore emerging practices in emergency medicine; and

WHEREAS, There are no publicly available guidelines for vendors or speakers outlining restrictions on specific words or topics; and

WHEREAS, Decisions regarding communication restrictions/censorship should be thoughtful, deliberate, and consistent with the organization's policies and ACEP's mission to promote education, evidence-based practice, and open discourse in emergency medicine; and

WHEREAS, Recent national discussions have raised concerns about the censorship or suppression of legitimate medical perspectives on topics such as gender-affirming care, reproductive health, addiction treatment, and pandemic response strategies; and

WHEREAS, Transparency around such restrictions is critical to preserve the trust of members, encourage diverse viewpoints, and ensure that evolving evidence can be freely discussed in professional forums; and

WHEREAS, Policies that limit what medical professionals may say – without clear justification or process – risk undermining scientific progress and may chill open discourse; therefore be it

RESOLVED, That ACEP publicly release its current guidelines on restricted or censored topics; and be it further

RESOLVED, That ACEP refrain from restricting or censoring vendors or speakers at Scientific Assembly unless such restriction is necessary to uphold legal or safety standards; and be it further

RESOLVED**,** That any restriction of vendors or speakers at Scientific Assembly be subject to review and approval by the Council to ensure transparency and accountability.

**Background**

This resolution requests ACEP to release the current guidelines on restricted or censored topics, refrain from restricting or censoring vendors or speakers at Scientific Assembly unless such restriction is necessary to uphold legal or safety standards. The last resolved requests that "any restriction of vendors or speakers at Scientific Assembly be subject to review and approval by the Council to ensure transparency and accountability."

Pertaining to the last resolved, although the Council can "advise and instruct the Board of Directors regarding any matter of importance to the College by means of Bylaws and non-Bylaws resolutions and other actions or appropriations enacted by the Council" (ACEP Bylaws Article VIII – Council, Section 2 – Powers of the Council), the "management and control of the College shall be vested in the Board of Directors, subject to the restrictions imposed by these Bylaws" (ACEP Bylaws IX – Board of Directors, Section 1 – Authority). It would be beyond the scope of responsibility for the Council to review and approve policies related to Scientific Assembly vendors and speakers.

Since the Council meets only once each year, at the annual meeting, it is impractical for the Council to review and approve any policy changes so that they may be enacted in a timely manner. Speakers are selected in the late winter-spring by the Scientific Assembly Planning Subcommittee for the fall annual meeting. Vendor purchases may occur at any time in advance of the annual meeting, but many, if not most, occur in the summer before the meeting.

ACEP adheres to the Council of Medical Specialty Societies (CMSS) "Code for Interactions with Companies" and ACEP's "Guiding Principles for Interactions with External Entities" to ensure that all interactions with corporate entities uphold the highest ethical standards of transparency, independence, and alignment with ACEP's goals.

*Speaker Guidelines and Educational Content*

ACEP's Scientific Assembly and educational meetings are designed to serve as premier forums for high-quality, evidence-based education for emergency physicians and related healthcare professionals. Faculty speakers are selected based on their subject matter expertise, relevant experience, and, when applicable, prior speaker evaluations and course content scores from previous engagements. Additionally, the Education Committee's Scientific Assembly Planning Subcommittee ensures all content is not contradictory to ACEP's Board approved policies. All CME-accredited content is governed by the Accreditation Council for Continuing Medical Education (ACCME) Standards for Integrity and Independence in Accredited Continuing Education, which require faculty to present fair, balanced, and scientifically valid content, free from commercial influence.

ACEP does not impose additional guidelines that restrict or censor the topics speakers may address beyond those required for CME accreditation. Presentations that comply with ACCME standards and are appropriate for our professional audience are not limited in the scope of discussion or content areas other than to ensure they do not contradict approved policies. Faculty are expected to uphold standards of professionalism, inclusion, and appropriate language, as outlined in the "Presentation Policy for ACEP Faculty." This policy is provided before the faculty agreement is signed and it reinforces ACEP's commitment to educational excellence and respect for a diverse audience.

*Exhibit Hall and Endorsements*

ACEP recognizes that some attendees may perceive the presence of exhibitors in the exhibit hall as an endorsement by the College. It is important to clarify that, while exhibitors are valued participants at Scientific Assembly, their products and services are not endorsed by ACEP. Exhibitor participation is governed by longstanding exhibit hall policies, which include restrictions on products related to firearms, tobacco, and alcohol. These policies align with ACEP's mission and are designed to maintain the integrity of the educational and professional environment of our meetings.

ACEP's rules and regulations for exhibitors state: "The Exhibitor agrees to abide by and assumes all responsibility for compliance with all pertinent laws, regulations and codes of duly authorized local, state and federal governing bodies including, but not limited to, fire, safety, environmental and health laws, ordinances, or regulations, together with the rules and regulations provided by ACEP and the operators and/or owners of the property where the exhibit space and or Event is located." The complete "Rules and Regulations" can be found **online here**. These established practices reflect ACEP's commitment to transparency, educational integrity, and trust within the emergency medicine community.

All exhibitors must meet ACEP's rules regarding "Eligibility for Exhibiting" (excerpted from the "Rules and Regulations"):

> The Event is the American College of Emergency Physicians' premier meeting. Its purpose is to enhance the professional and scientific education of the registrants in the field of emergency medicine. ACEP reserves the

exclusive and total right to control all aspects of the conduct of the Event. ACEP specifically reserves the right to determine the acceptability of applications for exhibit space. All applications must meet the following criteria:

- The products or services to be exhibited are of professional or educational interest or benefit to the registrants and are, in the opinion of ACEP, related to the field of emergency medicine or the physician's practice. Exhibiting at the Event does not imply ACEP's endorsement of products or services.
- The applicant or the goods or services to be exhibited will not be permitted if they, to the knowledge of ACEP staff, are contrary to Board-approved ACEP policies.
- The applicant is reasonably determined by ACEP to be highly ethical and reputable, and the goods and services to be exhibited are reasonably determined by ACEP not to be fraudulent.
- The applicant agrees to comply with ACEP Rules and Regulations governing the Event.
- The application and required documents must be filled out completely and accurately.
- Applications may be refused or booth space restricted due to space limitations or other reasons determined by ACEP.
- All pharmaceutical and medical device products exhibited must meet FDA guidelines and standards.
- All organizations in the Recruiting/Staffing category or those that are recruiting/staffing for physicians must complete the ACEP Employment Practices Survey. This includes physician groups, hospital systems, locums tenens companies, and government agencies. (Results of the surveys can be found on **ACEP Open Book** online.)

Exception: The only exception to the above guidelines pertains to those companies that are considered to be of "consumer interest" to the Event attendees. These companies may include, but are not limited to, automobile manufacturers, credit card companies, banking institutions, jewelers, etc. Exhibitor understands and agrees that the information contained in this website and the ACEP "Rules and Regulations" are an integral and binding part of the exhibit space contract.

ACEP reserves the right to refuse exhibits, even after an application has been approved, curtail activities, or to close exhibits or parts of the exhibit that do not by ACEP's determination comply with its rules and regulations.

In addition to the rules and regulations governing the exhibit hall, below are the terms that can be found on our Advertising Insertion Order used for conference-based advertising. These opportunities include, but are not limited to, print advertising in the "Onsite Schedule-at-a-Glance." hanging banners, escalator clings, email banner ads in daily eNewsletters, "know before you go" emails, etc.

*Advertising Insertion Order Terms*

- This order constitutes a legally binding agreement between the Advertiser and ACEP for the listed advertising opportunity(ies) at the ACEP25 Scientific Assembly, September 7-10 in Salt Lake City.
- It is represented and warranted by the Advertiser that the person signing this order is fully authorized to submit the order on behalf of the Advertiser.
- All advertisements submitted are subject to review and approval by ACEP,
- Advertisers may not use any ACEP name, mark, or logo in advertising with the exception of informational references, such as "See our booth at ACEP25 in Salt Lake City." Advertisers who violate this provision may not be allowed to participate in future ACEP meetings and may be subject to civil penalties. The ACEP25 logo may be used only with written permission from ACEP Show Management.
- The advertisement of products at ACEP25 does not constitute an endorsement by ACEP. Advertisers are not permitted to imply or represent in any media that ACEP has endorsed or approved their goods and services unless ACEP has specifically provided such an endorsement in writing.
- ACEP concludes that by signing the order, the Advertiser understands and confirms their commitment to the opportunity(ies) listed.
- If Advertiser cancels for any reason, there will be no refund, and Advertiser will remain responsible for any balance due.
- Advertiser grants ACEP a revocable, limited, non-exclusive license to use its name and logo and other pertinent intellectual property as specifically described in this Agreement and for no other purpose.

- Advertiser's Total Amount Payable listed above is due within 30 days from the date of this signed agreement by both parties and shall be payable to the **American College of Emergency Physicians** and may be mailed to: **American College of Emergency Physicians MISC ACEP | PO Box 222291 | Dallas, TX 75222-2291**
- For your accounting/legal purposes, ACEP's EIN is 38-1888798.

**ACEP Strategic Plan Reference**

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

**Fiscal Impact**

Budgeted staff resources.

**Prior Council Action**

Amended Resolution 19(23) Scientific Assembly Vendor Transparency adopted. Directed ACEP to encourage vendors recruiting emergency physicians for employment be encouraged to bring a current contract for physicians to review during Scientific Assembly exhibits and the sample contracts must include stipulations relating to non-compete clauses, due process, and policies on transparency in billing/collections.

Resolution 17(03) Certificate of Compliance referred to the Board of Directors. The resolution called for ACEP to require emergency physician staffing groups to comply with terms of a certificate as a prerequisite for being an exhibitor or sponsor for any ACEP activity. The certificate included multiple provisions that groups must attest to including "With the provisional period not to exceed one year, our physician group provides our emergency physicians access to predefined due process."

Substitute Resolution 10(01) Commercial Sponsorships adopted. The resolution called for the Board to continue initiatives to develop and implement policies on self-disclosure of compliance by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings with ACEP physicians' rights policies, including: "Emergency Physicians Rights and Responsibilities," "Emergency Physician Contractual Relationships," "Agreements Restricting the Practice of Emergency Medicine," and "Compensation Arrangements for Emergency Physicians."

**Prior Board Action**

Amended Resolution 19(23) Scientific Assembly Vendor Transparency adopted.

October 2017, approved the revised "Guiding Principles for Interactions with External Entities." These guiding principles contain the exhibitor policy contained in the "Rules and Regulations" for exhibitors.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

**Background Information Prepared by:** Robert Heard, MBA, CAE
Chief Operating Officer

Liz Cardello
Development Director

Ansley Colbeck
Senior Manager, Education Development

Stephanie Batson
Senior Manager, Exhibits and Corporate Development

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 33(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Emergency Medicine Public Education

PURPOSE: Identify and work with stakeholders to develop a public education campaign to help patients decide when it is appropriate to seek emergency care at an emergency department versus an urgent care facility.

FISCAL IMPACT: Budgeted committee and staff resources for ongoing communications work. Expanding current efforts with additional content creation and deliverables, such as video, PSA, stakeholder outreach, media placement, etc., could require additional unbudgeted costs of $100,000 – $500,000 depending on the scale and scope of the campaign.

WHEREAS, There is a spectrum of care and resources available to patients seeking urgent and emergency care in the United States, ranging from urgent care centers to freestanding emergency departments through emergency departments in hospital settings; and

WHEREAS, The available resources and capabilities across these sites often range broadly; and

WHEREAS, The cost of healthcare associated with each site varies greatly; and

WHEREAS, Patients seeking care in emergency departments for lower acuity issues that could similarly be addressed in other settings can have downstream impact to the timely care of other patients seeking care in emergency departments; and

WHEREAS, Patients seeking care at urgent care centers when they require emergency department resources can delay their care in emergent situations and increase their cost of healthcare when a patient is required to go from an urgent care center to an emergency department; and

WHEREAS, ACEP is the leader in unscheduled care in the United States and has members who practice and have expertise both in urgent care and emergency department settings; and

WHEREAS, There have been successful advertising campaigns in other countries such as England and Australia to educate patients on what complaints are better suited for an urgent care setting versus those better suited for an emergency department setting[1-4]; therefore be it

RESOLVED, That ACEP identify and work with other key stakeholders to develop a public education campaign targeted to help patients better understand which complaints are appropriate for an urgent care center environment versus an emergency department to help streamline their care and costs.

**References**


1. https://www.england.nhs.uk/urgent-emergency-care/about-uec/
2. https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-visit-an-urgent-treatment-centre/
3. https://www.health.gov.au/find-a-medicare-ucc/when-to-visit
4. https://www.aihw.gov.au/reports/primary-health-care/use-eds-lower-urgency-care-2020-21-and-2021-22/contents/lower-urgency-care/summary


## Background

This resolution calls for the College to identify and work with stakeholders to develop a public education campaign to

help patients decide when it is appropriate to seek emergency care at an emergency department versus an urgent care facility.

ACEP provides patient-facing content on www.emergencyphysicians.org. The site includes both the ACEP "Know When to Go" and "ER 101" campaigns in addition to multiple other topics. These materials are shared routinely through ACEP-owned social media channels and through traditional media.

Expanding public awareness efforts with a targeted campaign would require approximately 6-12 months from planning to launch and evaluation.

Key Steps:

- Strategy and Planning: Define goals, target audiences, and messaging.
- Stakeholder Collaboration: Identify, recruit and convene partners from urgent care associations, hospitals, insurers, and advocacy groups to co-develop and amplify the campaign.
- Content Development: Create easy-to-understand print, digital, and video materials tailored for diverse audiences.
- Campaign Launch: Roll out via social media, health care settings, and partner channels.
- Monitoring and Evaluation: Measure impact through web analytics, surveys, and care utilization trends.

Resources Needed:

- ACEP communications and public affairs staff
- Budget for content creation, media placement, and outreach (could range $100,000 – $500,000 depending on the scale and scope of the campaign)
- Input and amplification from partners

The success of such a campaign would depend on aligned messaging, amplification by trusted voices, and sustained engagement across partner channels.

**ACEP Strategic Plan Reference**

Member Engagement and Trust: Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

- Enhance ACEP brand positioning and communication strategy.

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency medicine.

**Fiscal Impact**

Budgeted committee and staff resources for ongoing communications work. Expanding current efforts with additional content creation and deliverables, such as video, PSA, stakeholder outreach, media placement, etc., could require additional unbudgeted costs of $100,000 – $500,000 depending on the scale and scope of the campaign.

**Prior Council Action**

Amended Resolution 23(21) Media Marketing of Value of Emergency Medicine Board Certification adopted. Directed ACEP to focus more on marketing to and educating the public on the value of emergency physician (as defined in ACEP's policy statement "Definition of an Emergency Physician") board certification in emergency medicine, focusing on the differences in education and training that board certified emergency physicians go through compared to non-board certified emergency physicians and non-physician practitioners; and focus more resources on a local, state, and national level campaign of marketing to the public through TV, radio, newspaper, social media, and public service announcements.

Amended Resolution 18(19) Promoting Emergency Medicine Physicians adopted. The resolution directed ACEP to create a public awareness campaign highlighting the unique skill set, knowledge base, and value of those that meet the ACEP definition of emergency physician; and partner with the American Medical Association and with other national medical specialty societies on a campaign to promote the unique skill set, knowledge base, and value of residency trained and board certified physicians.

Amended Resolution 30(17) Demonstrating the Value of Emergency Medicine to Policy Makers and the Public adopted. Directed ACEP to develop a repository of public relations materials on the ACEP Website demonstrating the value of emergency medicine and develop public relations materials regarding the value of emergency medicine for legislators; and

Amended Resolution 24(13) Promulgation of Emergency Medicine adopted. Directed ACEP to continue efforts to promulgate the value and role of emergency medicine as a critical component of an effective health care delivery system to other medical and healthcare organizations, the media, and the American public.

**Prior Board Action**

The Board has supported multiple public relations efforts to promote the value and role of emergency physicians and emergency medicine.

October 2017, approved funding of up to $100,000 to fund a study on the value and cost effectiveness of emergency care.

Amended Resolution 30(17) Demonstrating the Value of Emergency Medicine to Policy Makers and the Public adopted.

Amended Resolution 24(13) Promulgation of Emergency Medicine adopted.

**Background Information Prepared by:** Steve Arnoff
Director of Public Relations

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 34(25)

SUBMITTED BY: District of Columbia Chapter

SUBJECT: Recognition of Public Media as a Public Health Necessity

PURPOSE: Recognize public media as a public health necessity and support the use and protection of public media as a tool for improving health outcomes and enhancing emergency preparedness.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other advocacy work to support this effort.

WHEREAS, A well-informed public is essential for the prevention of disease, the promotion of healthy behaviors, and the effective response to public health emergencies[1]; and

WHEREAS, Public media reaches millions of Americans with free, fact-based, accessible information that often addresses health literacy gaps and underserved communities[2]; and

WHEREAS, Public media has historically played a critical role in communicating health information during crises such as natural disasters and disease outbreaks, particularly when other communication channels were inaccessible or distrusted[3]; and

WHEREAS, Emergency physicians are uniquely positioned to contribute to and benefit from public media's reach by communicating health guidance, correcting misinformation, and improving public trust in health care; and

WHEREAS, Diminishing funding or political threats to public media may jeopardize its ability to serve as a reliable source of timely, accurate, and science-based public health messaging; therefore be it

RESOLVED, That ACEP recognize public media as a public health necessity, which is a vital component of a well-informed public and public health infrastructure; and be it further

RESOLVED, That ACEP support the use and protection of public media as a tool for improving health outcomes and enhancing emergency preparedness.

**References**

[1] https://www.who.int/tools/your-life-your-health/a-healthy-world/people-s-roles/the-role-of-media-in-supporting-health
[2] https://cpb.org/aboutpb/what-public-media
[3] https://pmc.ncbi.nlm.nih.gov/articles/PMC3778998/

## Background

This resolution calls for the College to recognize public media as a public health necessity and support the use and protection of public media as a tool for improving health outcomes and enhancing emergency preparedness.

As of July 2025, the House has approved a Trump administration plan to rescind $9 billion in previously allocated funds, including $1.1 billion for the Corporation for Public Broadcasting (CPB). This action removes all federal support for National Public Radio (NPR), the Public Broadcasting System (PBS), and their member stations, as well as approximately $7 billion in foreign aid.

These cuts pose significant operational threats for public media outlets. NPR has warned that, "many of those stations, especially those broadcasting to rural areas or to underserved audiences, such as Native Americans, could be forced to

shut down as a result of the funding rollback." (Congress Rolls Back $9 Billion in Public Media Funding and Foreign Aid, NPR 7/18/25)

Public media airs health-focused shows and documentaries that explain medical topics, public health concerns, and wellness strategies (examples are PBS NewsHour and NOVA). Public service announcements can provide nonprofit organizations the opportunity to air short messages on issues such as mental health, nutrition and exercise, and disease prevention. Local stations can collaborate with their local health departments and community organizations to discuss local health issues. Finally children's programming teaches hygiene, emotions, and wellness.

However, the current media has changed drastically since the start of publicly supported media with many more streaming alternatives, podcasts, etc., with more access to free information than ever before. Critics contend that these services are duplicated by the media outlets of the CDC and National Institutes of Health. Others contend that while the public media has educational value, financial sustainability should come from diversified sources instead of government funding.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other advocacy work to support this effort.

**Prior Council Action**

None

**Prior Board Action**

None

**Background Information Prepared by:** Steve Arnoff
Director of Public Relations

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 35(25)


| | | |
|---|---|---|
| SUBMITTED BY: | James Humble, MD, FACEP | Delaware Chapter |
| | Joseph D. Lykins, MD | Illinois College of Emergency Physicians |
| | Daniel Martin, MD, MBA, FACEP | Dual Training Section |
| | Vinay Mikkilineni, MD | Observation Medicine Section |
| | Travis Olives, MD, MPH, FACEP | Pediatric Emergency Medicine Section |
| | Katherine Ren, DO | |


SUBJECT: Appropriate Representation in the Review Committee for Combined Emergency Medicine Residency Programs

PURPOSE: Work with the ACGME and the Emergency Medicine Review Committee to advocate for required representation from dual-trained physicians in writing requirements or create a separate Combined Emergency Medicine Review Committee.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort and engage with other subject matter experts.

WHEREAS, The American College of Emergency Physicians (ACEP) is committed to supporting the advancement of emergency medicine education across all pathways; and

WHEREAS, Combined emergency medicine residency programs are growing in number and complexity, requiring coordinated efforts to ensure educational standards, equity, and integration within the broader emergency medicine community as well as other specialties; and

WHEREAS, Our experience and research show that combined emergency medicine graduates provide unique values and perspectives reaching across departments with often taking roles in academics, leadership, education, and rural medicine while continuing to have high job satisfaction[1]; and

WHEREAS, Going forward, the Emergency Medicine Review Committee will have to dictate the unique needs and challenges of combined training pathways as they will be individually accredited and their accreditation will no longer be based on the accreditation of the parent programs (as of July 1, 2025); and

WHEREAS, Such a committee only has half the expertise to offer guidance on best practices for curriculum design, navigating dual-training requirements, faculty development, and career pathways for combined-program graduates; therefore be it

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education and the Emergency Medicine Review Committee to advocate for required representation from dual trained physicians in writing requirements or create a separate Combined Emergency Medicine Review Committee.

**Background**

This resolution requests that ACEP work with the Accreditation Council for Graduate Medical Education (ACGME) and the Emergency Medicine Review Committee to advocate for required representation from dual-trained physicians in writing requirements or create a separate Combined Emergency Medicine Review Committee
Combined emergency medicine residency training first started in 1989. There are now five Combined Emergency Medicine Residency Programs, including Emergency Medicine – Internal Medicine, Emergency Medicine – Family Medicine, Emergency Medicine – Anesthesiology, Emergency Medicine – Pediatrics, and Emergency Medicine –

Aerospace. This resolution seeks to update the composition of the ACGME Review Committee (RC) tasked with overseeing the accreditation of combined emergency medicine residency programs. Combined residency programs in emergency medicine and other specialties are increasingly important for training physicians capable of addressing diverse patient populations and complex clinical settings.

Effective February 2024, the ACGME Board of Directors approved a new plan to initiate accreditation of combined programs. Beginning July 1, 2025, and going forward, the accreditation of combined training programs will be under a single reviewing committee. There are currently 5 combined specialties.

| Specialty | Responsible RC | Number of Programs (2024 Match) | Number of Positions (2024 Match) |
|---|---|---|---|
| Aerospace-EM | Preventive Medicine | New | New |
| Anesthesia-EM | Anesthesia | 1 | 1 |
| EM-Pediatrics | EM | 4 | 8 |
| EM-Internal Medicine | EM | 13 | 34 |
| EM-Family Medicine | EM | 3 | 7 |

Currently the Emergency Medicine Review Committee includes:
3 members nominated by the American Board of Emergency Medicine (ABEM)
3 members nominated by the American College of Emergency Physicians (ACEP)
3 members nominated by the American Medical Association (AMA)
2 members nominated by the American Osteopathic Association (AOA)
1 public member
1 resident member
4 ex-officio members from each of the four constituent organizations (ABEM, ACEP, AMA, and AOA)

Review Committees currently have expertise and depth in specialty and subspecialty areas and may not have the same expertise in the combined specialty area. Dual training programs find themselves in a situation where they do not have the same representation on the RC as core programs. Requiring dual trained representatives could be the first step in advocating for improved representation on the RC. A Combined Emergency Medicine RC with appropriate representation would help support better standardization efforts, appropriate oversight, and ensure the growth and sustainability of these unique training pathways. However, given the small number of program and graduates, such an approach may not be feasible.

**Background References**

1. https://www.acgme.org/globalassets/pfassets/presentations/2025-specialty-updates/emergency-medicine-update-2025.pdf
2. https://www.acgme.org/programs-and-institutions/programs/combined-programs/
3. https://www.acgme.org/about/committees-and-members-selection-process/

## ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

## Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort and engage with other subject matter experts.

## Prior Council Action

None specific to advocating for required representation from dual trained physicians in writing requirements or to create a separate Combined Emergency Medicine Review Committee.

**Prior Board Action**

None

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
Manager, Clinical Ultrasound Accreditation Program

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 36(25)

SUBMITTED BY: California Chapter
Young Physicians Section

SUBJECT: Reaffirming Support for 3-Year and 4-Year Emergency Medicine Residency Program Accreditation

PURPOSE: Reaffirm the policy statement "Length of Residency in Training in Emergency Medicine," oppose any mandate requiring exclusive transition to three-year or four-year emergency medicine residency training without clear, substantial evidence of benefit of one training length, and reaffirm the commitment to represent ACEP policy statements when making public statements on behalf of the College.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency medicine residency programs in the United States have historically operated under both three-year and four-year training formats, each rigorously accredited by the Accreditation Council for Graduate Medical Education (ACGME); and

WHEREAS, The American Board of Emergency Medicine (ABEM) recognizes both three-year and four-year programs as valid routes to board eligibility; and

WHEREAS, Multiple peer-reviewed studies, including those published in *JACEP Open* and *AJEM*, have found no conclusive superiority in clinical performance, milestone achievement, or board certification outcomes between three- and four-year residency graduates[1-2]; and

WHEREAS, In 2023, ACEP adopted Council Resolution 22 "Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation," recognizing the value of choice in emergency medicine residency training formats and support for the continued accreditation of both three-year and four-year emergency medicine residency programs; and

WHEREAS, In April 2024, subsequent to the adoption of the aforementioned resolution, the Board adopted the policy statement "Length of Residency in Training in Emergency Medicine" affirming the value of both 3-year and 4 year programs; and

WHEREAS, The ACEP policy statement "Length of Residency in Training in Emergency Medicine" from April 2024 highlights "There is no current evidence to suggest superior or non-inferior educational outcomes of either three- or four-year programs"[3]; therefore be it

RESOLVED, That ACEP reaffirm the policy statement "Length of Residency in Training in Emergency Medicine," established by Council Resolution 22(23) recognizing the value of and supporting continued accreditation of both three- and four-year emergency medicine residency programs; and be it further

RESOLVED, That ACEP oppose any mandate requiring exclusive transition to three-year or four-year emergency medicine residency training without clear, substantial evidence of benefit of one training length; and be it further

RESOLVED, That the Board of Directors reaffirm their commitment to represent ACEP policy statements when making public statements on behalf of the College.

**Resolution References**
1. Beeson MS, Barton MA, Reisdorff EJ, et al. Comparison of performance data between emergency medicine 1-3 and 1-4 program formats. JACEP Open. 2023;4:e12991. doi:10.1002/emp2.12991
2. Nikolla DA, Zocchi MS, Pines JM, et al. Four- and three-year emergency medicine residency graduates perform similarly in their first year of practice compared to experienced physicians. Am J Emerg Med. 2023;69:100-107. doi:10.1016/j.ajem.2023.04.017
3. American College of Emergency Physicians. Length of Residency in Training in Emergency Medicine - Policy Statement. Originally approved April 2024. Available at: https://www.acep.org/patient-care/policy-statements/length-of-residency-in-training-in-emergency-medicine.

## Background

This resolution calls for ACEP to reaffirm the policy statement "Length of Residency in Training in Emergency Medicine," oppose any mandate requiring exclusive transition to three-year or four-year emergency medicine residency training without clear, substantial evidence of benefit of one training length, and reaffirm the commitment to represent ACEP policy statements when making public statements on behalf of the College.

ACEP's "Length of Residency in Training in Emergency Medicine" states:

> "The American College of Emergency Physicians (ACEP) recognizes the value of choice in emergency medicine residency training formats and supports the continued accreditation of both three-year and four-year programs. There is no current evidence to suggest superior or non-inferior educational outcomes of either three- or four-year programs. ACEP believes supporting both training formats benefits the specialty, trainees, and patients. Future changes to the length of training requirements in emergency medicine should be evidence-based."

The second resolved requesting ACEP to "oppose any mandate requiring exclusive transition to three-year or four-year emergency medicine residency training without clear, substantial evidence of benefit of one training length" would require ACEP to change the current policy. The 2023 resolution directed that ACEP support both models and did not direct ACEP to oppose a mandate.

Between 2004 and 2024, the Council has requested additional content to be added to the ACGME program requirements on multiple occasions including topics on rural medicine, telehealth, physician led teams, climate change, advocacy, early pregnancy loss, buprenorphine initiation and harm reduction skills, professional liability litigation process, risk management, sexual assault, stigma, telehealth, implicit bias training, etc. Every 10 years, the ACGME Review Committees undertake a process to revise the applicable specialty-specific Program Requirements. The process seeks input from key stakeholders and includes scenario-based strategic planning to think rigorously and creatively about what the specialty will look like in the future.[1]

In 2021, a workgroup of emergency medicine organizations convened to consider the anticipated revision of the emergency medicine program requirements. The workgroup included representatives from emergency medicine organizations, ACEP, Association of Academic Chairs in Emergency Medicine (AACEM), American College of Osteopathic Emergency Physicians (ACOEP), Council of Residency Directors in Emergency Medicine (CORD), Emergency Medicine Residents Association (EMRA), American Academic of Emergency Medicine (AAEM), AAEM Resident and Student Association (RSA), Society of Academic Emergency Medicine (SAEM), and SAEM Resident and Medical Student Association (RAMS). The group performed literature searches, reviewed existing evidence, and made consensus recommendations as a framework to guide future training requirements. The process focused on identifying gaps in current training and modifying the requirements to address them. The major consensus point was that the bar needed to be raised for emergency medicine training. Several themes emerged in the recommendations, which included procedural training, pediatric resuscitation, critical care, scholarly activity, curriculum/rotations, faculty, and facility requirements. Consensus could not be reached over the length of training, and therefore, the recommendation was that the future length of training should be based on curricular elements and the time needed to achieve competency.

The ACGME began the revision process in 2022. After nearly three years of strategic planning, data analysis, comment periods, and stakeholder input, the ACGME Emergency Medicine Review Committee released the proposed requirements on February 12, 2025.[2] The proposed changes included additional emergency medicine time, time in low

acuity and low resource time, and more pediatric and critical care exposure. New content areas added, including addiction medicine, acute psychiatric emergencies, administration, observation, and telemedicine. These additions encompass many of the content areas that have been debated at previous Council meetings and in the all-emergency medicine consensus report.

The program revision writing group also published a report entitled "Building the Future Curriculum for Emergency Medicine Residency Training." They described the process by which they "built the foundational residency curriculum to train emergency physicians of the future." They further state that they were encouraged to think about the revisions "free from constraints and biases" inherent in the current requirements used by existing programs.[3] The writing group took the approach of identifying the component blocks to build a curriculum. The themes and key insights that emerged included the length of training, curricular building blocks, resources, procedural, scholarly, and didactic aspects.

As part of the revision process, the ACGME conducted a survey of program directors to determine the ideal length of individual training components and then calculated the overall length of training needed by adding them up. The overall results of the program director's survey were an average total required training time for residents was 43.4 months (SD=10.8, median=42). According to the survey, program directors from 3-year programs summed average was 41.6 months (SD=10.4, median=40) with program directors from 4-year programs having a summed average of 50.7 months (SD=9.5, median=49).

This finding is remarkably consistent with a similar study conducted almost 10 years ago. In this 2014 study, program directors were asked about the ideal length of residency training and the ideal length of individual blocks. The ideal length of training averaged 41.5 months (SD = 5.5, range = 36 to 60 months). When asked to provide durations of individual clinical experiences for their ideal emergency medicine program, the sum total (n = 104) averaged 44.7 months (SD = 10.5). Program directors who directed and trained in PGY 1–3 format programs provided the shortest ideal duration (mean = 38.9 months), whereas program directors who directed and trained in PGY 1–4 and 2–4 format programs provided the longest ideal duration (mean = 46.6 months).

Currently, about 80% of emergency medicine residents and residencies are in the 3-year format, and according to both studies, individuals associated with 3-year formats express a preference for shorter training lengths. Interestingly, both studies found that the average ideal length of training for 3-year program directors was more than 36 months.

Studies on performance on ABEM exams and measures of clinical care and practice patterns related to efficiency, safety, and flow have found similar results for 3-year and 4-year graduates. The length of stay, patient-to-hour ratio, RVUs, and 72-hour returns were similar for all.[5,6]

Currently, the ACGME requirements allow both 3- and 4-year training formats. Emergency medicine is the only specialty that allows for two different training lengths. Only pediatrics, internal medicine, and family medicine have 3-year programs, all of which are primary care-based. All other ACGME specialties are a minimum of 4 years in length.

The ACGME requested comments about the proposed changes to the emergency medicine program requirements by May 1, 2025. ACEP President Alison Haddock, MD, FACEP, held several town hall listening sessions with members to hear comments and concerns about the proposed changes and to help inform ACEP's response to the ACGME. ACEP members were also encouraged to submit their comments directly to the ACGME. ACEP submitted comments to the ACGME by the May 1 deadline and posted a statement on the ACEP website about the response. The statement included reference to ACEP's current policy statement, based on a 2023 Council resolution, that "supports the value of both three-year and four-year emergency medicine training programs" and "acknowledges that the increasing complexity and demands of emergency medicine require us to be open-minded to the evolution of the specialty and the existing policy. ACEP supports ACGME in making changes to program requirements, including the length of training, using a robust, evidence-based approach, and gathering sufficient input from key stakeholders to inform final decisions."

**Background References**

1. Regan L, McGeeD, Davis F, Murano T. Building the Future Curriculum for Emergency Medicine Residency Training. J Grad Med Educ

2025; doi: https://doi.org/10.4300/JGME-D-25-00101.1
2. Requirements for Review and Comment: Proposed Program Requirements Emergency Medicine. Accessed Feb 16, 2025. https://www.acgme.org/globalassets/pfassets/reviewandcomment/2025/110_emergencymedicine_rc_02122025.pdf
3. Gray, BK, Lumpkin JR, Gallery ME, Rorrie CC. Length of residency training in emergency medicine: An outcome-oriented approach. Annals of Emergency Medicine, 15(4), 493.
4. Hopson L, Regan L, Gisondi MA, Cranford JA, Branzetti J. Program Director Opinion on the Ideal Length of Residency Training in Emergency Medicine. Acad Emerg Med. 2016 Jul;23(7):823-7. doi: 10.1111/acem. 12968. Epub 2016 Jun 20. PMID: 26999762.
5. Beeson MS, Barton MA, Reisdorff EJ, et al. Comparison of performance data between emergency medicine 1-3 and 1-4 program formats. JACEP Open. 2023;4:e12991. doi:10.1002/emp2.12991
6. Nikolla DA, Zocchi MS, Pines JM, et al. Four- and three-year emergency medicine residency graduates perform similarly in their first year of practice compared to experienced physicians. Am J Emerg Med. Apr 15 2023;69:100-107.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Remain diligent in addressing workforce solutions to ensure emergency physicians set the course for the future

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Resolution 22(23) Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation adopted. Acknowledges that ACEP recognizes the value of choice in emergency medicine residency training formats and supports the continued accreditation of both three-year and four-year programs.

Resolution 48(20) Residency Program Expansion referred to the Board of Directors. Requested ACEP to engage the ACGME and other stakeholders to construct objective criteria for new residency accreditation considering workforce needs, competitive advantages and disadvantages, geographic distribution, and demand for physicians.

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted. Directed ACEP to address workforce shortages and lobby for the removal of barriers to increasing the number of residency slots available in emergency medicine. Also directed ACEP to investigate broadening access to ACGME or AOA accredited emergency medicine residency programs to physicians who have previously trained in another specialty.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted. Directed ACEP to work with other emergency medicine organizations to use existing workforce data to identify current and future needs for board certified emergency physicians, recommend strategies based on the projected need to ensure appropriate numbers of emergency medicine residency graduates meet the need, and advocate to eliminate barriers to create adequate numbers of emergency medicine residency positions and achieve optimal funding for those positions.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted. Directed ACEP to continue long-range planning for projecting emergency physician needs based on patient visits and physician attrition and continue to work toward preservation of adequate numbers of residency positions in emergency medicine, and to continue intensive lobbying efforts to preserve funding for adequate numbers of residency positions in emergency medicine.

Resolution 28(92) Emergency Medicine Residency Training Pilot Program not adopted. The resolution called on ACEP to facilitate, develop, and pilot a model training program in emergency medicine designed to allow practicing emergency physicians who completed training in other specialties to meet the requirements of the RRC-EM and become eligible for the ABEM exam. The pilot programs would be completed in a timely manner, through part-time

and independent work, while in practice.

Substitute Resolution 43(91) Development of New Residency Programs adopted. The resolution directed ACEP to strongly encourage the Residency Review Committee for Emergency Medicine to consistently apply existing special requirements used in reviewing prospective emergency medicine residency programs and meet with the ACGME to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted. Directed ACEP to promote the expansion of existing and the development of additional emergency medicine programs, particularly in those areas of emergency physician shortage.

**Prior Board Action**

April 30, 2025, discussed the ACGME's proposed changes to the emergency medicine residency program requirements.

February 26, 2025, discussed the ACGME's proposed changes to the emergency medicine residency program requirements.

April 2024, approved the policy statement "Length of Residency in Training in Emergency Medicine."

Resolution 22(23) Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation adopted.

January 2021, appointed a multi-organization ACGME Emergency Medicine Requirements Consensus Task Force appointed to develop recommendations in response to Referred Resolution 48(20) Residency Program Expansion.

June 2018, reaffirmed the policy statement "Emergency Medicine Training, Competency, and Professional Practice Principles;" reaffirmed April 2012; revised and approved January 2006; originally approved November 2001.

Amended Resolution 15(09) Emergency Medicine Workforce Solution adopted.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted.

Amended Substitute Resolution 43(91) Development of New Residency Programs adopted. The Board amended the substitute resolution to meet with the Residency Review Committee for Emergency Medicine (RRC-EM) to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted**.**

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 37(25)

SUBMITTED BY: International Emergency Medicine Section
Maryland Chapter

SUBJECT: Support for Funding Resident Training Away from Home Institutions

PURPOSE: Advocate for changes in Centers for Medicare & Medicaid Services policy to allow funding of resident physicians during educational rotations outside their primary institution, including international and rural placements, to enhance cultural competence and patient care.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Emergency physicians serve an increasingly multicultural and diverse population, requiring cultural understanding to provide effective care; and

WHEREAS, Immersive experiences, whether abroad or in underserved domestic settings, offer unique opportunities to deepen cultural competence and clinical adaptability; and

WHEREAS, Current Centers for Medicare & Medicaid Services regulations prohibit funding for resident physicians during clinical rotations away from their primary training site, creating a barrier to such experiences; therefore be it

RESOLVED, That ACEP advocate for changes in Centers for Medicare & Medicaid Services policy to allow funding of resident physicians during educational rotations outside their primary institution, including international and rural placements, to enhance cultural competence and patient care.

**Background**

This resolution calls for ACEP to advocate for changes in Centers for Medicare & Medicaid Services (CMS) policy to allow funding of resident physicians during educational rotations outside their primary institution, including international and rural placements, to enhance cultural competence and patient care.

Medicare is the largest single payer for graduate medical education (GME) in the U.S., playing a central role in funding residency training programs. However, current CMS regulations typically restrict reimbursement to training that occurs within a resident's primary hospital affiliation or closely affiliated sites. These regulations limit the ability of medical residents to participate in rotations that take place in rural, underserved, or international settings – areas where clinical experience could enhance cultural competency, broaden clinical skills, and address workforce gaps. Professional liability coverage is another concern related to international rotations.

ACEP's policy statement "Workforce Diversity in Health Care Settings" illustrates the College's beliefs about the value of diversity towards inclusive work environments and equitable patient care:

- Hospitals and emergency physicians should work together to promote staffing of hospitals and their emergency departments with highly qualified individuals of diverse race, ethnicity, sex (including gender, gender identity, sexual orientation, pregnancy, marital status), nationality, religion, age, disability, or other characteristics that do not otherwise preclude an individual emergency physician from providing equitable, competent patient care.
- Attaining diversity with well qualified physicians in emergency medicine that reflects our multicultural society is a desirable goal.

- Health professionals, educators, and administrators must recognize and address institutional barriers and policies that may contribute to underrepresentation of certain groups in the workforce.
- To maintain and increase the supply of primary care physicians who care for vulnerable populations over the coming decades, educational and health care entities should establish and promote pipelines to develop and support future professionals.
- A diverse workforce can display increased cultural competence across cultural practices, languages, and social issues.
- Culturally congruent health care interactions can improve adherence, trust, and patient experience, thereby expanding quality of, and access to, care for traditionally hesitant or disengaged populations.

The policy statement also provides context about the value of increasing diversity within the health care workforce:

> "In 2004, the Institute of Medicine, later renamed the National Academy of Medicine, identified ensuring diversity in health care settings as a compelling interest. Physicians who belong to URM groups are much more likely to practice in environments where they treat minority patients and patients of lower socioeconomic strata. Studies show that diversity among health professionals promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[3-5] Additionally, increasing diversity in the workforce has the potential to reduce existing health disparities and decrease their associated economic and social burdens."

ACEP's policy statement "Cultural Awareness and Emergency Care" supports that "cultural awareness is essential to the training of health care professionals in providing quality patient care. It also confirms ACEP's position that resources should be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background.

With respect to the longstanding workforce and staffing needs for rural communities, according to the AHA nearly 35% of hospitals in the US are considered rural. The "National Study of the Emergency Physician Workforce, 2020," reported that the nation's rural emergency physician shortage is expected to worsen in the coming years, the authors note. Of the 48,835 clinically active emergency physicians in the United States, 92 percent (44,908) practice in urban areas with just 8 percent (3,927) practicing in rural communities, down from 10 percent in 2008.

There are several barriers to rural experiences for emergency medicine residents. Medicare GME funding is tied to resident rotating at the home institution, so when a resident rotates at rural site, it may result in the loss of the funding for the duration of the rotation. However, as part of the year-end omnibus appropriations package passed in December 2020, Congress included ACEP-supported provisions to address the Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations, allowing hospitals to host a certain number of medical residents for short-term rotations without triggering the permanent full-time equivalent resident cap or Per Resident Amounts (PRAs). The law also included 1,000 new Medicare-funded GME positions (the first increase in Medicare GME positions in nearly two decades), with 10 percent of those positions dedicated to rural areas. Other legislative efforts to increase the number of Medicare-funded residency positions continue, such as the "Resident Physician Shortage Reduction Act," (H.R. 3890) introduced by Reps. Terri Sewell (D-AL) and Brian Fitzpatrick (R-PA), which would add an additional 14,000 new slots over a seven-year period to train more physicians and address the projected physician shortage. The bill specifically addresses primary care and rural areas, but does not address international placements.

Accreditation Council for Graduate Medical Education (ACGME) requirements may also create challenges for faculty and supervision of residents during rural rotations, considering larger workforce and faculty shortage challenges. According to section II.B.2.g) of the ACGME Program Requirements in Emergency Medicine, "Faculty members supervising emergency medicine residents in an adult emergency department must either be ABEM/AOBEM board-eligible or have current ABEM and/or AOBEM certification in emergency medicine."

ACEP has had three separate task forces in the past ten years to address the issue of attracting emergency physicians to practice in rural areas. They have identified several strategies, including rural rotations for emergency medicine residents and loan forgiveness programs. However, a survey of emergency medicine residency graduates showed that

few, if any, of those who answered the survey took jobs in the rural area, even though those jobs paid an average of $100,000 more in compensation and included loan forgiveness programs. Though they were not asked directly why they did not take rural positions, they were asked the major factors for their decision. The most common responses were spouse, job needs, and to be near family. Despite an increased supply of emergency physicians and higher salaries in rural areas there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board-certified physicians working in rural EDs.

ACEP's current legislative and regulatory priorities for the First Session of the 119th Congress also include:

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs.
- Support innovative models of care that enable or promote access to emergency care, such as Rural Emergency Hospitals, digital health, Free Standing Emergency Departments, telehealth, etc.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

**Fiscal Impact**

Budgeted resources for current advocacy initiatives.

**Prior Council Action**

Amended Resolution 44(24) Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations adopted. The resolution directed ACEP to: 1) continued to advocate for CAH funding for emergency medicine resident rotations at rural CAHs; 2) support the Rural Emergency Medicine Section in maintaining a central "Rural Rotation List" to be managed by the section and shared with the Council of Residency Directors in Emergency Medicine; and 3) request the ACGME to encourage all emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

Amended Resolution 38(23) Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals adopted. Called for ACEP to advocate for sufficient reimbursement for emergency physician services in critical access hospitals and rural emergency hospitals to ensure the availability of board certified emergency physicians who possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient safety, and supporting the sustainability of health care services in rural communities.

Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings adopted. The resolution directed ACEP to support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work in rural settings; and support working with the Accreditation Council for Graduate Medical Education and Centers for Medicare and Medicaid Services to increase resident exposure and remove regulatory barriers to rural emergency medicine.

Resolution 49(22) Enhancing Rural Emergency Medicine Patient Care not adopted. The resolution called for ACEP to support initiatives that encourage the placement of emergency medicine-trained and board certified medical directors in all U.S. EDs, whether in person or virtual; support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-emergency medicine physicians, physician assistants, and nurse practitioners already working in rural EDs.

Resolution 35(21) Preserving Care in Rural Critical Access Hospitals and Rural Emergency Hospitals first two resolveds adopted and last three resolveds referred to the Board of Directors. The resolution directed ACEP to: 1) Support the rural critical access hospital program, including conversion of certain rural hospitals into rural emergency hospitals; 2) support rural health services research to better understand the optimal funding mechanism for rural hospitals; 3) support cost-based reimbursement for rural critical access hospitals and rural emergency hospitals at a minimum of 101% of patient care; 4) support changes in CMS regulation to allow rural off-campus EDs and rural emergency hospitals to collect the facility fee as well as the professional fee; and 5) advocate for insurance plans to aggregate all institutional and professional billing related to an episode of care and send one unified bill to the patient.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas adopted. The resolution directed that ACEP engage appropriate stakeholders, including at the federal and state levels, to find innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to work with stakeholders within the college including the Rural Emergency Medicine Section and chapters to provide a regular mechanism to seek input from rural physicians in legislation that impacts rural communities; seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Affairs Committee to reflect the fact that nearly half of all US EDs are located in rural areas.

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to Board. Directed ACEP to: 1) work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; 2) identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; 3) develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and 4) encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

**Prior Board Action**

June 2025, reaffirmed the policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" revised and approved June 2018 with the current title; reaffirmed April 2012 and October 2006; originally approved June 2000 titled "Resident Training for Practice in Non-Urban Areas."

January 2025, March 2024, February 2023, January 2022, and January 2021 approved legislative and regulatory priorities that included several initiatives related to rural emergency care.

Amended Resolution 44(24) Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations adopted.

Amended Resolution 38(23) Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals adopted.

Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings adopted.

June 2022, approved the revised policy statement "Rural Emergency Medical Care" with the current title; originally approved June 2017 titled "Definition of Rural Emergency Medicine."

Resolution 35(21) Preserving Care in Rural Critical Access Hospitals and Rural Emergency Hospitals first two resolveds adopted and last three resolveds referred to the Board of Directors.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas adopted.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

**Background Information Prepared by:** Fred Essis, MA, MBA
Congressional Lobbyist

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 38(25)

SUBMITTED BY: Jamila Goldsmith, MD, FACEP
Alexandra N. Thran, MD, FACEP
Vermont Chapter
Locum Tenens Section

SUBJECT: Inclusion of ACEP Leadership Roles as Approved Practice Improvement Activities for ABEM Certification

PURPOSE: Advocate for ABEM to acknowledge participation in ACEP leadership positions as approved practice improvement activities that meet certification requirements, work with ABEM to develop a framework outlining the specific criteria and processes by which participation in leadership roles within ACEP can be deemed as fulfilling practice improvement requirements for maintenance of certification, and work with ABEM toward implementing the criteria and process while informing ACEP members of new opportunities for fulfilling practice improvement obligations through leadership involvement.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort.

WHEREAS, The American Board of Emergency Medicine (ABEM) requires all emergency physicians to participate in approved, externally developed Practice Improvement (PI) activities as a component of their Maintenance of Certification (MOC) process; and

WHEREAS, These Practice Improvement activities are essential for ensuring that emergency physicians maintain up-to-date medical knowledge and improve the quality of care provided to patients; and

WHEREAS, The current ABEM guidelines for PI activities do not recognize participation in leadership roles within the American College of Emergency Physicians (ACEP) – including serving on national committees, state chapter leadership positions, national leadership positions, including serving on the ACEP board, or fulfilling roles as a section chair, section board member, councilor, or Council Speaker or Vice-speaker as qualifying for fulfilling PI requirements; and

WHEREAS, Engaging in ACEP leadership roles fosters professional development, enhances the practice of emergency medicine, and contributes to the advancement of the profession by allowing physicians to influence policies and practices that directly affect patient care; and

WHEREAS, Recognizing these leadership roles as valid Practice Improvement activities would not only incentivize greater participation in ACEP leadership but would also enhance the overall quality of emergency medicine practice through shared leadership experiences and collective improvements in patient care; therefore be it

RESOLVED, That ACEP advocate for the American Board of Emergency Medicine to acknowledge participation in ACEP leadership positions as approved practice improvement activities that meet certification requirements; and be it further

RESOLVED, That ACEP collaborate with the American Board of Emergency Medicine to develop a framework outlining the specific criteria and processes by which participation in leadership roles within ACEP can be deemed as fulfilling practice improvement requirements for maintenance of certification; and be it further

RESOLVED, That ACEP and the American Board of Emergency Medicine work toward implementing the

criteria and process while informing ACEP members of new opportunities for fulfilling practice improvement obligations through leadership involvement.

**Background**

This resolution seeks for ACEP advocate for ABEM to acknowledge participation in ACEP leadership positions as approved practice improvement activities that meet certification requirements, work with ABEM to develop a framework outlining the specific criteria and processes by which participation in leadership roles within ACEP can be deemed as fulfilling practice improvement requirements for maintenance of certification, and work with ABEM toward implementing the criteria and process while informing ACEP members of new opportunities for fulfilling practice improvement obligations through leadership involvement.

One of the elements of ABEM's continuing certification process is the Improvement in Medical Practice (IMP). This requirement focuses on practice-based learning and improvement in areas such as patient care and communication. To fulfill this requirement you must attest to the completion of one **Patient Care Practice Improvement (PI) Activity** during each 5-year certification cycle.

According to the ABEM, a Practice Improvement (PI) activity is a structured process where emergency physicians assess their clinical practice, identify areas for improvement, implement changes, and then re-evaluate those changes to ensure they have a positive impact on patient care. It is a core component of ABEM's Maintenance of Certification program, requiring physicians to demonstrate ongoing commitment to improving their practice.

To be considered a valid PI activity for ABEM, it must include the following four steps:

1. Measurement: The physician selects a specific clinical care process, outcome, or area related to the Model of the Clinical Practice of Emergency Medicine and collects data on it, focusing on at least ten patients.
2. Comparison to Standards: The collected data is compared to established benchmarks, guidelines, or standards of care to identify areas where performance falls short.
3. Improvement: The physician implements changes or interventions aimed at addressing the identified gaps in performance, such as adopting new protocols, enhancing communication, or modifying workflows.
4. Re-measurement: After implementing the changes, the physician re-measures the same clinical care process or area to assess the impact of the interventions and confirm whether the desired improvements were achieved.

Finally, after completing the activity, the physician must attest to the activity and submit the name of the person who can verify completion of the PI activity. This is considered a fifth step in addition to the four steps of the traditional PI process.

Examples of PI activities include projects focused on improving:

- Door-to-doctor times: Reducing the time it takes for patients to be seen by a physician.
- Door-to-balloon times: Reducing the time it takes for patients with ST-elevation myocardial infarction (STEMI) to receive percutaneous coronary intervention (PCI).
- Pain management: Improving the timeliness and effectiveness of pain management for patients with various conditions.
- Patient experience: Enhancing patient satisfaction and communication.
- Throughput times: Improving the efficiency of patient flow through the emergency department.
- Compliance with clinical guidelines: Ensuring adherence to established guidelines for specific conditions or procedures.

ABEM also provides resources and guidance on how to select, implement, and report PI activities through their portal and through resources like the ABEM Improvement in Medical Practice Attestation Process.

Currently, ABEM requires a patient improvement plan to be completed based on a physician's own patient data. For emergency physicians who work at multiple sites or perform locums work, the process can be more challenging. This is especially true as they may not be participating or part of ongoing department-sponsored PI activities like door-to-balloon time and other measures.

This resolution proposes that ACEP support participation in College leadership activities in lieu of the local PI activities. Leadership participation would include chapter and section leadership roles, serving on national committees, participating in Council meetings, or serving on the Board of Directors. Careful consideration would be needed to create a model where ACEP service would follow the four steps of patient care practice improvement (measure, compare to standard, implement an improvement, and re-measure) to meet the ABEM requirement.

**Background References**
https://www.abem.org/stay-certified/improvement-in-medical-practice/
https://www.abem.org/wp-content/uploads/2024/07/imp-faqs.pdf
https://www.abem.org/wp-content/uploads/2024/07/practice-improvement-guide.pdf

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort.

**Prior Council Action**

Resolution 24(17) Maintenance of Competence for Practicing Emergency Physicians referred to the Board of Directors. The referred resolution sought for ACEP to: 1) study the needs and cost-effective evidence-based requirements to support practicing board-certified emergency physicians to demonstrate ongoing competence and skills necessary for their own practice setting; 2) Develop appropriate guidelines for "maintenance of competence" with minimum and legitimate barriers to continued practice; and 3) Develop a report for the 2018 Council.

Amended Resolution 31(15) American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure adopted. Directed ACEP to communicate appreciation to ABEM for sensitivity in interpreting ABMS mandates; develop policy supporting the ABMS MOC as appropriate state medical license MOL, but actively oppose mandates that linking MOC as requirements for ongoing MOL; and develop policy opposing efforts of ABMS and its specialty boards to become independent sole source and for-profit autonomous entities mandating continuing education credit and uncontrolled fiduciary and financial autonomy

**Prior Board Action**

April 2023, approved revised policy statement ACEP Recognized Certifying Bodies in Emergency Medicine

October 2016, the Board approved the committee's recommendations regarding Amended Resolution 31(15) to: 1) communicate appreciation to ABEM for its efforts in the realm of ABMS mandates; 2) take no further action *at this time* regarding development of a policy opposing mandates linking maintenance of certification as the only path to maintenance of licensure; and 3) take no further action *at this time* regarding development of a policy opposing specialty boards as the sole source mandating continuing education credit.

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs.

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 39(25)

SUBMITTED BY: New Mexico Chapter
Michigan College of Emergency Physicians

SUBJECT: Support Board Certification as an Exemption for State Mandated CME Topics

PURPOSE: 1) Collaborate with ABEM, AOBEM, and ABMS to advocate to states that board certification should be an exemption and obviates the need for state-mandated CME. 2) ACEP, ABEM, AOBEM, and ABMS work with state medical boards and state legislatures to ensure CME for non-boarded physicians is specialty-relevant and based on science. 3) ACEP develop and disseminate educational materials about the problem with state-mandated CME requirements that can be used for advocacy.

FISCAL IMPACT: Opposing merit badges and mandated CME is a current initiative of the College. The advocacy component and the development of educational materials are unbudgeted and would require diverting current budgeted staff resources from other work to support this effort.

WHEREAS, State legislatures increasingly mandate continuing medical education (CME) topics for physician licensure, often without adequate medical oversight; and

WHEREAS, Forty states currently mandate one or more CME topics such as pain management, palliative care, geriatrics, medical ethics, professional responsibility, sexual harassment prevention, cultural competency, implicit bias training, infection control, child abuse, patient safety, behavioral health, sexual assault, domestic violence, medical error prevention, diversion and addiction, risk management, suicide prevention, human trafficking, and weapons of mass destruction; and

WHEREAS, Available courses to fulfill these legislatively mandated CME topics may lack relevance to specific medical specialties, potentially diverting physicians from essential, specialty-specific education; and

WHEREAS, The American Board of Medical Specialties (ABMS) board certification process is designed to ensure rigorous and comprehensive physician knowledge within their respective specialties; and

WHEREAS, Board certification and maintenance of certification processes already address many of the core competencies targeted by state-mandated CME, potentially leading to redundant and less specialty-specific educational requirements; and

WHEREAS, Precedent exists for the exemption of board certified physicians from other mandated CME such as the exemption of “all practitioners that are board certified in addiction medicine or addiction psychiatry” from the 2023 Consolidated Appropriations Act of 2023, which mandated eight hours of opioid CME for Drug Enforcement Agency (DEA) certificate renewal; and

WHEREAS, The imposition of disparate state-mandated CME topic requirements creates an administrative burden for physicians holding licenses in multiple states; and

WHEREAS, The potential exists for politically motivated or scientifically unsound state-mandated CME topics to negatively impact patient care; and

WHEREAS, ACEP has previously lobbied against “merit badge” medicine such as ATLS, ACLS, and more as superfluous for American Board of Emergency Medicine (ABEM) and American Osteopathic Board of Emergency Medicine (AOBEM) boarded emergency physicians; and

WHEREAS, ACEP, ABEM, AOBEM, and ABMS share a commitment to ensuring the highest standards of physician competence and patient care; therefore be it

RESOLVED, That ACEP actively engage with the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, and the American Board of Medical Specialties to advocate for the recognition of board certification as an exemption for relevant state-mandated CME requirements; and be it further

RESOLVED, That ACEP, in collaboration with American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, and the American Board of Medical Specialties, and other relevant medical organizations, initiate a proactive effort to work with state medical boards and legislatures to ensure that mandated continuing medical education topics for non-boarded physicians are evidence-based, specialty-relevant, and aligned with the principles of best medical practice; and be it further

RESOLVED, That ACEP create and distribute educational materials to its members highlighting the potential pitfalls of poorly designed state-mandated "merit badge" continuing medical education and the benefits of relying on American Board of Medical Specialties board certification for ensuring physician competence and support its members in their efforts to educate and advocate to state legislatures on this issue.

**Background**

This resolution asks for ACEP to collaborate with ABEM, AOBEM, and ABMS to advocate to states that board certification should be an exemption, thereby obviating the need for state-mandated CME. Additionally, it asks that these groups work with state medical boards and state legislatures to ensure that CME for non-boarded physicians is specialty-relevant and based on science. Finally, the resolution calls on ACEP to develop and disseminate educational materials about the problem with state-mandated CME requirements that can be used for advocacy.

Physicians' continuing medical education (CME) requirements vary significantly by state. Generally, states require a specific number of CME hours within a set timeframe (e.g., every two years) for license renewal. Some states may also have specific requirements for certain topics, such as pain management, opioid use disorders, or geriatric care.

ACEP has engaged in many efforts to educate hospitals and medical staff credentialing entities on the training, core competencies and scope of care that is encompassed in accredited emergency medicine residency training and validated via subsequent board certification by the ABEM, AOBEM, or American Board of Pediatrics (ABP) and ABEM partner boards for dual/subspecialties. Emergency physicians are trained in a broad range of acute medical conditions during residency and must complete an intensive written and oral examination demonstrating mastery of the skills necessary to diagnose and treat these conditions. Emergency physicians must complete their Maintenance of Certification, which tests these skills on an ongoing basis, to maintain board certification.

ACEP has a number of existing policies regarding required CME and short courses.

The policy statement "CME Burden" discusses the increasing burden of required courses. The policy states:

> "The American College of Emergency Physicians (ACEP) believes that continuous board certification by the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, skills, and current understanding in the practice of emergency medicine regardless of any additional CME mandated or obtained."
>
> and
>
> "Therefore, ACEP, in supporting high-quality, safe, and efficient emergency care for all patients, believes that CME requirements as a part of maintenance of board certification should be self-determined by the specialty organization and by practicing emergency physicians to reflect their practice environments."

ACEP's policy statement "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment" states:

> "The American College of Emergency Physicians (ACEP) believes that board certification by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, knowledge, and skill in the practice of emergency medicine." It goes on to say that ACEP strongly opposes required completion of courses such as "Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), and Basic Trauma Life Support (BTLS), or a specified number of CME hours in a sub-area of emergency medicine, as conditions for privileges, renewal of privileges, employment, qualification by hospitals, government agencies, or any other credentialing organization's standards to provide care for designated disease entities."

ACEP's policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" states:

> "ACEP believes that the ED medical director* should be responsible for assessing and making recommendations to the hospital's credentialing body related to the qualifications of providers of emergency care with respect to the clinical privileges granted to them. At a minimum, those applying for privileges as emergency physicians should be eligible for ACEP membership. Board certification by ABEM or AOBEM, or pediatric emergency medicine subspecialty certification by the American Board of Pediatrics is an excellent, but not the sole benchmark for decisions regarding an individual's ability to practice emergency medicine. Especially in rural areas, physicians who trained in other specialties may provide emergency care and be granted privileges by an objective measurement of care provided, sufficient experience, prior training, and evidence of continuing medical education."
>
> "*ED medical director refers to the chair, medical director, or their designee."

ACEP provides a set of personalized cards attesting they are currently board certified by ABEM or AOBEM and have expertise in procedural sedation, cardiac resuscitation, and trauma. ABEM also offers a personalized letter attesting to these same areas of expertise.

ACEP is a CME partner for an ABEM MyEMCert module on resuscitation and physicians receive a certificate of completion.

ACEP is heavily involved with other emergency medicine organizations opposing such requirements, particularly when the material is already part of emergency medicine certification/maintenance of certification. In early 2017, the Coalition Opposing Medical Merit Badges (COMMB, now called COBCEP – the Coalition of Board Certified Emergency Physicians) was formed with the following members: American Academy of Emergency Medicine (AAEM), AAEM/RSA, ABEM, ACEP, Association of Academic Chairs in Emergency Medicine (AACEM), Council of Residency Directors in Emergency Medicine (CORD), Emergency Medicine Residents' Association (EMRA), and the Society for Academic Emergency Medicine (SAEM). SAEM/RAMS has subsequently joined the coalition. The purpose of the coalition states:

> "Board-certified emergency physicians who actively maintain their board certification should not be required to complete short-course certification in advanced resuscitation, trauma care, stroke care, cardiovascular care, or pediatric care in order to obtain or maintain medical staff privileges to work in an emergency department. Similarly, mandatory targeted continuing medical education (CME) requirements do not offer any meaningful value for the public or for the emergency physician who has achieved and maintained board certification. Such requirements are often promulgated by others who incompletely understand the foundation of knowledge and skills acquired by successfully completing an Accreditation Council for Graduate Medical Education–accredited Emergency Medicine residency program. These "merit badges" add no additional value for board-certified emergency physicians. Instead, they devalue the board certification process, failing to recognize the rigor of the ABEM Maintenance of Certification (MOC) Program. In essence, medical merit badges

> set a lower bar than a diplomate's education, training, and ongoing learning, as measured by initial board certification and maintenance of certification. **The Coalition finds no rational justification to require medical merit badges for board-certified emergency physicians who maintain their board certification.** Our committed professional organizations provide the best opportunities for continuous professional development and medical merit badges dismiss the quality of those educational efforts."

The coalition has met at least quarterly since 2017. Through the years the group has created the aforementioned letter from ABEM and cards from ACEP and AAEM, worked to clarify the requirements of The Joint Commission (TJC), worked with the American College of Surgeons Committee on Trauma (ACS-COT) which ultimately removed the requirement for Advanced Trauma Life Support (ATLS) for ABEM/AOBEM certified emergency physicians, worked with the VA hospital and American Society of Anesthesiology on a procedural sedation policy, clarification of the Pediatric Emergency Care Coordinator as part of the Pediatric Readiness Project, sent multiple letters and personal contacts regarding the NY State requirement for Pediatric Advanced Life Support/Advanced Pediatric Life Support (PALS/APLS), created a letter regarding a waiver of required CLIA competency assessments for point of care testing, and opposed Pennsylvania Department of Health requirement for Basic Cardiac Life Support (BCLS) training. In 2019, COMMB changed its name to the Coalition of Board Certified Emergency Physicians (COBCEP) and they continue to work on the military requirement for Basic Life Support (BLS) and requirements for BLS, ACLS, and PALS for emergency physicians who practice in Puerto Rico. The group is currently working on the impact of state required physician education. After ACEP assisted with pilot testing through the Emergency Medicine Practice Research Network, ABEM sent a survey to their diplomates regarding the types of courses required, the estimated time to complete these requirements, the estimated cost of meeting these requirements, and the usefulness of the material required. Several thousand individuals completed the survey. Their findings have been published in *JACEP Open*.[1] Key findings show that 83.6% of physicians practicing in states with state-mandated, topic-specific CME requirements perceived that participation in ABEM continuing certification could be used to reduce the need for state-mandated, topic-specific CME requirements, and 70.8% believed that state-mandated, topic-specific requirements were unlikely to improve patient care. The authors concluded that, although well-intended, state CME requirements may lack relevancy and could place an undue burden on emergency physicians. Tailoring CME requirements to increase relevance to their patient populations and reducing barriers to completing CME could enhance knowledge translation and improve patient outcomes.

The Federation of State Medical Boards (FSMB) serves as a central resource for state medical boards, supporting them in their efforts to protect the public's health and safety through various means. They achieve this by providing education, assessment, data, research, and advocacy, ultimately promoting patient safety, quality healthcare, and regulatory best practices. Advocating with the FSMB to use ABEM/AOBEM board certification to eliminate the need for state-specific CME would probably be an important step.

This resolution would also seek to ease the state-specific CME burden for legacy emergency physicians by ensuring the requirements are evidence-based and relevant to the practice of emergency medicine.

ACEP's policy statement "The Role of the Legacy Emergency Physician in the 21st Century" states:

> "ACEP acknowledges that emergency medicine's development and rapid growth resulted in a workforce that includes physicians who are not eligible for ABEM or AOBEM specialty certification. These legacy emergency physicians, many of whom are residency trained and/or board certified in other specialties, began the practice of emergency medicine prior to the 21st century.
>
> ACEP acknowledges that legacy emergency physicians, by virtue of their primary training and emergency medicine practice experience, still play an important role in the current emergency medicine workforce and patient care safety net."

**Background Reference**

1. Gausche-Hill, M., Bhakta Y., Bond, M. C., Schneider, S. M., Druck, J., Livingston, C. E., Moreno-Walton, L., Jones, J. S., and Barton, M. A. (2024). Emergency physicians' perspectives of state continuing medical education requirements for medical licensure. Journal of the American College of Emergency Physicians Open, 5(5). **https://doi.org/10.1002/emp2.13314**

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

**Fiscal Impact**

Opposing merit badges and mandated CME is a current initiative of the College. The advocacy component and the development of educational materials are unbudgeted and would require diverting current budgeted staff resources from other work to support this effort.

**Prior Council Action**

Resolution 54 (23) Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions adopted. Directed ACEP to discuss with TJC ACEP's opposition to credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

Amended Resolution 43(15) Required CME Burden adopted. Called for the College to address annual requirements for CME in specific areas that could lead to reduced ongoing education in other clinical area and work with other organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to care for all ED patients.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted. Directed ACEP to adopt a position that board certification in emergency medicine through the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, and/or sub-board on Pediatric Emergency Medicine of the American Board of Pediatrics, along with participation in Maintenance of Certification programs currently required by these Boards is sufficient for practicing emergency physicians to maintain hospital privileges, health plan participation and medical group inclusion, and Maintenance of Licensure, and requiring additional certifications beyond board certification for emergency physicians, such as Basic Life Support, Advanced Cardiac Life Support, Advanced Trauma Life Support, and Pediatric Advanced Life Support, and other maintenance programs is redundant and unnecessary.

Resolution 21(09) Opposition to Credentialing, Certification, or "Signing-Off" Processes by Other Specialties adopted. Directed ACEP to establish College liaisons and relationships with other medical specialty societies, the American Medical Association, the Alliance for Specialty Medicine, the Coalition for Patient -Centric Imaging, and other interested parties actively and fully opposes the imposition upon the specialty of Emergency Medicine of a requirement of any credentialing, certification, or "signing -off" process by other specialties for any core skill within the scope of practice of emergency medicine.

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted. This resolution called for the College to open dialogue with the American Hospital Association, third party payers, and accreditation entities regarding the inappropriate use of ACLS and similar courses for credentialing of board-certified emergency physicians.

Amended Resolution 14(98) Merit Badge Medicine referred to the Board. This resolution called for the College policy on "Merit Badge Medicine" to read as follows: The ACEP believes that certification of knowledge and skills in emergency medicine can result only from successful completion of examinations administered by a recognized board in emergency medicine. The successful completion of any course, or series of courses, or a specified number of CME hours in a sub-area of emergency medicine, may serve as evidence of knowledge and skill of a certain sub-area of medicine. However, the completion of such does not serve as an acceptable substitute for certification of knowledge and skills to practice emergency medicine. Therefore, ACEP opposes the use of certificates of completion of courses

such as ATLS, ACLS, PALS, BTLS or a specified number of CME hours in a sub-area of emergency medicine as requirements for credentialing or employment of any physician certified in emergency medicine by the ABEM or the AOBEM.

Substitute Resolution 9(91) Merit Badge Medicine adopted. The resolution called for the College to request ABEM provide a statement that board certification supersedes successful completion of courses taught in ACLS, ATLS, APLS, etc., and that ACEP disseminate its current policy on "Merit Badge Medicine" with recommendations on methods for their use by membership.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted. This resolution called for the College to develop appropriate language that can be incorporated into legislation and regulations that would reflect the College's position opposing the use of certificates of completion of short courses in special areas relating to emergency medicine as criteria for employment, staff appointment, licensure, or facility designations when such physicians are board certified in emergency medicine.

**Prior Board Action**

March 2024, approved the revised policy statement "The Role of the Legacy Emergency Physician in the 21st Century;" reaffirmed February 2018 and April 2012; originally approved June 2006.

January 2024, reaffirmed the policy statement "Emergency Medicine Training, Competency, and Professional Practice Principles;" reaffirmed June 2018 and April 2012; revised and approved January 2006; originally approved November 2001.

Resolution 54 (23) Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions adopted.

January 2022, approved the revised policy statement "CME Burden;" originally approved April 2016.

January 2022, approved the revised policy statement, "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment" revised and approved January 2016 and April 2012; reaffirmed September 2005; Revised in June 1999, June 1997, August 1992; originally approved January 1984 titled "Certification in Emergency Medicine.

April 2017, approved the revised policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" revised and approved October 2014, June 2006, and June 2004; reaffirmed October 1999; Revised with current title September 1995 and June 1991; originally approved April 1985 titled, "Guidelines for Delineation of Clinical Privileges in Emergency Medicine."

Amended Resolution 43(15) Required CME Burden adopted.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted.

Resolution 21(09) Opposition to Credentialing, Certification, or "Signing-Off" Processes by Other Specialties adopted.

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted.

Substitute Resolution 9(91) Merit Badge Medicine adopted.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted.

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 40(25)

SUBMITTED BY: Access, Belonging, & Community Section

SUBJECT: Support Ongoing Education on Implicit Bias and Structural Inequity

PURPOSE: Provide and encourage ongoing education for members on implicit bias systemic, inequities, culturally responsive, and equal access to care for all.

FISCAL IMPACT: Budgeted committee and staff resources for current and ongoing initiatives.

WHEREAS, Implicit bias and structural inequities significantly contribute to disparities in health care access, quality, and outcomes, particularly in emergency medicine; and

WHEREAS, Ongoing education on these topics equips physicians to deliver more equitable, culturally responsive care and aligns with ACEP's commitment to lifelong learning and professional development; therefore be it

RESOLVED, That ACEP provide and encourage ongoing education for members on implicit bias, systemic inequities, culturally responsive, and equal access to care for all as part of its life-long learning commitment.

**Background**

This resolution requests ACEP to provide and encourage ongoing education for members on implicit bias, systemic inequities, culturally responsive, and equal access to care for all as part of its life-long learning commitment.

Implicit biases – unconscious attitudes or stereotypes – can have negative influences on clinical decision-making, communication between patients and physicians or other health care professionals, and perpetuate health disparities, particularly for marginalized groups. These biases can lead to inequitable care, reduced patient trust, and poorer health outcomes.[1-5] Education that addresses implicit bias increases awareness of self-biases, provides strategies to mitigate their impact, and fosters critical reflection, which are essential for delivering equitable care. Without such education, biases may remain unrecognized and unaddressed, contributing to ongoing disparities in health care delivery and outcomes. Integrating implicit bias education is a critical step toward advancing health equity and professionalism in medicine[1-5]

ACEP has taken several steps to address implicit bias within emergency medicine. These actions include developing and promoting educational resources, supporting policy changes, and encouraging open dialogue about bias.[6-8] Amended Resolution 14(19) Implicit Bias Awareness and Training called for developing and publicizing a policy statement that promotes implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles; and continue to create and advertise free, CME- eligible, online training related to implicit bias. The policy statement "Implicit Bias Awareness and Training" was developed in response to Amended Resolution 14(19). Additionally, a Policy Resource & Education Paper (PREP) was developed by the Academic Affairs Committee as an adjunct to the policy statement. (The PREP is pending journal publication. It will be available on the ACEP website as soon as available.)

ACEP currently offers a wide range of educational content and resources to address implicit bias. The following educational sessions have been presented at previous ACEP annual meetings and are available in ACEP Anytime:

Racism and Bias in the ED Environment (2024) – Jenice Baker, MD, FACEP
How to Talk About Race and Medicine With Patients (2024) – Jenice Baker, MD, FACEP

Belonging: The Intersection of Diversity, Equity and Inclusion and Physician Well-Being (2024)
- Al'ai Alvarez, MD, FACEP

Belonging: The Intersection of Diversity, Equity, and Inclusion, and Physician Well-Being (2023) – Al'ai Alvarez, MD, FACEP
Unlearning Implicit Bias 2023 – Al'ai Alvarez, MD, FACEP
Unlearning Implicit Bias 2022 – Bernard Lopez, MD, FACEP

ACEP Anytime will be updated to include additional courses as they are developed.

Recently, several states have enacted laws restricting or banning certain types of implicit bias training, particularly in educational and health care settings. Florida, North Dakota, Tennessee, and Texas have passed legislation restricting the use of state or federal funds for diversity, equity, and inclusion (DEI) programs, including mandatory implicit bias training. Tennessee has gone further by prohibiting public institutions from mandating implicit bias training for educators and employees, according to Tennessee State Government (.gov). These laws often focus on prohibiting mandatory training that promotes what they consider "divisive concepts" or "identity politics." Other states such as California, Delaware, Maryland, Massachusetts, Michigan, New Jersey, and Washington have enacted legislation requiring implicit bias training, especially for health care providers. Illinois and Minnesota also have such requirements for health care professionals.[9] It is important to note that the legal landscape regarding implicit bias training is complex and constantly evolving. Some laws prohibiting bias training have faced legal challenges. Additionally, some states or organizations may still implement such training without a specific state mandate, or even if they face restrictions, they may adapt their training programs to be compliant with current laws and regulations.

Both the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) have recently taken steps to suspend enforcement of certain "diversity" requirements. This action follows concerns about potential conflicts between these requirements and state laws, as well as criticism from some regarding the emphasis on DEI in medical education.[10,11]

**Background References**

1. Twelve Tips for Teaching Implicit Bias Recognition and Management. Gonzalez CM, Lypson ML, Sukhera J. Medical Teacher. 2021;43(12):1368-1373. doi:10.1080/0142159X.2021.1879378.
2. The Time Is Now: Addressing Implicit Bias in Obstetrics and Gynecology Education. Royce CS, Morgan HK, Baecher-Lind L, et al. American Journal of Obstetrics and Gynecology. 2023;228(4):369-381. doi:10.1016/j.ajog.2022.12.016.
3. Educational Strategies in the Health Professions to Mitigate Cognitive and Implicit Bias Impact on Decision Making: A Scoping Review. Thompson J, Bujalka H, McKeever S, et al. BMC Medical Education. 2023;23(1):455. doi:10.1186/s12909-023-04371-5.
4. Implicit Bias in Health Professions: From Recognition to Transformation. Sukhera J, Watling CJ, Gonzalez CM. Academic Medicine : Journal of the Association of American Medical Colleges. 2020;95(5):717-723. doi:10.1097/ACM.0000000000003173.
5. Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs. Vela MB, Erondu AI, Smith NA, et al. Annual Review of Public Health. 2022;43:477-501. doi:10.1146/annurev-publhealth-052620-103528.
6. https://www.acep.org/news/acep-newsroom-articles/change-is-happening-fast-acep-is-your-voice-in-washington-when-it-matters-most
7. https://www.acepnow.com/article/addressing-bias-racism-and-disparities-in-the-emergency-department/
8. https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/implicit-bias-and-cultural-sensitivity---effects-on-clinical-and-practice-management.pdf
9. https://www.asha.org/advocacy/state/state-mandates-around-diversity-equity-and-inclusion/states-with-restrictions-on-diversity-equity-and-inclusion-concepts-in-higher-education/
10. https://www.acgme.org/newsroom/2025/5/acgme-board-executive-committee-action/#:~:text=The%20ACGME%20has%20heard%20significant,for%20approval%20of%20accreditation%20requirements.
11. https://lcme.org/announcement-may-19-2025/#:~:text=On%20May%2019%2C%202025%2C%20the,information%20related%20to%20Element%203.3.

## ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head-on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment
- Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

## Fiscal Impact

Budgeted committee and staff resources for current and ongoing initiatives.

**Prior Council Action**

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted. The resolution directed ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism as it pertains to emergency care; continue to explore models of health care that would make equitable health care accessible to all; and continue to use its voice as an organization and support its members who seek to reform discriminatory systems and advocate for policies promoting the social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members.

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

**Prior Board Action**

September 2024, approved the policy statement "Diversity, Equity, and Inclusion."

July 2024, reviewed the "Implicit Bias Awareness and Training" Policy Resource & Education Paper (PREP).

June 2023, approved the revised policy statement "Workforce Diversity in Health Care Settings;" revised and approved November 2017; reaffirmed June 2013 and October 2007; originally approved October 2001.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; revised and approved April 2008 with current title; originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with current title; originally approved October 2005 titled "Non-Discrimination."

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

Substitute resolution 41(05) Sexual Orientation Non-Discrimination adopted.

October 2017, reviewed the information paper "Disparities in Emergency Care."

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 Council Meeting
# Reference Committee Members

**Reference Committee B – Advocacy & Public Policy**
Resolutions 41-60

Erik Blutinger, MD, MSc, FACEP (NY) – Chair
Brett H. Cannon, MD, JD, MBA, FACEP (GA)
Carrie de Moor, MD, FACEP (TX)
Comfort A. Orebayo, DO (CA)
George RJ Sontag, MD, FACEP (OH)
James C. Mitchiner, MD, MPH, FACEP (MI)

Brianna Hanson, MPH
Ryan McBride, MPP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 41(25)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Advocate for No-Fault Medical Liability Reform and Redefinition of Negligence in Health Care

PURPOSE: 1) Support the development and implementation of a no-fault medical liability system that prioritizes patient compensation and systemic health care improvements over physician punishment; 2) Collaborate with stakeholders and legal experts to advocate for legislative and regulatory changes to shift away from a fault-based system to a no-fault compensation model; and 3) Promote reevaluation of the legal definition of negligence in health care advocating for a standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and aligns with the American Law Institute's updated guidelines to better reflect modern health care practice and patient safety goals.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to develop policy positions and messaging, build up a coalition of stakeholder partners, and consult with legal experts. Costs for outside legal consultation could range in excess of $30,000 depending on the scope of work and the timeline for completion.

WHEREAS, The current definition of negligence in medical malpractice cases is based on a fault-based system that does not account for the complexities of modern health care; and

WHEREAS, Negligence is often defined as a deviation from the standard of care, but in reality, errors in medicine frequently result from systemic issues rather than individual incompetence or malfeasance; and

WHEREAS, The fear of malpractice lawsuits contributes to defensive medicine, leading to unnecessary tests and procedures that increase health care costs without improving patient outcomes; and

WHEREAS, A no-fault medical liability system, similar to those implemented in other countries, could provide fair compensation to patients while reducing the adversarial nature of medical malpractice claims; and

WHEREAS, Shifting to a no-fault model would encourage reporting and analysis of medical errors, allowing for systemic improvements in patient safety rather than punitive measures against individual practitioners; and

WHEREAS, Narrow-scope no-fault compensation systems such as Florida's and Virginia's birth-related neurological injury programs, as well as state workers' compensation laws, demonstrate that limited no-fault models can reduce litigation costs, provide timely compensation, and promote system-level safety improvements; and

WHEREAS, These programs have successfully operated within the U.S. legal framework, offering precedent for expanding no-fault principles to broader areas of medical care, particularly in high-risk or systemically complex domains; and

WHEREAS, Physicians and hospitals often face financial and reputational damage from lawsuits that fail to differentiate between system-based errors and actual misconduct; and

WHEREAS, In 2024, the American Law Institute revised the legal standard for assessing medical negligence, moving away from strict reliance on customary practice toward a more patient-centered concept of reasonable medical care that incorporates evidence-based guidelines and acknowledges systemic factors affecting patient safety; and

WHEREAS, The new legal standard, while still including elements of prevailing medical practice, invites courts to focus more directly on promoting patient safety and improving care delivery, thus creating an opportunity to reconsider how medical negligence is assessed; and

WHEREAS, This shift aligns with the concept of a no-fault medical liability system by recognizing that medical errors are often multifactorial and rooted in system deficiencies rather than individual failure; and

WHEREAS, ACEP has recognized that the increasing use of criminal liability for adverse medical outcomes, despite a lack of criminal intent, undermines the culture of safety and fails to account for the systemic factors influencing medical errors, highlighting the urgent need for legal frameworks that distinguish between human error and true criminal conduct; and

WHEREAS, ACEP has long supported comprehensive tort reform through federal and state legislation, including policies such as non-economic damage caps, expert witness standards, and communication resolution programs, reinforcing the College's commitment to legal reforms that balance accountability with fairness and support innovation in addressing medical liability; therefore be it

RESOLVED, That ACEP support the development and implementation of a no-fault medical liability system that prioritizes patient compensation and systemic health care improvements over physician punishment; and be it further

RESOLVED, That ACEP collaborate with relevant stakeholders and legal experts to advocate for legislative and regulatory changes that shift medical liability from a fault-based system to a no-fault compensation model; and be it further

RESOLVED, That ACEP promote a reevaluation of the legal definition of negligence in health care, advocating for a standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and aligns with the American Law Institute's updated guidelines to better reflect modern health care practice and patient safety goals.

**References**

1. American College of Emergency Physicians. *Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided.* Policy Statement. Approved June 2022. Available at: https://www.acep.org/patient-care/policy-statements/protection-of-physicians-and-other-health-care-professionals-from-criminal-liability-for-medical-care-provided/
2. American College of Emergency Physicians. *Reform of Tort Law.* Policy Statement. Revised October 2023. Available at: https://www.acep.org/patient-care/policy-statements/reform-of-tort-law/

## Background

This resolution requests ACEP to support the development and implementation of a no-fault medical liability system that prioritizes patient compensation and systemic health care improvements over physician punishment, collaborate with stakeholders and legal experts to advocate for legislative and regulatory changes to shift away from a fault-based system to a no-fault compensation model, and promote reevaluation of the legal definition of negligence in health care advocating for a standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and aligns with the American Law Institute's updated guidelines to better reflect modern health care practice and patient safety goals.

Emergency physicians face a uniquely high-risk practice environment with significant external factors and systemic contributors outside of their control that can impact patient safety and outcomes, and ACEP has long prioritized advocating for reform of the current medical liability system. Individual ACEP chapters, often with ACEP's support, have also pursued liability reform through legislation, ballot initiatives, and other efforts.

As the resolution notes, errors in medicine frequently result from systemic issues rather than individual incompetence or malfeasance. One common such systemic issue is that of boarding and/or crowding in EDs, which multiple studies have shown are associated with a reduction in quality of care, resulting in unfavorable clinical outcomes and adverse

events (Rocha et al.; Loke et al.). ACEP has done significant work in recent years to bring more attention to the boarding crisis and push policymakers to act on proposed solutions.

The resolution also calls for ACEP to collaborate and advocate for legislative and regulatory changes that shift medical liability from a fault-based system to a no-fault compensation model that prioritizes patient compensation and systemic health care improvements over physician punishment. ACEP has recognized the increasing use of criminal liability for adverse medical outcomes, despite a lack of criminal intent, and taken steps to address this growing problem. In March of 2022, a Tennessee nurse was convicted of reckless homicide and impaired adult abuse as a result of a patient dying as the result of medical mistakes in the care of that patient. The nurse admitted to medical error, and it seemed to be acknowledged in the case that the mistakes were not intentional. While physicians and other health care providers have long been subject to civil liability with regard to alleged mistakes in the provision of medical care, this case seems to break new ground in regarding such errors as opening the door to criminal prosecution. ACEP's policy statement Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided" provides guidance on this important topic.

The resolution also calls for ACEP to promote a reevaluation of the legal definition of negligence in health care, advocating for a standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and aligns with the American Law Institute's updated guidelines to better reflect modern health care practice and patient safety goals.

Root Cause Analysis (RCA) is a structured method used to analyze serious adverse events and other patient safety incidents. RCAs help health care organizations that have experienced sentinel events determine and understand contributing factors (including underlying causes, latent conditions, and active failures) and allows them to identify opportunities to change their culture, systems, and processes to prevent unintended harm. ACEP's Medical-Legal Committee recently developed a policy statement "Legal Protection of Participants in Peer Review" that was passed by the ACEP Board that affirmed ACEP's support for the passage and strengthening of state laws that provide QI/QA activities with legal protections, such as RCA, Peer Review, and similar activities.

The Medical-Legal Committee also currently has an objective to develop an information paper describing use of Communication and Resolution Programs (CRPs) and their impact on liability claims in states with and without traditional liability reforms, working with the College's State Legislative and Regulatory Committee. As well, ACEP's advocacy staff currently track and display state tort reform and patient safety measures as part of its State Legislative Dashboard. ACEP's policy, "Reporting of Medical Errors," supports a standardized system of medical error reporting for the purpose of aiding practitioners and institutions in efforts to improve patient safety. The policy calls for statutory protection from liability to providers and institutions that report data to the system.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Member Engagement and Trust: Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to develop policy positions and messaging, build up a coalition of stakeholder partners, and consult with legal experts. Costs for outside legal consultation could range in excess of $30,000 depending on the scope of work and the timeline for completion

**Prior Council Action**

Amended Resolution 26(24) Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events adopted. Directed ACEP to advocate for and support the development of policies to ensure appropriate consideration of context of contemporaneous boarding and overcrowding during Root Cause Analysis and related patient safety processes in hospitals; commit resources for establishing best practices and assisting hospitals with considering relevant corrective actions for medical errors committed as a result of ED overcrowding; and provide a written proposal to the Joint Commission and other relevant accrediting organizations suggesting a revision to the framework for Root Cause Analysis and corrective actions that includes emergency department and hospital capacity constraints and overcrowding as a "Root Cause Type" and "Causal Factor" as part of the root cause analysis.

Resolution 37(22) Enhance Patient Safety and Physician Wellness adopted. The resolution directed ACEP to support the protection of the integrity of the quality improvement/patient safety/peer review process and its participants and work with chapters to identify and lobby against state laws that limit these important discussions.

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted. The resolution directed ACEP to oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Resolution 7(15) Apology adopted. Directed ACEP to support legislative efforts to enact legal protections for physicians who apologize regarding an unfortunate outcome or event.

Amended Resolution 32(10) Support for Reform of the Present System of Medical Liability adopted. It called for ACEP to endorse and promote a policy that transforms the medical liability system and encourage the need for a baseline culture of safety facilitating blame-free communication, rigorous patient safety improvement efforts, and alternative dispute resolution mechanisms.

Resolution 15(07) Apology adopted. It called for the College to support legislation to protect and make non-discoverable the apology or expression of sympathy or regret thereto, during any legal proceedings that might take place.

Resolution 35(05) Health Courts adopted. The resolution endorsed the need for comprehensive litigation reform and supported the concept of health courts as an alternative to the current process

Resolution 29(04) Medical Liability Reform – Alternative Dispute Resolution adopted. Directed the College to advocate for the concepts of alternative dispute resolution, including mediation, and medical courts, as alternatives to the current tort system as part of the federal medical liability reform initiative.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted. The resolution called on the College to take the position that meaningful medical malpractice reform be an essential component of any health care reform measures and direct the College's lobbyist to further that position with Congress and via its key contact system

Amended Resolution 27(87) State Liability and Tort Reform adopted. The resolution called on the College to encourage chapters to take an active role in their state medical societies' liability and tort reform efforts and independently where appropriate.

Amended Resolution 28(85) Malpractice and Practice Modification adopted. Directed ACEP to endorse in principle the use of practice analysis and resultant recommendations for practice modification to reduce the incidence and severity of medical malpractice.

Amended Resolution 27(85) Malpractice Premiums and Tort Legal Reforms adopted. The resolution endorsed in principle state legislation or constitutional amendments to implement specific tort legal reforms.

**Prior Board Action**

January 2025, approved the policy statement, "Legal Protection of Participants in Peer Review".

Amended Resolution 26(24) Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events adopted.

October 2023, approved the revised policy statement, "Reform of Tort Law;" reaffirmed April 2017; revised and approved April 2011 and August 2009; reaffirmed October 1998; originally approved September 1985 titled "Reform of Tort Law."

March 2023, approved the revised policy statement, "Disclosure of Medical Errors;" revised and approved April 2017 and April 2010; originally approved September 2003.

Resolution 37(22) Enhance Patient Safety and Physician Wellness adopted.

June 2022, approved the policy statement, "Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided".

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted.

Resolution 7(15) Apology adopted.

Amended Resolution 32(10) Support for Reform of the Present System of Medical Liability adopted.

Resolution 15(07) Apology adopted.

Resolution 35(05) Health Courts adopted.

Resolution 29(04) Medical Liability Reform – Alternative Dispute Resolution adopted.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted.

Amended Resolution 27(87) State Liability and Tort Reform adopted.

Amended Resolution 28(85) Malpractice and Practice Modification adopted.

Amended Resolution 27(85) Malpractice Premiums and Tort Legal Reforms adopted.

**Background Information Prepared by:** Laura Wooster, MPH
Associate Executive Director, Advocacy & Practice Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 42(25)

SUBMITTED BY: Jeffrey D. Anderson, MD, FACEP
Sean Vanlandingham, MD, MBA, FACEP
Alabama Chapter

SUBJECT: Occurrence-Based Malpractice Coverage for All Emergency Physicians

PURPOSE: Collaborate with relevant stakeholders to conduct a focused feasibility study on the implementation of occurrence-based malpractice insurance as a new industry standard for emergency physicians and use the results to advocate for malpractice insurance models that prioritize long-term physician security, accountability, and the sustainability of the emergency medicine workforce.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort. Use of an outside consultant could be utilized to conduct the feasibility study. Costs could range in excess of $30,000 depending on the scope of work and the timeline for completion.

WHEREAS, Professional liability insurance is an essential and non-optional requirement for the practice of emergency medicine; and

WHEREAS, Many emergency physicians are provided with claims-made malpractice coverage, which requires a costly "tail" policy upon separation from an employer to maintain protection against future claims; and

WHEREAS, Recent bankruptcies of major contract management groups—including NES Health, American Physician Partners, and Envision Healthcare—have resulted in emergency physicians being left without promised tail coverage and without compensation for clinical services rendered; and

WHEREAS, These failures have placed individual emergency physicians at risk of personal financial liability and legal exposure through no fault of their own, undermining trust in employer-provided coverage structures; and

WHEREAS, These vulnerabilities contribute to a toxic and destabilizing practice environment, especially in a landscape increasingly influenced by corporate and private equity interests; therefore be it

RESOLVED, That ACEP collaborate with relevant stakeholders, including insurers, physician advocacy groups, and regulatory bodies, to conduct a focused feasibility study on the implementation of occurrence-based malpractice insurance as a new industry standard for emergency physicians; and be it further

RESOLVED, That ACEP use the results of a feasibility study on the implementation of occurrence-based malpractice insurance to advocate for malpractice insurance models that prioritize long-term physician security, accountability, and the sustainability of the emergency medicine workforce.

**Background**

This resolution directs ACEP to collaborate with relevant stakeholders to conduct a focused feasibility study on the implementation of occurrence-based malpractice insurance as a new industry standard for emergency physicians and use the results to advocate for malpractice insurance models that prioritize long-term physician security, accountability, and the sustainability of the emergency medicine workforce.

Emergency physicians face a uniquely high-risk practice environment that necessitates comprehensive and reliable malpractice coverage. Traditionally, physician groups have provided claims-made malpractice insurance policies with tail coverage, which requires an additional premium to cover claims made after the physician leaves the group. While this model has functioned in stable corporate settings, employers having to make difficult decisions under financial stress have exposed significant vulnerabilities for frontline emergency physicians. Recently, several prominent emergency physician groups have undergone financial reorganization or bankruptcy, without always honoring their commitment to provide tail malpractice coverage for employed physicians. These bankruptcies have exposed emergency physicians to long-term legal and financial risks. Many were faced with the prospect of personally funding expensive tail policies or assuming open-ended legal liability for their prior clinical work having been unaware that their tail coverage was not guaranteed in the event of corporate bankruptcy. These events have created distrust in existing malpractice insurance arrangements. The use of claims-made malpractice insurance with tail coverage places undue risk on the individual physician, especially when coverage is contingent on the solvency of an employer. Establishing fair contracts would improve career stability and well-being for emergency physicians. The proposed resolution to study the feasibility of requiring occurrence-based malpractice insurance supports systemic reforms that prioritize physician protection and reduce administrative burdens and post-employment legal threats.

ACEP maintains resources for members (Medical Professional Liability Insurance) that defines the types of malpractice insurance models. Occurrence insurance policies provide coverage for incidents that happened during the policy period, no matter when the claim is filed. Premiums tend to be more expensive than claims-made policy premiums (until the claims-made policy reaches maturity). Because of the high initial costs, occurrence policies remain relatively rare for physicians since insurers have difficulty estimating the cost of claims long after a policy expires.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Member Engagement and Trust: Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort. Use of an outside consultant could be utilized to conduct the feasibility study. Costs could range in excess of $30,000 depending on the scope of work and the timeline for completion.

**Prior Council Action**

None

**Prior Board Action**

None

**Background Information Prepared by:** Adam Krushinskie, MPA
Senior Director, State Legislative and Reimbursement

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 43(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians
Emergency Medicine Workforce Section

SUBJECT: Support for Eliminating Physician Non-Compete Clauses in Contracts

PURPOSE: Support emergency physicians in removing restrictive non-compete clauses from their contracts by creating a generic support letter for use in negotiations and publicly affirming that such clauses are unfair, ethically problematic, and harmful; and continue monitoring and updating members on state and federal efforts to prohibit non-compete agreements that interfere with a physician's ability to provide care.

FISCAL IMPACT: Budgeted staff resources for current advocacy initiatives.

WHEREAS, Non-compete clauses in emergency physician (EP) contracts that restrict the ability to practice clinical medicine within a geographic area are increasingly recognized as antithetical to the ethical practice of medicine and detrimental to patient access, continuity of care, and public health; and

WHEREAS, The American Medical Association (AMA) has issued policy (E-9.02) stating that non-compete agreements that restrict a physician's right to practice medicine after termination are unethical if they unduly restrict access to care or disrupt continuity of care;[1] and

WHEREAS, Professional organizations such as the American Academy of Emergency Medicine (AAEM), and American Academy of Family Physicians (AAFP) have taken formal positions opposing restrictive covenants that impede the clinical practice of medicine;[2,3] and

WHEREAS, The Federal Trade Commission (FTC) finalized a nationwide rule in April 2024 banning most non-compete clauses, citing extensive evidence that they depress wages, restrict worker mobility, and limit patient access to needed services in the healthcare sector;[4] and

WHEREAS, Non-competes designed to prevent direct competition for hospital or group contracts may be distinct from those that prevent a physician from continuing to practice medicine altogether in a geographic area, with the latter representing a greater threat to professional autonomy and patient welfare; and

WHEREAS, Contractual provisions that prohibit clinical practice – rather than guarding legitimate business interests – often force physicians to relocate, abandon patients, or accept lower-quality positions, leading to burnout and workforce instability;[5] therefore be it

RESOLVED, That ACEP develop and make available publicly a generic support letter that emergency physicians may use during contract negotiations to advocate for the removal of non-compete clauses that prohibit clinical practice within a defined region; and be it further

RESOLVED, That ACEP clearly state in a generic support letter that emergency physicians can use during contract negotiations that non-compete clauses restricting the clinical practice of medicine, as opposed to limiting contractual competition for hospital coverage, are fundamentally unfair, ethically problematic, and harmful to public health and physician well-being; and be it further

RESOLVED, That ACEP continue monitoring and updating members on state and federal developments regarding non-compete reform and support physician advocacy efforts on this issue.

**References**
1. American Medical Association. AMA Code of Medical Ethics Opinion 9.02: Restrictive Covenants
2. American Academy of Emergency Medicine. Position Statement on Non-Compete Clauses.
3. American Academy of Family Physicians. Advocacy Against Restrictive Covenants.
4. Federal Trade Commission. Final Rule on Non-Compete Clauses. April 2024.
5. Jackson, J. The Impact of Non-Compete Clauses on Physician Workforce Mobility. Health Affairs Blog, 2023.

## Background

This resolution calls for the College to support emergency physicians in removing restrictive non-compete clauses from their contracts by creating a generic support letter for use in negotiations and publicly affirming that such clauses are unfair, ethically problematic, and harmful. The resolution also calls on the College to continue monitoring and supporting state and federal efforts to prohibit non-compete agreements that interfere with a physician's ability to provide care.

ACEP has been a national leader in efforts to ban non-compete clauses in emergency medicine. The College strongly supported the Federal Trade Commission's (FTC) proposed rule in 2024 banning most non-compete agreements, citing the damaging effect these clauses have on emergency physician mobility, wages, and patient access. ACEP actively engaged with the FTC during the rulemaking process, submitted member testimony, and represented emergency physicians in high-level discussions with FTC leadership and key legislators.

ACEP's policy statement "Emergency Physician Contractual Relationships" includes the following provisions:

- ACEP supports the emergency physician receiving early notice of a problem with his or her performance and an opportunity to correct any perceived deficiency before disciplinary action or termination is contemplated.
- All entities contracting with or employing emergency physicians to provide clinical services, either indirectly or directly, should ensure an adequate and fair discovery process prior to deciding whether or not to terminate or restrict an emergency physician's contract or employment to provide clinical services.
- Emergency physicians employed or contracted should be informed of any provisions in the employment contract or the contracting vendor's contract with the hospital concerning termination of a physician's ability to practice at that site. This includes any knowledge by the contracting vendor of substantial risk of hospital contract instability.
- Emergency physician contracts should explicitly state the conditions and terms under which the physician's contract can be reassigned to another contracting vendor or hospital with the express consent of the individual contracting physician.
- The emergency physician should have the right to review the parts of the contracting entities' contract with the hospital that deal with the term and termination of the emergency physician contract.

The College emphasizes that employment agreements should support the professional independence of emergency physicians and the continuity of patient care. ACEP has expressed concern that non-compete provisions may limit physician mobility, contribute to burnout, increase consolidation, and exacerbate staffing shortages, particularly in underserved areas. The June 2025 RAND report highlights how these trends may limit access to emergency services, reduce transparency, and undermine physician leverage in employment negotiations. Consolidation can also result in lower compensation, diminish due process protections, and greater barriers to employment mobility, including the use of noncompete clauses.

Additionally, ACEP has supported throughout multiple sessions of Congress the "Workforce Mobility Act" (S. 2031), bipartisan legislation introduced by Sens. Christopher Murphy (D-CT), Todd Young (R-IN), Kevin Cramer (R-ND) and Tim Kaine (D-VA) that would prohibit the use of non-compete clauses in employment contracts across all industries, including health care. ACEP believes this legislation will empower physicians to make career decisions that reflect their needs and their patients' best interests without being unfairly restricted by coercive contract terms.

ACEP has a current legislative priority to "Support efforts to protect physician autonomy and monitor legislative efforts regarding non-compete clauses, consolidation, and transparency in health care ownership and financing."

ACEP leadership and staff developed contracting and employment resources on the ACEP website to assist members and develop requirements for increasing transparency among members and entities that employ emergency physicians regarding adherence to ACEP policy statements. There are dozens of pages of resources on the ACEP website dedicated to the topics of Employment Contracts and other practice and legal issues, as well as a growing set of resources from ACEP's Democratic Group Practice section. In an effort to better support all members as they face unprecedented challenges in hiring, ACEP staff embarked on a process to update, curate and develop educational and other assets into a complete set of resources designed to educate and empower physicians, at any point in their career, to more knowledgeably evaluate contract terms and pushback on unfair business practices, regardless of employment model or practice type.

The Medical-Legal Committee has developed a new contract resource, a checklist of "Key Considerations in an Emergency Medicine Employment Contract." The checklist is available on the EMRA website and the ACEP website in the Medical-Legal Resources. Additionally, ACEP members have access to legal and financial support assistance through an affinity program with Mines & Associates, the College's wellness and counseling partner. This service includes a 30-minute in-person consultation for each individual legal matter, a 30-minute telephone consultation per financial matter, and 25% discount on select legal and financial services all with MINES network of legal and financial professionals. Under the category of Business Legal Services, this includes advice, consultation and representation regarding contracts, incorporation, partnerships, and other commercial activities.

**ACEP Strategic Plan Reference**

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency medicine.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

**Fiscal Impact**

Budgeted staff resources for current advocacy initiatives.

**Prior Council Action**

Amended Resolution 19(22) Due Process and Interaction with ACEP adopted.

Resolution 17 (21) Fair Emergency Physician Employment Contract Template not adopted. The resolution called for the collect to develop sample contracts for employees and independent contractors to ensure members are effective and educated self-advocates when considering potential employment opportunities.

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at entities that deny an emergency physician this right; 2) revise the policy statement "Emergency Physician Rights and Responsibilities;" 3) adopt a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted. Directed ACEP to adopt a new policy statement addressing continuity of fair compensation including monetary compensation as well as uninterrupted provision of benefits and malpractice coverage during times of contract transitions.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted. Directed ACEP to develop model language for emergency physician employment contracts addressing termination for any emergency physician subjected to adverse action related to involvement in quality/performance improvement,

patient safety, or other medical staff activities, and specifying due process for physicians subjected to such adverse action.

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested that ACEP review the policy statement "Promotion of College Policies on Contracting and Compensation" for potential revisions, realign the policy statement "Promotion of College Policies on Contracting and Compensation" with other clearly stated College policy or rescind it entirely, and provide a report to the 2003 Council.

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted. Directed ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and to continue to promote the adoption of the principles outlined in the "Emergency Physician Rights and Responsibilities" policy statement by the various emergency medicine contract management groups, the American Hospital Association, and other pertinent organizations.

Resolution 12(01) Coercive Contracting not adopted. Called for the College to discourage any contracting practice that may be illegal, unethical, or any practice that may circumvent fair and equitable negotiations, explore the legal issues surrounding coercive contracting and, if appropriate, request an OIG opinion on contracts that force emergency physicians to accept less than fair market value reimbursement from third party payers in exchange for the right to retain their contract.

Substitute Resolution 10(01) Commercial Sponsorships adopted. Directed the Board to continue initiatives to develop and implement policies on self-disclosure of compliance by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings with ACEP physicians' rights policies, including: "Emergency Physicians Rights and Responsibilities," "Emergency Physician Contractual Relationships," "Agreements Restricting the Practice of Emergency Medicine," and "Compensation Arrangements for Emergency Physicians."

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans, and contract groups.

Substitute Resolution 50(94) Restrictive Covenants in Emergency Medicine adopted. The resolution directed ACEP to clarify, study, and report to the Council no later than September 1995 the issue of restrictive covenants (including non-compete clauses of various kinds).

Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue to make efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Resolution 40(90) Restrictive Covenants in Emergency Physician Contracts referred to the Board of Directors. The resolution called for the College to take a position against the use of restrictive covenants

**Prior Board Action**

Amended Resolution 19(22) Due Process and Interaction with ACEP adopted.

June 2021, approved developing and distributing a questionnaire to all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products in which they are asked to voluntarily provide information about their organizations.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised June 2018, October 2012, January 2006, March 1999, August 1993 with current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" revised April 2015, April 2002, June 1997. Reaffirmed October 2008, April 1992; originally approved June 1988.

February 2020, approved the policy statement "Protecting Emergency Physician Compensation During Contract Transitions."

July 2019, reviewed the updated information paper "Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships;" revised June 1997, originally reviewed July 1996.

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted.

July 2018, reviewed the Policy Resource and Education Paper (PREP) "Emergency Physician Contractual Relationships." The PREP is an adjunct to the policy statement "Emergency Physician Contractual Relationships."

May 2018, reviewed the information paper "Emergency Department Physician Group Staffing Contract Transition."

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Group adopted.

Substitute Resolution 50(94) Restrictive Covenants in Emergency Medicine adopted.

Amended Resolution 49(94) Information on Contract Issues adopted.

**Background Information Prepared by:** Fred Essis, MA, MBA
Congressional Lobbyist

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 44(25)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Advocating for National Leadership on Workplace Violence in Health Care through the AMA

PURPOSE: Direct the AMA Section Council on Emergency Medicine delegates to elevate workplace violence in health care as a top national advocacy priority, support mandatory and standardized reporting of violent incidents across all health care settings, and promote the development and implementation of evidence-based, trauma-informed strategies to protect the health care workforce.

FISCAL IMPACT: Budgeted staff resources to work with the AMA Section Council on Emergency Medicine.

WHEREAS, Nearly 75% of all workplace assaults in the United States occur in health care and social service settings, according to the Occupational Safety and Health Administration (OSHA); and

WHEREAS, Emergency departments are especially vulnerable to violence, with 91% of emergency physicians reporting that they, or a colleague, were a victim of violence in the past year). 47% of emergency physicians report being physically assaulted while at work, and 71% having witnessed a colleague be assaulted (ACEP Emergency Physician Workplace Violence Poll, 2024); and

WHEREAS, Workplace violence poses a direct threat to the well-being of health care professionals and undermines the delivery of safe, effective care to patients; and

WHEREAS, Workplace violence continues to impact emergency departments at alarming rates, with the 2024 ACEP Emergency Department Violence Poll reporting that 91% of emergency physicians had themselves or a colleague assaulted in the past year, 47% were physically assaulted, and 71% witnessed a colleague being assaulted; and

WHEREAS, The 2024 State of the U.S. Health Care Workforce report from the Health Resources and Services Administration (HRSA) found that nearly half of physicians report experiencing burnout, one in five report symptoms of depression, and nearly 29% of all health care workers, including physicians, intend to leave their jobs within two years—pointing to worsening workforce instability exacerbated by unsafe and stressful work environments; and

WHEREAS, Threatening and intimidating behavior towards healthcare workers contributes to an unsafe work environment and exacerbates critical staffing shortages; and

WHEREAS, The American College of Emergency Physicians (ACEP) has stated workplace violence against emergency physicians is a major public health problem and adopted a policy calling for stronger institutional protections and reporting mechanisms (*ACEP Policy Statement:* Protection from Violence and the Threat of Violence in the Emergency Department, revised June 2022); and

WHEREAS, Current efforts to collect and report workplace violence data are inconsistent across jurisdictions, limiting the ability of health systems and policymakers to understand and address trends at a national level; and (Institute for Healthcare Improvement, 2025)

WHEREAS, The American Medical Association plays a critical role in establishing physician advocacy priorities and promoting national health policy initiatives; therefore be it

RESOLVED, That ACEP direct its delegates to the American Medical Association to introduce and support AMA policy that prioritizes addressing workplace violence in health care as a top national advocacy issue; and be it further

RESOLVED, That ACEP direct its delegates to the American Medical Association to advocate for mandatory, standardized reporting of workplace violence incidents across all health care settings and support the aggregation and public dissemination of this data to inform research, benchmarking, and national policy development; and be it further

RESOLVED, That ACEP direct its delegates to the American Medical Association to advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce.

**References**


- American College of Emergency Physicians. *ED Violence: Dangerous, Rising and Unacceptable.* (Workplace Poll) January 2024 https://www.acep.org/siteassets/new-pdfs/advocacy/acepmemberpoll-edviolencejan2024.pdf
- Health Resources & Services Administration, Bureau of Health Workforce. (November 2024). State of the U.S. health care workforce, 2024 (pdf). U.S. Department of Health and Human Services. Retrieved from Health Resources & Services Administration website
- Institute for Healthcare Improvement. *Framework for Standardized Data Collection of Workplace Violence Incidents in Health Care*. Boston, MA: Institute for Healthcare Improvement; 2025. https://www.ihi.org/sites/default/files/resources/publications/Framework-Standardized-Data-Collection-Workplace-Violence-Incidents-Health-Care.pdf
- Occupational Safety and Health Administration. *Workplace Violence in Healthcare: Understanding the Challenge*. OSHA 3826-12/2015.
- Protection from Violence and the Threat of Violence in the Emergency (reviewed June 22) https://www.acep.org/patient-care/policy-statements/protection-from-violence-and-the-threat-of-violence-in-the-emergency-department


## Background

This resolution calls for the College to direct the American Medical Association (AMA) Section Council on Emergency Medicine delegates to elevate workplace violence in health care as a top national advocacy priority, support mandatory and standardized reporting of violent incidents across all health care settings, and promote the development and implementation of evidence-based, trauma-informed strategies to protect the health care workforce.

The AMA has fairly extensive policy, directives, and activity around workplace violence in health care, such as the following, several of which touch on supporting mandatory reporting of violence incidents and use of evidence-based strategies to protect the health care workforce:

- Directive: Affirmatively Protecting the Safety and Dignity of Physicians and Trainees as Workers D-515.977 · Directive: Preventing Violent Acts Against Health Care Providers D-515.983
- Policy: Violence and Abuse Prevention in the Health Care Workplace H-515.966
- Policy: Protecting Physicians and Other Healthcare Workers in Society H-515.950
- Policy: Workplace Violence Prevention H-215.978
- Policy: Violent Acts Against Physicians H-515.982
- Policy: Violence Against Medical Facilities and Health Care Practitioners and Their Families H-5.997

The AMA Section Council on Emergency Medicine is a specialty advisory body representing emergency medicine to the AMA, serving as a forum for the discussion of emergency medicine related issues within the AMA. It relates, through its chair, to the AMA leadership, other section councils, caucuses, committees, task forces, and Councils of the AMA when requested. The purpose of the Section Council is to bring together EM organizations to work with the AMA, state medical societies, and national specialty societies on issues affecting the health care environment in general and EM in particular, and to assist the AMA in the development of policy through appropriate mechanisms including the introduction of resolutions on issues of importance to emergency medicine.

Members of the Section Council on Emergency Medicine are chosen from the membership of the specialty societies representing emergency physicians who meet the criteria for representation in the AMA House of Delegates and who are also members of the AMA. Currently, these are ACEP and the American Academy of Emergecy Medicine (AAEM). ACEP currently has 9 delegate seats in the AMA and AAEM has 3 seats. ACEP provides funding for our 9 delegates to attend the AMA Annual House of Delegates meeting in June as well as the interim meeting in November.

ACEP's president and president-elect are also funded to attend both meetings as alternate delegates. Based on this structureand process, while ACEP's delegates and alternate delegates who comprise a portion of the Section Council on Emergency Medicine can bring ACEP's priority issues to the attention of the Section Council for consideration and potential action, such as introduction of a resolution, there is not a mechanism for them to direct the Section Council's activity, as called for in this resolution.

ACEP's Legislative & Regulatory Priorities for the First Session of the 119th Congress include:

- Advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED and secure new congressional champions.(Legislative)
- Continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department. (Regulatory)
- Support legislation and identify new opportunities to promote comprehensive violence prevention and intervention efforts, such as hospital-based violence intervention programs, increased community-specific resources, research funding, and educational initiatives.(Legislative)

ACEP has taken a leading role in addressing the growing problem of violence in emergency departments. Surveys conducted by ACEP in 2024, 2022, and 2018 reveal an alarming and escalating trend: nearly half of emergency physicians reported being physically assaulted at work in 2018, with 91% indicating in 2024 that they or a colleague had experienced violence within the past year. Many physicians believe hospitals can do more to enhance safety through increased security measures, such as deploying security personnel, installing surveillance systems, and implementing stricter visitor screening protocols. In response, ACEP has collected more than 800 personal accounts from emergency physicians detailing workplace violence and has advocated for improved local reporting mechanisms. These findings highlight the prevalence regarding workplace violence in emergency settings.

ACEP has advocated for local reporting of violence in the ED. While a national database of violent acts would provide important information on the incidence and prevalence of ED based or hospital violence, creation of such a portal would be costly and time consuming. It would require a data analyst to clean the data and compile the reports. It would also require input of data from a sufficient number of hospitals to be meaningful, which would require a standardized reporting structure as well as universal terminology. ACEP has learned from the implementation of the Clinical Emergency Data Registry, and even with the CDC, hospitals are reluctant to provide such data outside of state or federal requirements.

Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts and has been featured as one of the key advocacy priorities during several ACEP Leadership & Advocacy Conference (LAC) meetings in Washington, DC, including as recently as 2024.

ACEP helped inform and continues to support the "Workplace Violence Prevention Act for Health Care and Social Service Workers" (H.R. 2531/S.1232), introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI). This legislation would compel the Occupational Safety and Health Administration (OSHA) to issue federal standards to require health care and social service employers to create and implement workplace violence prevention plans. ACEP was the first physician organization to ever endorse this legislation and has worked closely with the sponsors for several Congresses. Among the provisions of this bill are:

- The OSHA standard mandates that employers shall investigate each incident of workplace violence as soon as practicable, document the findings, and take corrective measures.
- The OSHA standard requires that employers must record workplace violence incidents in a Violent Incident Log ("Log"). An annual summary of the Log shall be posted in the workplace in the same manner as the posting of the OSHA Annual Summary of Injuries and Illnesses, and similarly shall be transmitted to OSHA. Employers shall maintain records related to the Plan, and employees are provided the right to examine and make copies of the Plan, the Log and related Plan documents, with appropriate protections for patient and worker privacy. Patient names and personal identifying information will be excluded from the Violent Incident Log.

- The OSHA standard prohibits retaliation against a covered employee for reporting a workplace violence incident, threat, or concern to an employer, law enforcement, local emergency services, or a government agency. A violation of this prohibition shall be enforceable as a violation of an OSHA standard.

ACEP has also worked directly with OSHA for many years as they have attempted to develop and issue regulations on this front, efforts that have been in progress since 2015. The agency had hoped to release a proposed rule for a workplace violence prevention in health care and social service facilities in December 2024, however the agency ultimately did not release the proposed rule prior to the end of President Biden's term.

ACEP also helped inform and supports the bipartisan, "Save Healthcare Workers Act" (H.R. 3178/S.1600), previously known as the "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768) in past Congresses. This bipartisan, bicameral legislation was introduced by Madeleine Dean (D-PA) and Reps. Mariannette Miller-Meeks (R-IA), and Sens. Cindy Hyde-Smith (R-MS) and Angus King (I-ME). This legislation would establish federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP President Alison Haddock, MD, FACEP, was quoted in the press release when the legislation was introduced.

In early 2024, ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA). ACEP, along with the with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA), hosted another congressional briefing on workplace violence in March 2024. And in July 2024, ACEP and AHA hosted another congressional briefing focused on the Senate, with Senator Joe Manchin (D-WV) attending to deliver remarks to the audience as well. ACEP has also established and leads a coalition of other medical specialties to further amplify these advocacy efforts on Capitol Hill.

ACEP also provided input on The Joint Commission's "Workplace Violence Prevention" project in 2021 and, as a result of that work, TJC announced new requirements for accredited hospitals to ensure safer work environments. The new and revised requirements that went into effect January 1, 2022 include directives for hospitals to have a workplace violence prevention program; conduct annual worksite analysis related to its workplace violence prevention program; establish a process to continually monitor, report, and investigate safety incidents including those related to workplace violence; and to provide training, education and resources to leadership, staff, and licensed practitioners to address prevention, recognition, response and reporting of workplace violence. The Workplace Violence Standards Fact Sheet provides an overview of the standards.

ACEP began a partnership with ENA in 2019 to launch the "No Silence on ED Violence" campaign to draw more public attention to the problem of violence in the emergency department, to drive policymaker action to address the issue, and to provide resources and support to emergency physicians and emergency nurses. The campaign website, www.stopEDviolence.org, includes fact sheets and advocacy materials highlighting the severity of the issue, as well as resources for members seeking ways to reduce the incidence of violence in the ED. ACEP continues working closely with ENA on this issue. Additionally, ACEP has communicated with the American Nurses Association (ANA) and the National District Attorneys Association (NDAA) to gain a better understanding of the various issues that contribute to the current workplace violence landscape where violence against emergency physicians and other health care workers is either not reported or not prosecuted, and the College continues working to develop a better understanding of the patchwork of state laws related to health care workplace violence. In May 2022, No Silence on ED Violence Press Conference leaders and members of ENA and ACEP, together with Senator Tammy Baldwin (D-WI), held a press conference on Capitol Hill calling on Congress to pass legislation aimed at reducing violence against health care workers." ACEP and ENA hosted a similar press conference on Capitol Hill after LAC2023, and continue closely partnering on related efforts.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of Violence in the Emergency Department" calls workplace violence "a preventable and significant public health problem" and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a

page with a wealth of resources entitled "Violence in the Emergency Department: Resources for a Safer Workplace." The site includes links to information papers on the "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED and "Emergency Department Violence: An Overview and Compilation of Resources" and the "How Safe is Your Workplace" sample checklist.

ACEP's State Legislative/Regulatory Committee (SLRC) has a work group assigned to address workplace violence issues. Part of their work involves discussions with the law enforcement community to ensure that convictions for workplace violence are not dismissed by district attorney offices. Additionally, the SLRC has advocated for mandatory reporting of workplace violence, similar to legislation in North Carolina, which requires hospitals to track and report such incidents.

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

**Fiscal Impact**

Budgeted staff resources to work with the AMA Section Council on Emergency Medicine.

**Prior Council Action**

Substitute Resolution 56(24) Patient and Visitor Code of Conduct adopted. Directed ACEP to develop and adopt a universal code of conduct for patients and visitors in the emergency department.

Amended Resolution 41(24) Workplace Violence Data Collection adopted. Directed ACEP to advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. This resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against healthcare providers , advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on violence prevention issue and encourage the National Institute of Mental Health and Centers for Disease Control and Prevention, among others, to make financial support available for research.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

**Prior Board Action**

Substitute Resolution 56(24) Patient and Visitor Code of Conduct adopted.

Amended Resolution 41(24) Workplace Violence Data Collection adopted.

Approved as legislative and regulatory priorities in January 2025, March 2024, February 2023, January 2022, and January 2022 to continue advocating for reintroduction or passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved with the title "Protection from Violence in the Emergency Department" April 2016; revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

April 2021, approved the policy statement "Safer Working Conditions for Emergency Department Staff."

Resolution 55(17) Workplace Violence adopted.

May 2016, reviewed the information paper "Emergency Department Violence: An Overview and Compilation of Resources."

November 2015, reviewed the information paper, "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

August 2014, reviewed the information paper "Hospital-Based Violence Intervention Programs."

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

**Background Information Prepared by:** Fred Essis, MA, MBA
Congressional Lobbyist

Laura Wooster, MPH
Associate Exec Director, Advocacy & Practice Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 45(25)

SUBMITTED BY: California Chapter
New Jersey Chapter
American Association of Women Emergency Physicians Section
Young Physicians Section

SUBJECT: Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid-Related Policies

PURPOSE: Continue to advocate for the full preservation and expansion of Medicaid; create a unified policy statement affirming strong support for Medicaid and include current ACEP policy statements to create a single, robust policy statement on Medicaid; and affirm ACEP's opposition to administrative or financial barriers that reduce timely access to emergency care for Medicaid beneficiaries and promote emergency physicians' roles as key stakeholders in Medicaid policy development and reform.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, The Medicaid program serves as a critical safety net for more than 85 million Americans, including millions of emergency department patients[1]; and

WHEREAS, Medicaid financing has been shown to support hospital operations, reduce uncompensated care costs, and sustain emergency physician services, particularly in rural and underserved areas[2-4]; and

WHEREAS, Uncompensated care burdens fell sharply in Medicaid expansion states between 2013 and 2015, from 3.9 percent to 2.3 percent of operating costs, with estimated savings across all hospitals in Medicaid expansion states totaling $6.2 billion[5]; and

WHEREAS, About two thirds (69%) of rural hospital closures from 2014 to 2024 occurred in states that had not expanded Medicaid, and rural hospitals in non-expansion states had median operating margins of -0.7 percent when excluding documented relief funds[3,4]; and

WHEREAS, 55% of an emergency physician's time is spent providing uncompensated care, and uncompensated and undercompensated ED care has increased and resulted in nonpayment of 20% of expected payment to ED physicians across all payer types, or about $5.9 billion annually[6,7]; and

WHEREAS, From 2011 and 2021, Medicaid ED visits as a share of all payers increased to 45% from 34%, demonstrating Medicaid's critical role in emergency care access[7]; and

WHEREAS, ACEP has existing policy statements titled "Medicaid Expansion"[8,] "Opposition to Copays for Medicaid Beneficiaries"[9], and "Work Requirements for Medicaid Beneficiaries"[10], that individually affirm ACEP's strong opposition to barriers and support for access to care for Medicaid patients; and

WHEREAS, Consolidating and modernizing these Medicaid-related positions into a unified policy document will improve ACEP's advocacy clarity and operational impact; therefore be it

RESOLVED, That ACEP continue to advocate for the full preservation and expansion of the Medicaid program as an essential component of equitable access to emergency care; and be it further

RESOLVED, That ACEP create a unified policy statement affirming strong support for Medicaid and its importance as a safety net insurance to emergency medicine, and include within it the current policy statements

"Work Requirements for Medicaid Beneficiaries," "Medicaid Expansion," and "Opposition to Copays for Medicaid Beneficiaries" to create a single, robust policy statement on Medicaid; and be it further

RESOLVED, That ACEP policy affirm ACEP's opposition to administrative or financial barriers that reduce timely access to emergency care for Medicaid beneficiaries and promotes emergency physicians' roles as key stakeholders in Medicaid policy development and reform.

**References**

1. Centers for Medicare & Medicaid Services. January 2025 Medicaid & CHIP Enrollment Data Highlights. Available at: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed June 8, 2025.
2. Kaiser Family Foundation. Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes - Issue Brief. October 27, 2016. Available at: https://www.kff.org/report-section/understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes-issue-brief/. Accessed June 8, 2025.
3. Kaiser Family Foundation. 10 Things to Know About Rural Hospitals. May 2025. Available at: https://www.kff.org/health-costs/issue-brief/10-things-to-know-about-rural-hospitals/. Accessed June 8, 2025.
4. Kaiser Family Foundation. Rural Hospitals Face Renewed Financial Challenges, Especially in States That Have Not Expanded Medicaid. February 23, 2023. Available at: https://www.kff.org/health-costs/issue-brief/rural-hospitals-face-renewed-financial-challenges-especially-in-states-that-have-not-expanded-medicaid/. Accessed June 8, 2025.
5. Blavin F, Garrett B, Gangopadhyaya A, et al. The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal. The Commonwealth Fund. May 2017. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2017/may/impact-acas-medicaid-expansion-hospitals-uncompensated-care. Accessed June 8, 2025.
6. American College of Emergency Physicians. The Impact of Unreimbursed Care on the Emergency Physician. Available at: https://www.acep.org/administration/reimbursement/the-impact-of-unreimbursed-care-on-the-emergency-physician. Accessed June 8, 2025.
7. RAND Corporation. Strategies for Sustaining Emergency Care in the United States. Declining payment rates, Medicaid volumes, and downcoding strain EDs. HFMA. April 14, 2025. Available at: https://www.hfma.org/financial-challenges-hospital-emergency-departments/. Accessed June 8, 2025.
8. American College of Emergency Physicians. Medicaid Expansion. Annals of Emergency Medicine. January 2025. Available at: https://www.annemergmed.com/article/S0196-0644(25)00134-9/fulltext. Accessed June 8, 2025.
9. American College of Emergency Physicians. Opposition to Copays for Medicaid Beneficiaries. Reaffirmed January 2025. Originally approved October 2019. Available at: https://www.acep.org/patient-care/policy-statements/opposition-to-copays-for-medicaid-beneficiaries. Accessed June 8, 2025.
10. American College of Emergency Physicians. Work Requirements for Medicaid Beneficiaries. Policy Statements Approved June 2022. *Annals of Emergency Medicine*, Volume 80, Issue 5, e75 - e82 Available at: https://www.annemergmed.com/article/S0196-0644(22)01035-6/fulltext. Accessed June 8, 2025.

## Background

This resolution calls for ACEP to continue to advocate for the full preservation and expansion of the Medicaid program as an essential component of equitable access to emergency care; create a unified policy statement affirming strong support for Medicaid and its importance as a safety net insurance to emergency medicine, and include within it the current policy statements "Work Requirements for Medicaid Beneficiaries," "Medicaid Expansion," and "Opposition to Copays for Medicaid Beneficiaries" to create a single, robust policy statement on Medicaid; and, ensure that ACEP policy affirms ACEP's opposition to administrative or financial barriers that reduce timely access to emergency care for Medicaid beneficiaries and promotes emergency physicians' roles as key stakeholders in Medicaid policy development and reform.

This resolution is similar to Resolution 48(25) Support for Full Preservation of Medicaid. Much of the background information is the same for both resolutions.

As the resolution notes, ACEP has several current policies related directly to Medicaid:

- "Work Requirements for Medicaid Beneficiaries"
  - "The American College of Emergency Physicians (ACEP) opposes the imposition of work requirements mandating employment or pursuit of employment for Medicaid beneficiaries to obtain or retain access to health insurance coverage."

- "Opposition to Copays for Medicaid Beneficiaries"
  - "The American College of Emergency Physicians (ACEP) opposes the imposition of copays for Medicaid beneficiaries seeking care in the emergency department."

- "Medicaid Expansion"
  - "The American College of Emergency Physicians (ACEP) advocates for the expansion of Medicaid to the levels allowable by federal law as a crucial step towards improving health care access for our community's most vulnerable populations. This expansion will not only ensure that individuals receive the care they need but will also reduce the financial burden of uncompensated care on emergency departments, allowing for more efficient and effective health care delivery.

    ACEP urges policymakers to prioritize Medicaid expansion, recognizing its profound impact on public health, economic stability, and the overall efficiency of our health care system. By supporting this expansion, ACEP reaffirms our commitment to advancing health equity and providing high-quality, accessible care for all."

The resolution seeks to modernize and consolidate these policies into a single, unified policy statement to improve the College's advocacy clarity and operational impact. An objective has already been assigned to the State Legislative/ Regulatory Committee for 2025-26 that addresses the second resolved:

> Create a unified policy statement affirming strong support for Medicaid and its importance as a safety net insurance to emergency medicine, and include within it the current policy statements "Work Requirements for Medicaid Beneficiaries," "Medicaid Expansion," and "Opposition to Copays for Medicaid beneficiaries" to create a single, robust policy statement on Medicaid.

Protecting and improving Medicaid has been and remains a legislative and regulatory priority for the College. The Legislative and Regulatory Priorities for First Session of 119th Congress, as approved by the ACEP Federal Government Affairs (FGA) Committee and the Board of Directors, include:

- Ensure Prudent Layperson Standard extends to Medicaid FFS and compliance measures are in place for other health plans.
- Monitor efforts to establish block grants, per-capita allotments for federal share of Medicaid funding, establishment of Medicaid work requirements, or other proposals regarding Medicaid eligibility requirements/restrictions.
- Seek permanent repeal of Medicaid IMD exclusion.
- Monitor efforts to establish/change Medicaid work requirements.
- Monitor legislative efforts to voluntarily expand Medicare or Medicaid to additional patient populations.

Especially over the first half of 2025, ACEP federal advocacy has prioritized the preservation of Medicaid in light of the substantial changes to the program that were being considered by Congress and were ultimately included in H.R. 1, the "One Big Beautiful Bill Act," (P.L. 119-21) that was signed into law on July 4, 2025. Among the major Medicaid provisions included in the law are:

- **"Community Engagement" Requirements**: Establishment of work requirements for eligible adults that are part of the Affordable Care Act's Medicaid expansion population. The law requires that able-bodied individuals must work at least 80 hours per month or complete volunteer, community service, or other eligible educational programs, with limited exceptions. 40 states and the District of Columbia have expanded Medicaid to cover most adults under 138% of the federal poverty level (FPL). According to the Kaiser Family Foundation (KFF), "As of June 2024, over 20 million people were enrolled through Medicaid expansion, representing nearly a quarter of total Medicaid enrollment across all states and 31% of total enrollment in expansion states."

- **State provider tax freeze and reduction**: Freezes the current Medicaid provider tax thresholds for all states for two years, and reduces the maximum allowable provider tax for expansion states from 6 percent to 3.5 percent by 2032 (in 0.5 percent increments annually).

  - Context: Medicaid is jointly financed by the federal government and the states, and states are permitted to finance their non-federal share through multiple sources, including state general funds, taxes on providers (most commonly hospitals and/or nursing facilities), and local government funds. All states except for Alaska finance some of their state costs with taxes on these health care providers. These revenues are used to boost Medicaid provider payments, thereby increasing the state's Medicaid costs that in turn increase the Federal Matching Assistance Percentage (FMAP) rate provided by the federal government.
  - Federal law requires a provider tax to be uniform and broad-based, meaning it must be applied at the same level and to all Managed Care Organizations (MCOs) in the state, not just Medicaid MCOs. A state can apply to the Centers for Medicare & Medicaid Services (CMS) to waive the broad-based and uniform requirements if the net impact of the tax is generally redistributive and the tax amount is not directly correlated to Medicaid payments. States must conduct a statistical test to demonstrate that the tax is generally redistributive.

- **State directed payment limits**: Sets the limit for state directed payments (SDPs) to 110 percent of Medicare rates for non-expansion states, and 100 percent of Medicare for expansion states. For states that newly expand Medicaid, all SDPs will be subject to this provision, even if previously approved.
  - Context: SDPs allow states to direct MCOs to pay providers according to specific rates or methods, and can be used to establish minimum or maximum fee schedules for certain types of providers, to require participation in value-based payment arrangements, or to make uniform payment rate increases. States have had significant discretion in developing SDPs (including determining which providers receive SDPs and the amounts of the payments). The Biden administration's managed care rule capped the SDP ceiling for certain services at the average commercial rate.

- **Medicaid cost-sharing & copays**: Requires states to impose cost-sharing/copays on certain services for Medicaid expansion adults with incomes above 100 percent of the federal poverty level (FPL). Cost-sharing will be at a rate determined by the state and must be above $0 but may not exceed $35 per service. The total aggregate amount for the family may not exceed 5 percent of the family income. Certain types of services are exempted, including primary care, prenatal care, pediatric care, emergency room care (except for non-emergency care provided in an emergency room), mental health and substance use disorder services, and services to certain community health centers.
  - Context: Under existing federal law, such cost-sharing requirements by a state Medicaid program were already permitted with the above limitations, but now will be required. States with existing Medicaid copay policies for non-emergent ED use include Florida, Kentucky, Minnesota, Montana, Ohio, Pennsylvania, South Carolina, and Washington.

ACEP created a summary of the emergency medicine-specific provisions of the law detailing these and other relevant provisions and associated implementation timelines and deadlines.

ACEP's existing policies have served and continue to serve as the foundation of the College's ongoing advocacy work, supplemented by the April 2025 RAND report, "Strategies for Sustaining Emergency Care in the United States," other ACEP resources, and coalition efforts among other physician and provider specialties.

Protecting the emergency care safety net, including protecting Medicaid, was also a key legislative priority during the 2025 ACEP Leadership & Advocacy Conference (LAC) in Washington, DC in April 2025. Emergency physician advocates went to Capitol Hill urging Congress to help repair and stabilize the safety net, highlighting continued financial threats to the viability of emergency medicine through declining Medicare reimbursements that also do not account for inflation, declining commercial payments, and the vital role of Medicaid in supporting emergency care in particular, even despite payment rates that are well below the costs of providing care.

In addition to regular federal legislative advocacy work and numerous grassroots campaigns throughout the budget reconciliation process, in May 2025, ACEP was part of a coalition of 42 national medical organizations that sent a letter to congressional leadership opposing the House of Representatives' proposed changes to Medicaid in their budget reconciliation proposal (H.R. 1). ACEP President Alison Haddock, MD, FACEP, also issued a statement later in May urging Congress to reject the proposed Medicaid changes that the non-partisan Congressional Budget Office (CBO) estimates will lead to millions more individuals without insurance coverage, highlighting the disproportionate

impact on emergency medicine and emergency departments that are already under significant strain. In June 2025, ACEP once again joined a coalition of 31 national medical organizations in a letter to Senate leadership, urging changes to the House-passed language and asking the Senate to protect Medicaid access by severely reducing or ideally eliminating the Medicaid provisions that are projected to directly or indirectly increase the number of uninsured patients. On July 1, 2025, Dr. Haddock issued another statement after the Senate passed their amended version of the bill, noting concerns that "…this legislation will carry serious, long-term consequences for the emergency care safety net, the broader health care system, and most importantly, the patients we serve." The statement urged Congress to reject the most damaging provisions of the reconciliation package, "…particularly those that would increase the number of uninsured, further strain emergency departments, and diminish the pipeline of future emergency physicians."

ACEP continues monitoring legislative activity in the wake of the passage and enactment of the "Big Beautiful Bill," as some Republican legislators have indicated they are seeking changes to some of the Medicaid provisions of the law. For example, on July 15, 2025, Senator Josh Hawley (R-MO) introduced the "Protect Medicaid and Rural Hospitals Act," (S. 2279), which would repeal the law's provider tax moratorium and future reduction of provider tax authority, repeal provisions in the reconciliation bill regarding state directed payments that could reduce Medicaid provider reimbursements, double the funding for the Rural Health Transformation Fund from $50 billion to $100 billion and extending the duration of the funding distribution from five to ten years. However, some legislators have indicated there may be another push to do another budget reconciliation bill in the next fiscal year (beginning October 1, 2025) that could once again target increased savings from federal health programs and funding. House Budget Committee Chairman Jodey Arrington (R-TX) has indicated that potential savings targets for another reconciliation bill include additional reductions to the Medicaid FMAP for the expansion population and additional penalties to states that fail to enforce existing laws preventing the use of Medicaid funds/benefits for undocumented individuals, among other savings proposals like site-neutral payments under Medicare. It remains unclear as of writing what further Medicaid reductions are realistically under consideration and if another budget reconciliation package will be pursued by Congress.

ACEP will continue the ongoing work to fight for the preservation and expansion of Medicaid to the fullest extent possible.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

**Fiscal Impact**

Budgeted resources for current advocacy initiatives.

**Prior Council Action**

Resolution 40(22) Support for Medicaid Expansion adopted. Directed the College to develop a policy statement in support of expanding Medicaid to the levels allowable by federal law and develop a toolkit to assist ACEP chapters in efforts to advocate for Medicaid expansion in their states.

Amended Resolution 39(19) Work Requirements for Medicaid Beneficiaries adopted. Directed ACEP to oppose mandatory work requirements for Medicaid beneficiaries to prove they are employed, or seeking employment, to get or keep health insurance.

Amended Resolution 29(19) Extending Medicaid Coverage to 12-Months Post-Partum adopted. The resolution directed that ACEP support the extension of Medicaid coverage to 12 months postpartum.

Resolution 24(18) ED Copayments for Medicaid Beneficiaries adopted. Directed ACEP to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED and submit a resolution to the American Medical Association House of Delegates to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED.

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.

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). A health policy report, "Emergency Medicine and the Debate Over the Uninsured: A Report from the Task Force on Health Care and the Uninsured" was developed and included in the published proceedings of ACEP's educational conference "National Congress for Preserving America's Healthcare Safety Net." The report included several principles developed by the task force, including the urgent need to expand health insurance coverage.

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.

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.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

**Prior Board Action**

January 2025, approved the Legislative and Regulatory Priorities for First Session of 119th Congress.

January 2025, approved the policy statement "Medicaid Expansion."

January 2025, approved the revised policy statement "Opposition to Copays for Medicaid Beneficiaries;" originally approved October 2019.

June 2022, approved the policy statement "Work Requirements for Medicaid Beneficiaries."

January 2021, reaffirmed the policy statement "Universal Health Care Coverage;" reaffirmed June 2015; revised and approved August 2009; originally approved December 1999.

Resolution 40(22) Support for Medicaid Expansion adopted.

Amended Resolution 39(19) Work Requirements for Medicaid Beneficiaries adopted.

Amended Resolution 29(19) Extending Medicaid Coverage to 12-Months Post-Partum adopted.

Resolution 24(18) ED Copayments for Medicaid Beneficiaries adopted.

July 2018, reviewed the information paper "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine."

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.

Substitute Resolution 31(14) Financing 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.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Congressional Affairs Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 46(25)

SUBMITTED BY: Abbas Husain, MD, FACEP
District of Columbia Chapter
American Association of Women Emergency Physicians Section
Wellness Section

SUBJECT: Support for Full Preservation of Medicaid

PURPOSE: Advocate for federal and state Medicaid funding levels that allow for comprehensive benefit coverage for the poor, regardless of pregnancy, parental, or work status; and publicly affirm support for comprehensive Medicaid benefits for patients across the United States.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Medicaid covers approximately 19% of all patients in the United States; and

WHEREAS, Approximately 45% of all emergency department (ED) patients are insured through Medicaid; and

WHEREAS, Medicaid beneficiaries currently have access to timely, high-quality, and appropriate care in all payment systems; and

WHEREAS**,** The loss or reduction of Medicaid benefits could result in deferred or delayed care, leading to exacerbation of medical conditions and increased reliance on emergency departments, where treatment is often more complex and costly; and

WHEREAS**,** Medicaid cuts would increase healthcare costs, reduce access to care for low-income individuals, and place significant financial pressure on healthcare providers; and

WHEREAS**,** Denial or limitation of Medicaid insurance could result in the closure of hundreds of rural hospitals, delayed care with significant health consequences, worsening of pediatric and mental health outcomes, and impediments to emergency physicians in coordinating care for high-risk patients; and

WHEREAS**,** Reduction in Medicaid coverage would increase the number of uninsured and further strain the emergency care safety net; and

WHEREAS**,** Medicaid cuts will impede the ability of emergency physicians to provide timely and needed care, thereby worsening moral injury and potentially leading to more burnout and emergency physicians exiting the specialty; therefore be it

RESOLVED, That ACEP advocate for federal and state Medicaid funding levels that allow for comprehensive benefit coverage for the poor, regardless of pregnancy, parental, or work status; and be it further

RESOLVED, That ACEP publicly affirm support for comprehensive Medicaid benefits for patients across the United States.

**Background**

This resolution calls for ACEP to advocate for federal and state Medicaid funding levels that allow for comprehensive benefit coverage for the poor, regardless of pregnancy, parental, or work status; and, to publicly affirm support for

comprehensive Medicaid benefits for patients across the United States.

This resolution is similar to Resolution 47(25) Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid-Related Policies. Much of the background information is the same for both resolutions.

Protecting and improving Medicaid, including increasing funding levels and advocating for more robust reimbursement levels, has been and remains a legislative and regulatory priority for the College. The Legislative and Regulatory Priorities for First Session of 119th Congress, as approved by the ACEP Federal Government Affairs (FGA) Committee and the Board of Directors, include:

- Ensure Prudent Layperson Standard extends to Medicaid FFS and compliance measures are in place for other health plans.
- Monitor efforts to establish block grants, per-capita allotments for federal share of Medicaid funding, establishment of Medicaid work requirements, or other proposals regarding Medicaid eligibility requirements/restrictions.
- Seek permanent repeal of Medicaid IMD exclusion.
- Monitor efforts to establish/change Medicaid work requirements.
- Monitor legislative efforts to voluntarily expand Medicare or Medicaid to additional patient populations.

The College has also developed materials and resources designed to assist ACEP chapters in advocating for fair and adequate reimbursement at the state level and how to advocate for reforms that protect access to emergency care for all who need it, while at the same time promoting fiscal responsibility and the provision of quality care.

ACEP has longstanding policy, "Universal Health Care Coverage," promoting access for all Americans to health benefits coverage that provides for timely, unrestricted access to emergency care. The policy states:

> "The American College of Emergency Physicians (ACEP) believes:
> - All Americans must have health care coverage;
> - Health care coverage will contain a benefits package that provides for timely, unrestricted access to quality emergency care;
> - Any benefit package should reflect generally accepted standards of medical practice supported by outcome-based evidence, where available."

ACEP also has several current policies related directly to Medicaid:

- "Opposition to Copays for Medicaid Beneficiaries"
  - "The American College of Emergency Physicians (ACEP) opposes the imposition of copays for Medicaid beneficiaries seeking care in the emergency department."
- "Medicaid Expansion"
  - "The American College of Emergency Physicians (ACEP) advocates for the expansion of Medicaid to the levels allowable by federal law as a crucial step towards improving health care access for our community's most vulnerable populations. This expansion will not only ensure that individuals receive the care they need but will also reduce the financial burden of uncompensated care on emergency departments, allowing for more efficient and effective health care delivery.

    ACEP urges policymakers to prioritize Medicaid expansion, recognizing its profound impact on public health, economic stability, and the overall efficiency of our health care system. By supporting this expansion, ACEP reaffirms our commitment to advancing health equity and providing high-quality, accessible care for all."

Especially over the first half of 2025, ACEP federal advocacy has prioritized the preservation of Medicaid in light of the substantial changes to the program that were being considered by Congress and were ultimately included in H.R. 1, the "One Big Beautiful Bill Act," (P.L. 119-21) that was signed into law on July 4, 2025. Among the major Medicaid provisions included in the law are:

- **"Community Engagement" Requirements**: Establishment of work requirements for eligible adults that are part of the Affordable Care Act's Medicaid expansion population. The law requires that able-bodied individuals must work at least 80 hours per month or complete volunteer, community service, or other eligible educational programs, with limited exceptions. 40 states and the District of Columbia have expanded Medicaid to cover most adults under 138% of the federal poverty level (FPL). According to the Kaiser Family Foundation (KFF), "As of June 2024, over 20 million people were enrolled through Medicaid expansion, representing nearly a quarter of total Medicaid enrollment across all states and 31% of total enrollment in expansion states."

- **State provider tax freeze and reduction**: Freezes the current Medicaid provider tax thresholds for all states for two years, and reduces the maximum allowable provider tax for expansion states from 6 percent to 3.5 percent by 2032 (in 0.5 percent increments annually).
  - Context: Medicaid is jointly financed by the federal government and the states, and states are permitted to finance their non-federal share through multiple sources, including state general funds, taxes on providers (most commonly hospitals and/or nursing facilities), and local government funds. All states except for Alaska finance some of their state costs with taxes on these health care providers. These revenues are used to boost Medicaid provider payments, thereby increasing the state's Medicaid costs that in turn increase the Federal Matching Assistance Percentage (FMAP) rate provided by the federal government.
  - Federal law requires a provider tax to be uniform and broad-based, meaning it must be applied at the same level and to all Managed Care Organizations (MCOs) in the state, not just Medicaid MCOs. A state can apply to the Centers for Medicare & Medicaid Services (CMS) to waive the broad-based and uniform requirements if the net impact of the tax is generally redistributive and the tax amount is not directly correlated to Medicaid payments. States must conduct a statistical test to demonstrate that the tax is generally redistributive.

- **State directed payment limits**: Sets the limit for state directed payments (SDPs) to 110 percent of Medicare rates for non-expansion states, and 100 percent of Medicare for expansion states. For states that newly expand Medicaid, all SDPs will be subject to this provision, even if previously approved.
  - Context: SDPs allow states to direct MCOs to pay providers according to specific rates or methods, and can be used to establish minimum or maximum fee schedules for certain types of providers, to require participation in value-based payment arrangements, or to make uniform payment rate increases. States have had significant discretion in developing SDPs (including determining which providers receive SDPs and the amounts of the payments). The Biden administration's managed care rule capped the SDP ceiling for certain services at the average commercial rate.

- **Medicaid cost-sharing & copays**: Requires states to impose cost-sharing/copays on certain services for Medicaid expansion adults with incomes above 100 percent of the federal poverty level (FPL). Cost-sharing will be at a rate determined by the state and must be above $0 but may not exceed $35 per service. The total aggregate amount for the family may not exceed 5 percent of the family income. Certain types of services are exempted, including primary care, prenatal care, pediatric care, emergency room care (except for non-emergency care provided in an emergency room), mental health and substance use disorder services, and services to certain community health centers.
  - Context: Under existing federal law, such cost-sharing requirements by a state Medicaid program were already permitted with the above limitations, but now will be required. States with existing Medicaid copay policies for non-emergent ED use include Florida, Kentucky, Minnesota, Montana, Ohio, Pennsylvania, South Carolina, and Washington.

ACEP created a summary of the emergency medicine-specific provisions of the law detailing these and other relevant provisions and associated implementation timelines and deadlines.

ACEP's existing policies have served and continue to serve as the foundation of the College's ongoing advocacy work, supplemented by the April 2025 RAND report, "Strategies for Sustaining Emergency Care in the United States," other ACEP resources, and coalition efforts among other physician and provider specialties.

Protecting the emergency care safety net, including protecting Medicaid, was also a key legislative priority during the 2025 ACEP Leadership & Advocacy Conference (LAC) in Washington, DC in April 2025. Emergency physician advocates went to Capitol Hill urging Congress to help repair and stabilize the safety net, highlighting continued financial threats to the viability of emergency medicine through declining Medicare reimbursements that also do not account for inflation, declining commercial payments, and the vital role of Medicaid in supporting emergency care in particular, even despite payment rates that are well below the costs of providing care.

In addition to regular federal legislative advocacy work and numerous grassroots campaigns throughout the budget reconciliation process, in May 2025, ACEP was part of a coalition of 42 national medical organizations who sent a letter to congressional leadership opposing the House of Representatives' proposed changes to Medicaid in their budget reconciliation proposal (H.R. 1). ACEP President Alison Haddock, MD, FACEP, also issued a statement later in May urging Congress to reject the proposed Medicaid changes that the non-partisan Congressional Budget Office (CBO) estimates will lead to millions more individuals without insurance coverage, highlighting the disproportionate impact on emergency medicine and emergency departments that are already under significant strain. In June 2025, ACEP once again joined a coalition of 31 national medical organizations in a letter to Senate leadership, urging changes to the House-passed language and asking the Senate to protect Medicaid access by severely reducing or ideally eliminating the Medicaid provisions that are projected to directly or indirectly increase the number of uninsured patients. On July 1, 2025, Dr. Haddock issued another statement after the Senate passed their amended version of the bill, noting concerns that "…this legislation will carry serious, long-term consequences for the emergency care safety net, the broader health care system, and most importantly, the patients we serve." The statement urged Congress to reject the most damaging provisions of the reconciliation package, "…particularly those that would increase the number of uninsured, further strain emergency departments, and diminish the pipeline of future emergency physicians."

ACEP continues monitoring legislative activity in the wake of the passage and enactment of the "Big Beautiful Bill," as some Republican legislators have indicated they are seeking changes to some of the Medicaid provisions of the law. For example, on July 15, 2025, Senator Josh Hawley (R-MO) introduced the "Protect Medicaid and Rural Hospitals Act," (S. 2279), which would repeal the law's provider tax moratorium and future reduction of provider tax authority, repeal provisions in the reconciliation bill regarding state directed payments that could reduce Medicaid provider reimbursements, double the funding for the Rural Health Transformation Fund from $50 billion to $100 billion and extending the duration of the funding distribution from five to ten years. However, some legislators have indicated there may be another push to do another budget reconciliation bill in the next fiscal year (beginning October 1, 2025) that could once again target increased savings from federal health programs and funding. House Budget Committee Chairman Jodey Arrington (R-TX) has indicated that potential savings targets for another reconciliation bill include additional reductions to the Medicaid FMAP for the expansion population and additional penalties to states that fail to enforce existing laws preventing the use of Medicaid funds/benefits for undocumented individuals, among other savings proposals like site-neutral payments under Medicare. It remains unclear as of writing what further Medicaid reductions are realistically under consideration and if another budget reconciliation package will be pursued by Congress.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

**Fiscal Impact**

Budgeted resources for current advocacy initiatives.

**Prior Council Action**

Resolution 40(22) Support for Medicaid Expansion adopted. Directed the College to develop a policy statement in support of expanding Medicaid to the levels allowable by federal law and develop a toolkit to assist ACEP chapters in efforts to advocate for Medicaid expansion in their states.

Amended Resolution 39(19) Work Requirements for Medicaid Beneficiaries adopted. Directed ACEP to oppose mandatory work requirements for Medicaid beneficiaries to prove they are employed, or seeking employment, to get or keep health insurance.

Amended Resolution 29(19) Extending Medicaid Coverage to 12-Months Post-Partum adopted. The resolution directed that ACEP support the extension of Medicaid coverage to 12 months postpartum.

Resolution 24(18) ED Copayments for Medicaid Beneficiaries adopted. Directed ACEP to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED and submit a resolution to the American Medical Association House of Delegates to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED. 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.

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). A health policy report, "Emergency Medicine and the Debate Over the Uninsured: A Report from the Task Force on Health Care and the Uninsured" was developed and included in the published proceedings of ACEP's educational conference "National Congress for Preserving America's Healthcare Safety Net." The report included several principles developed by the task force, including the urgent need to expand health insurance coverage.

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.

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.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

**Prior Board Action**

January 2025, approved the Legislative and Regulatory Priorities for the First Session of 119th Congress.

January 2025, approved the policy statement "Medicaid Expansion."

January 2025, approved the revised policy statement "Opposition to Copays for Medicaid Beneficiaries;" originally approved October 2019.

June 2022, approved the policy statement "Work Requirements for Medicaid Beneficiaries."

January 2021, reaffirmed the policy statement "Universal Health Care Coverage;" reaffirmed June 2015; revised and approved August 2009; originally approved December 1999.

Resolution 40(22) Support for Medicaid Expansion adopted.

Amended Resolution 39(19) Work Requirements for Medicaid Beneficiaries adopted.

Amended Resolution 29(19) Extending Medicaid Coverage to 12-Months Post-Partum adopted.

Resolution 24(18) ED Copayments for Medicaid Beneficiaries adopted.

July 2018, reviewed the information paper "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine."

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.

Substitute Resolution 31(14) Financing 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.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Congressional Affairs Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 47(25)

SUBMITTED BY: District of Columbia Chapter

SUBJECT: Protecting Medicaid Disproportionate Share Hospital (DSH) Payments to Preserve Emergency Care Access

PURPOSE: Recognize the Disproportionate Share Hospital cuts are of specific concern to emergency physicians, have been shown to increase the amount of rural hospital closures; partner with relevant organizations such as America's Essential Hospitals (AEH) to further the cause of protecting Disproportionate Share Hospital payments; and advocate for H.R. 2665, the Supporting Safety Net Hospitals Act, to repeal or delay the Medicaid Disproportionate Share Hospital cuts for fiscal years 2026 through 2028

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Medicaid Disproportionate Share Hospital (DSH) payments provide critical financial support to hospitals that care for a high volume of low-income and uninsured patients, including many emergency departments; and

WHEREAS, Emergency physicians serve on the front lines of care for vulnerable populations, and reductions in DSH funding threaten the financial viability of emergency departments in both urban and rural safety-net hospitals; and

WHEREAS, Studies and national health data show that past DSH cuts have been correlated with increased hospital closures, particularly in rural areas, disproportionately impacting access to emergency care; and

WHEREAS, Rural and underserved communities often rely on a single hospital or emergency department for timely care, and closures due to funding shortfalls can lead to delayed treatment, worsened outcomes, and increased mortality; and

WHEREAS**,** The loss of DSH payments places greater financial strain on hospitals with high levels of uncompensated care, making it more difficult for them to maintain emergency services, staffing, and critical infrastructure; and

WHEREAS**,** ACEP is committed to advocating for equitable access to emergency care for all patients, including those who are uninsured or underinsured; and

WHEREAS**,** America's Essential Hospitals and other national organizations have already mobilized campaigns to repeal or delay the DSH cuts, which have been successful in the past, and have invited collaboration with physician specialty societies to strengthen advocacy; and

WHEREAS**,** Bipartisan legislation, such as the Supporting Safety Net Hospitals Act (H.R. 2665), has been introduced in Congress to delay DSH cuts through fiscal year 2028 and has received widespread support from hospitals and patient advocacy groups; and

WHEREAS, ACEP has a strong history of partnering with allied organizations to advance healthcare policies that support emergency medicine and protect safety-net resources; and

WHEREAS, Failure to act against impending DSH reductions will disproportionately harm hospitals that serve a majority of Medicaid and uninsured patients, threatening the stability of the nation's emergency care safety net;

therefore be it

RESOLVED, That ACEP recognize the Disproportionate Share Hospital cuts are of specific concern to emergency physicians as they have been shown to increase the amount of rural hospital closures; and be it further

RESOLVED, That ACEP partner with relevant organizations such as America's Essential Hospitals to further the cause of protecting Disproportionate Share Hospital payments; and be it further

RESOLVED, That ACEP advocate for H.R. 2665, the Supporting Safety Net Hospitals Act, to repeal or delay the Medicaid Disproportionate Share Hospital cuts scheduled for fiscal years 2026 through 2028.

**Background**

The resolution directs ACEP to recognize the Disproportionate Share Hospital (DSH) cuts are of specific concern to emergency physicians as they have been shown to increase the amount of rural hospital closures; partner with relevant organizations such as America's Essential Hospitals (AEH) to further the cause of protecting DSH payments; and, advocate for H.R. 2665, the Supporting Safety Net Hospitals Act, to repeal or delay the Medicaid Disproportionate Share Hospital cuts for fiscal years 2026 through 2028.

Medicaid Disproportionate Share Hospital (DSH) payments are paid to qualifying hospitals that serve disproportionately large volumes of Medicaid and low-income uninsured patients. States are provided with an annual allotment to account for the costs of caring for these populations that are not paid by other payers (i.e., commercial insurance, Medicare, etc.) in order to help particularly vulnerable hospitals with the financial burdens associated with higher volumes of uncompensated care. DSH payments have been made to hospitals since 1981 when Medicaid hospital payments were decoupled from Medicare, and Congress set limits on DSH payments in 1991 in order to curtail the rapid spending growth that resulted.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) imposed annual reductions for DSH payments that were scheduled to phase in gradually between fiscal year (FY) 2014 through FY 2020. The justification for reducing DSH payments was based on the assumption that the Medicaid expansion, one of the cornerstones of the ACA, would be adopted uniformly by all states and thereby reduce the number of uninsured individuals by extending Medicaid coverage to nearly all those under age 65. Thus, DSH payments could be reduced to reflect lower uncompensated care costs that were anticipated. However, as the Medicaid expansion provisions were later deemed unconstitutionally coercive by the U.S. Supreme Court (*National Federation of Independent Business v. Sebelius*, 2012), Medicaid expansion effectively became optional and fewer states expanded their programs and more individuals remained uninsured than had been expected; however, the scheduled reductions to DSH payments remained in statute.

The DSH cuts have never gone into effect as Congress has delayed or eliminated these cuts more than a dozen times, most recently in H.R. 1968, the March 2025 continuing resolution (CR) to provide continued funding for the federal government, until the end of the current fiscal year that ends on September 30, 2025. The impending DSH cut for FY 2026 is $8 billion, with another $8 billion for each of the next two fiscal years following for a total of $24 billion. Historically, advocacy to prevent the DSH cuts has been led by hospitals and health systems as they are the direct recipients of the payments.

H.R. 2665, the "Supporting Safety Net Hospitals Act," was a bipartisan bill introduced in the U.S. House of Representatives during the 118th Congress (2023-2024) by Reps. Yvette Clarke (D-NY), Dan Crenshaw (R-TX), Diana DeGette (D-CO), and Michael Burgess, MD (R-TX), with a total of 131 bipartisan cosponsors. The legislation proposed delaying pending DSH cuts by two years, moving back the implementation date for cuts scheduled to take effect in FY 2024 until FY 2026. Similar language was included in the "Lower Costs, More Transparency Act," that was passed by the House of Representatives in December 2023, but this legislation was not considered by the Senate before the end of the 118th Congress. In the current 119th Congress, the "Protect DSH Act" (H.R. 3581) was introduced on May 23, 2025, by Representative Dan Crenshaw (R-TX), to delay the DSH cuts from taking effect from

FY2029 through FY2031 (instead of FY2026-FY2028). Unlike previous iterations of this effort, H.R. 3581 was not introduced with bipartisan sponsors and has zero cosponsors as of July 21, 2025.

Concerns regarding the continued stability and viability of both urban and rural safety net hospitals have been front and center in the 119th Congress, particularly with respect to the considerable reductions in Medicaid spending included in H.R. 1, the "One Big Beautiful Bill Act," (P.L. 119-21) that was signed into law on July 4, 2025. The law does not make modifications or delays to the DSH program, but organizations like America's Essential Hospitals (AEH) urged Congress to reject the proposals that would reduce overall Medicaid funding given the myriad financial threats facing essential hospitals especially. The law did include a provision to establish a $50 billion "Rural Health Transformation Fund" to help provide some funding stability and certainty for hospitals and health care providers as a result of the law's major changes to Medicaid; however, hospitals and health systems remain concerned about the significant financial pressures on the horizon.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

**Fiscal Impact**

Budgeted resources for current advocacy initiatives.

**Prior Council Action**

The Council has discussed and adopted many resolutions regarding Medicaid, however, none that are specific to the Medicaid Disproportionate Share Hospital (DSH) payments.

Resolution 40(22) Support for Medicaid Expansion adopted. Directed the College to develop a policy statement in support of expanding Medicaid to the levels allowable by federal law and develop a toolkit to assist ACEP chapters in efforts to advocate for Medicaid expansion in their states.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted. The resolution asked for swift action to identify any adverse effects on public health, safety, and access to emergency services resulting from the Act that could result in making many persons covered by Medicaid ineligible, thus increasing the number of uninsured, and to seek immediate government action if any of these are jeopardized.

**Prior Board Action**

January 2025, approved the policy statement "Medicaid Expansion."

Resolution 40(22) Support for Medicaid Expansion adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Congressional Affairs Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 48(25)

SUBMITTED BY: Scott H. Pasichow MD, MPH, FACEP
New Jersey Chapter
American Association of Women Emergency Physicians Section
Young Physicians Section

SUBJECT: Affirming Emergency Physicians' Ethical and Legal Obligations Under EMTALA

PURPOSE: Directs ACEP to: 1) update the policy statement "Access to Reproductive Health Care in the Emergency Department" to include language that explicitly affirms emergency physicians' obligations under EMTALA to provide necessary stabilizing care for all patients presenting with emergency medical conditions, including pregnant patients when stabilizing treatment may require pregnancy termination; 2) affirm that federal EMTALA obligations supersede conflicting state laws or mandates; 3) advocate for clear federal protections for emergency physicians providing care in accordance with EMTALA requirements; 4) work with relevant federal agencies, medical societies, and stakeholders to ensure consistent interpretation and enforcement of EMTALA requirements that protect both patients and physicians; and 5) provide educational resources and support to emergency physicians navigating complex legal landscapes while maintaining their professional and ethical obligations to provide emergency medical care.

FISCAL IMPACT: Budgeted committee and staff resources to update the policy statement. Budgeted resources for current advocacy initiatives.

WHEREAS, The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) that requires any hospital with an emergency department that participates in Medicare to provide a medical screening examination and stabilizing treatment for any emergency medical condition, regardless of a patient's ability to pay[1]; and

WHEREAS, EMTALA obligates participating hospitals to provide stabilizing treatment for patients with emergency medical conditions and defines "stabilizing treatment" as medical treatment necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during transfer of the individual from a facility[2]; and

WHEREAS, In July 2022 Centers for Medicare & Medicaid Services (CMS) issued guidance titled "Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss," which clarified that emergency medical conditions involving pregnant patients may include ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders such as preeclampsia, and stated that "a physician's professional and legal duty to provide stabilizing medical treatment preempts any directly conflicting state law or mandate that might otherwise prohibit or prevent such treatment"[3]; and

WHEREAS, Effective June 3, 2025, CMS rescinded the July 2022 directive (QSO-22-22-Hospitals and QSO-21-22-Hospitals) stating it "[does] not reflect the policy of this Administration"[3]; and

WHEREAS, Despite rescinding the guidance, CMS affirmed it "will continue to enforce EMTALA, which protects all individuals who present to an emergency department seeking examination or treatment, including for identified emergency medical conditions that place the health of a pregnant woman or her unborn child in serious jeopardy";[4] and

WHEREAS, The American College of Emergency Physicians (ACEP)'s current policy on "Access to Reproductive Health Care in the Emergency Department" supports the position that early termination of pregnancy is

a medical procedure involving shared decision-making between patients and physicians, and ACEP specifically opposes penalization of patients, physicians, healthcare workers, and health systems for receiving, assisting, or referring patients to receive reproductive health services, and supports clear legal protections for emergency physicians providing federally mandated emergency care, particularly in cases of conflict between state and federal laws;[5] and

WHEREAS, The fundamental statutory requirements of EMTALA remain unchanged regardless of administrative guidance and emergency physicians retain both legal obligations under federal law and ethical obligations to provide life-saving stabilizing care; and

WHEREAS, The rescission of the 2022 guidance has created legal uncertainty for hospitals and physicians regarding emergency abortion care, with medical experts expressing concern that this policy shift will make physicians more reluctant to provide life- or health-saving care for pregnant patients,[6] though the removal of specific CMS guidance does not remove emergency physicians' ethical obligation to provide medically necessary emergency care consistent with the intent and requirements of federal law; and

WHEREAS, The obligation to provide life-saving stabilizing care for anyone who presents to an emergency department is not only a legal obligation under EMTALA, but also an ethical obligation for physicians as outlined in ACEP policy;[5] therefore be it

RESOLVED, That ACEP update its policy statement "Access to Reproductive Health Care in the Emergency Department" to include language that explicitly affirms emergency physicians' unwavering ethical and legal obligations under EMTALA to provide necessary stabilizing care for all patients presenting with emergency medical conditions, including pregnant patients when stabilizing treatment may require pregnancy termination; and be it further

RESOLVED, That ACEP affirm that federal EMTALA obligations supersede conflicting state laws or mandates that would prevent emergency physicians from providing medically necessary stabilizing treatment for emergency medical conditions; and be it further

RESOLVED, That ACEP advocate for clear federal protections for emergency physicians providing care in accordance with EMTALA requirements, particularly when such care conflicts with state laws; and be it further

RESOLVED, That ACEP work with relevant federal agencies, medical societies, and stakeholders to ensure consistent interpretation and enforcement of EMTALA requirements that protect both patients and physicians; and be it further

RESOLVED, That ACEP provide educational resources and support to emergency physicians navigating complex legal landscapes while maintaining their professional and ethical obligations to provide emergency medical care.

**References**

1. Zibulewsky J. The Emergency Medical Treatment and Active Labor Act (EMTALA): what it is and what it means for physicians. Proc (Bayl Univ Med Cent). 2001 Oct;14(4):339-46. doi: 10.1080/08998280.2001.11927785. PMID: 16369643; PMCID: PMC1305897.
2. 42 U.S.C. § 1395dd. Examination and treatment for emergency medical conditions and women in labor. Emergency Medical Treatment and Labor Act (EMTALA).
3. Centers for Medicare & Medicaid Services. Rescinded Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss. May 29, 2025. Available at: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos/policy-memos-states-and-cms-locations/rescinded-reinforcement-emtala-obligations-specific-patients-who-are-pregnant-or-are-experiencing
4. Centers for Medicare & Medicaid Services. CMS Statement on Emergency Medical Treatment and Labor Act (EMTALA). June 3, 2025. Available at: https://www.cms.gov/newsroom/press-releases/cms-statement-emergency-medical-treatment-and-labor-act-emtala
5. American College of Emergency Physicians. Access to Reproductive Health Care in the Emergency Department. Policy Statement. June 2023. Available at: https://www.acep.org/patient-care/policy-statements/access-to-reproductive-health-care-in-the-emergency-department
6. ABC News. Revoking EMTALA guidance on abortions will only further confuse doctors, experts say. June 6, 2025. Available at: https://abcnews.go.com/US/revoking-emtala-guidance-abortions-confuse-doctors-experts/story?id=122552727

**Background**

This resolution directs ACEP to: 1) update the policy statement "Access to Reproductive Health Care in the Emergency Department" to include language that explicitly affirms emergency physicians' obligations under EMTALA to provide necessary stabilizing care for all patients presenting with emergency medical conditions, including pregnant patients when stabilizing treatment may require pregnancy termination; 2) affirm that federal EMTALA obligations supersede conflicting state laws or mandates; 3) advocate for clear federal protections for emergency physicians providing care in accordance with EMTALA requirements; 4) work with relevant federal agencies, medical societies, and stakeholders to ensure consistent interpretation and enforcement of EMTALA requirements that protect both patients and physicians; and 5) provide educational resources and support to emergency physicians navigating complex legal landscapes while maintaining their professional and ethical obligations to provide emergency medical care.

Last year, the Council and the Board of Directors adopted Resolution 37(24) Reinforcing EMTALA in Pregnancy Related Emergency Medical Care directing ACEP to develop a policy statement reinforcing that: EMTALA applies universally to all emergency medical conditions without exception; support that treatment decisions, including those involving abortion, should be made solely between the patient and emergency clinician without legal interference; and emphasize the importance of allowing emergency physicians to provide care based on medical best practices without restrictions on treatment options. The resolution was assigned to ACEP's Medical-Legal Committee to develop a policy statement and that work is currently in progress.

In September 2021 HHS had released guidance reaffirming physicians' legal obligations under EMTALA, specifically when treating patients who are pregnant or are experiencing pregnancy loss.

The following year, the June 24, 2022 decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization* held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. Because emergency departments commonly see patients presenting with obstetrical emergencies, this decision immediately triggered significant uncertainty on whether, in light of the existing federal EMTALA law, restrictions or prohibitions could now be imposed on their treatment in states with abortion and related reproductive health restrictions. In response to the ruling, ACEP issued a statement expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, and reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship.

Just weeks later, in July 2022 CMS issued additional EMTALA guidance. In this updated guidance, CMS:

- Reiterates that EMTALA pre-empts any directly contradicting state laws around the medical screening examination, stabilizing treatment, and transfer requirements. It specifically clarifies that if a physician believes that an abortion needs to be performed to stabilize a patient with an emergency medical condition, the physician MUST provide the treatment regardless of any state law that may prohibit abortions.
- States that with respect to what constitutes an EMC, the determination of an EMC "is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment."
- States that EMTALA pre-empts "any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital."

Yet some grey area remained after the additional guidance from CMS, since while it noted that EMTALA can be raised as a defense by a physician facing state action, it does not provide any *proactive* protection to prevent an emergency physician from facing criminal charges brought by the state for providing this federally-mandated care. Some state restrictions only have an exception to allow abortion if it's to prevent the death of the pregnant patient, but as noted EMTALA requires stabilizing treatment to prevent "serious impairment of bodily functions," "serious dysfunction of any bodily organ or part," or to prevent placing the health of the patient "in serious jeopardy." ACEP has noted this is a key area of concern, potentially forcing emergency physicians in such states to choose between following EMTALA to avoid potential civil monetary penalties or following the state law to avoid potential criminal charges.

Therefore, ACEP joined amicus briefs addressing these issues. ACEP and the Idaho Chapter submitted a brief in the U.S. District Court for the District of Idaho on August 15, 2022, in support of the U.S. Department of Justice's challenge to an Idaho law in *United States v. State of Idaho*. Because the Idaho law only allows for abortion if the life of the mother is in danger, the brief argued that if applied to emergency medical care, Idaho Law would force physicians to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA – or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services' guidance on the EMTALA. The State of Texas had filed suit (*State of Texas v. Becerra*) arguing the federal government did not have the authority to provide medical guidance. The amicus brief emphasized the proper interpretation of EMTALA and the possibility that what under Texas law would constitute pregnancy termination may be appropriate in the emergency department when deemed necessary to provide stabilizing treatment of the patient, and that the Federal guidance merely restated physicians' obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

Since that time, there has been significant activity at the state level, in the courts, and at the federal level regarding EMTALA and pregnancy-related emergencies.

**State**

- Several states, including Colorado, New York, Illinois, and Washington have added EMTALA-like protections into state statutes to ensure emergency abortion care is mandatory at the state level regardless of federal guidance or activity.
- Following the May 29, 2025 rescission of the Biden-era EMTALA guidance, 22 states' Attorneys General jointly sent a letter to the American Hospital Association (AHA) to remind hospitals that they are obliged to provide emergency abortion care to patients under EMTALA.
- On June 4 the Centers for Medicare & Medicaid Services released its investigative findings that a Texas hospital had violated EMTALA in failing to provide an appropriate Medical Screening Exam for a patient who presented to its ED with an ectopic pregnancy.

**Courts**

- *United States v. State of Idaho*: following the Supreme Court's ruling in June of dismissing the case as improvidently granted (essentially returning it to the lower courts), the case was reheard by the Ninth Circuit in December 2024. The Justice Department under newly-elected President Trump's second term filed to drop the lawsuit in March 2025. However, ahead of this, St. Luke's, the largest hospital system in Idaho, filed a separate challenge to the state law, and had obtained a similar injunction to allow hospitals to provide emergency abortion serviced under the federal requirement in the state. On July 17, a consent decree approved by a federal judge prevents the state's Attorney General and county prosecutors from prosecuting healthcare providers who refer, counsel, or otherwise provide information to patients seeking abortions in other states.
- *State of Texas v. Becerra:* following the Fifth Circuit's ruling that EMTALA does not mandate abortion in emergency settings and is not preemptive of Texas law, in October 2024 the U.S. Supreme Court declined to intervene in the case, leaving in place that injunction limiting federal enforcement of EMTALA-based abortion guidance in Texas.

**Federal**

- On May 29, 2025, HHS rescinded the Biden Administration's 2022 guidance referenced above. Since that 2022 guidance largely reiterated existing EMTALA law, it's rescission created some uncertainty regarding what, if any, impact it would hold on emergency physicians, especially in states with restrictions related to pregnancy or reproductive health. Following that rescission, ACEP quickly put out a press release reiterating its commitment to EMTALA and its importance in ensuring emergency physicians can provide stabilizing care to any patient who needs it, including pregnant patients, and urging policymakers and federal officials to continue to uphold and enforce the law in a manner that protects patients and supports emergency physicians' clinical judgment and autonomy. reaffirm
- On June 17, 2025, HHS' Secretary Kennedy sent a letter to provider organizations with new guidance

reaffirming HHS' commitment to enforcing EMTALA and clarifying that EMTALA continues to ensure pregnant women facing medical emergencies have access to stabilizing care. It provides examples of obstetric emergencies that the EMTALA obligation applies to, such as "ectopic pregnancies, miscarriages, premature ruptures of membranes, trophoblastic tumors, and other similar conditions." The guidance then states, "Although EMTALA preempts any State or local law that 'directly conflicts' with its requirements, providers should not misconstrue existing State laws, or rely on inaccurate media reports, as a basis for denying stabilizing care to any pregnant woman facing an emergency medical condition. EMTALA continues to be the law of the land, and HHS commits to both expeditious review of complaints filed and appropriate and timely action if violations are found, to ensure that pregnant women facing emergency medical conditions have access to stabilizing care."

- On June 24, 2025, Sec. Kennedy spoke about the letter and reiterated the Administration's commitment in it when asked while testifying during the House Energy & Commerce Committee's hearing on the President's 2026 budget. Short (3 min) clip here.
- In November 2024, the Centers for Medicare and Medicaid Services (CMS) finalized two changes to the Conditions of Participation (CoP) program: a new Obstetrical Services CoP, focused on obstetrical services, and changes to the existing Emergency Services CoP (42 CFR §482.55). As part of these changes, facilities with dedicated emergency units will be subject to new requirements regarding emergency services readiness and transfer protocols. The American College of Obstetricians and Gynecologists (ACOG) and ACEP have partnered to provide information for members (to be released soon) on the second set of requirements that went into effect on July 1, 2025: emergency services readiness and transfer protocols, since more specific federal guidance is still pending.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

**Fiscal Impact**

Budgeted resources for current advocacy initiatives.

**Prior Council Action**

Resolution 37(24) Reinforcing EMTALA in Pregnancy Related Emergency Medical Care adopted. The resolution directed ACEP to develop a policy statement reinforcing that: EMTALA applies universally to all emergency medical conditions without exception; support that treatment decisions, including those involving abortion, should be made solely between the patient and emergency clinician without legal interference; and emphasize the importance of allowing emergency physicians to provide care based on medical best practices without restrictions on treatment options

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted. Directed ACEP to work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss referred to the Board of Directors.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals. Directed ACEP to support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted. Directed that ACEP oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

**Prior Board Action**

Resolution 37(24) Reinforcing EMTALA in Pregnancy Related Emergency Medical Care adopted.

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted.

June 2023, approved the policy statement "Access to Reproductive Healthcare in the Emergency Department."

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

June 2022, approved the policy statement "Interference in the Physician-Patient Relationship"

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted.

October 2016, approved the revised "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy.

**Background Information Prepared by:** Laura Wooster, MPH
Associate Exec Director, Advocacy & Practice Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 49(25)

SUBMITTED BY: Joshua Davis, MD
John F. McMaster, MD, FACEP

SUBJECT: Support for EMTALA Reform to Ensure Timely Access to Definitive Care

PURPOSE: Support legislative, regulatory, and policy reforms to strengthen the EMTALA mandate for patients requiring transfer to a higher level of care and create legislation to update or replace EMTALA to better ensure that patients receive safe and timely care.

FISCAL IMPACT: Budgeted committee and staff resources and current advocacy initiatives. Alternatively, utilizing a consulting firm with specific legislative drafting expertise and services would incur unbudgeted costs ranging from $10,000 – $50,000 depending on the scope of services needed and the timeline for completion.

WHEREAS, The Emergency Medical Treatment and Labor Act (EMTALA) was enacted in 1986 to ensure that all individuals regardless of insurance status or ability to pay, receive emergency medical services and are not inappropriately denied or refused screening, stabilization, or appropriate transfer to higher levels of care; and

WHEREAS, Current EMTALA provisions mandate that all hospitals that participate in Medicare with or without specialized capabilities, accept transfers of patients requiring higher levels of care if capacity exists, but enforcement is inconsistent and self-serving while violations are difficult to address in real time; and

WHEREAS, The real time emergency physicians present at the bedside routinely encounter delays, denials, and refusals in transferring patients to appropriate facilities or covering sub-specialists—such as trauma centers, stroke centers, psychiatric hospitals, specialty care units, or sub-specialists—despite the clinical urgency and ethical/legal obligations of the receiving hospitals and sub-specialists; and

WHEREAS, Such barriers to transfer contribute to poorer patient outcomes, prolonged emergency department boarding, delayed definitive care, and increased risks to patient safety; and

WHEREAS, Systemic challenges including economics, capacity/sub-specialty gaming, opaque bed availability, and inadequate accountability mechanisms undermine the intent of EMTALA and place undue strain on emergency physicians, emergency departments, and patients alike; therefore be it

RESOLVED, That ACEP support legislative, regulatory, and policy reforms to strengthen the EMTALA mandate and ensure that patients requiring transfer to a higher level of care are not inappropriately denied or delayed; and be it further

RESOLVED, That ACEP investigate legislation to replace or update EMTALA with a more contemporary alternative that reflects the current practice of emergency medicine and better ensures that patients receive the medical care they need in a safe and timely manner.

**Background**

The resolution calls for ACEP to support legislative, regulatory, and policy reforms to strengthen the Emergency Medical Treatment and Active Labor Act (EMTALA) mandate for patients requiring transfer to a higher level of care and create legislation to update or replace EMTALA to better ensure that patients receive safe and timely care.

EMTALA is the federal law requiring Medicare-participating hospitals with emergency departments to screen and

treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status, national origin, race, creed, or color. EMTALA was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer. The law was enacted in 1986 in response to reports about "patient dumping," a practice where hospitals and emergency rooms would refuse to treat poor or uninsured patients or transfer or discharge emergency patients based upon the anticipation of high costs of diagnosis and treatment. EMTALA requires Medicare-participating hospitals, as a condition of participation (COP) under Medicare, to provide services to any individual presenting at an emergency department, regardless of insurance status or ability to pay, or face potential enforcement actions and penalties for violations.

Hospitals have three main obligations under EMTALA:

1. The law requires hospitals to provide a ***medical screening examination*** to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition (EMC).
2. If an individual is determined to have an emergency medical condition, the individual must receive ***stabilizing treatment*** within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized.
3. If the individual is not stabilized, ***they may only be transferred*** if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks (the Centers for Medicare & Medicaid Services, or CMS, states in the guidance that patients who request to be transferred can only be transferred after a physician certifies that the medical benefits of the transfer outweigh the risks.)

A hospital must report to CMS or the state survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA.

EMTALA violations may result in the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issuing civil monetary penalties on a hospital ($129,233 for hospitals with more than 100 beds, $64,618 for hospitals with fewer than 100 beds/per violation) or physician ($129,233 per violation) pursuant to 42 CFR §1003.500 for refusing to provide either unnecessary stabilizing care for an individual presenting with an emergency medical condition that requires such stabilizing treatment, or an appropriate transfer of that individual if the hospital does not have the capacity to stabilize the emergency condition. The HHS OIG also has the authority to exclude physicians from participation in Medicare and State health care programs, and the Centers for Medicare & Medicaid Services (CMS) may also penalize a hospital by terminating its provider agreement. Additionally, private citizens who are harmed by a physician's or hospital's failure to provide stabilizing treatment may file a civil suit against the hospital to obtain damages available under the personal injury laws of that state in which the hospital is located, in addition to recouping and equitable relief as appropriate.

Under current federal regulations (42 CFR §489.24) the term "capacity" under EMTALA is defined as "the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits."

As the overall shape of the U.S. health care system has evolved over the decades since the enactment of EMTALA, some suggest that the law has not similarly evolved and does not reflect the current reality of care delivery in emergency departments and hospitals throughout the country. In particular, some suggest these conditions have led to perverse incentives that discourage hospitals and facilities from accepting transfers of patients from transferring facilities in direct conflict with the intended purpose of EMTALA's fundamental patient protections. ACEP's policy statement "Appropriate Interfacility Patient Transfer" outlines principles regarding patient transfer for those patients who require transfer from the ED to another facility. Among these principles is that "[a]greement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer."

Adding to the complexity of this problem is that despite being only four pages when signed into law and focused on protecting patient access to emergency medical care, EMTALA now functions in a more expansive manner as a result of several subsequent amendments, regulatory interpretation and enforcement, and legal determinations that have shaped the law since its enactment. The resolution notes that in 1986, medical center "capacity" was defined as "the number of physically unoccupied beds and OR tables," and that since then, "capacity" has subsequently been redefined as the number of "staffed beds" which is determined by arbitrary "nursing ratios." The resolution goes on to explain that this interpretation has resulted in perverse incentives or consequences, where transfers of patients to higher care facilities are refused because of this interpretation of "capacity," and that hospitals refuse to declare or place contingency or emergency standards of care in effect to override nursing ratio requirements in order to facilitate accepting additional transfers into unoccupied beds from facilities that cannot provide care, leading to dangerous delays in care, even death, hours of frustration for transferring personnel, and often transfers of hundreds and even thousands of miles from the nearest capable medical centers for patients.

The issue of patient transfers given the constraints of the federal EMTALA mandate remains an area of concern and persistent challenge for overwhelmed EDs. In some cases, an ED or hospital with insufficient resources or ability to care for a patient with complex needs is unable to transfer that patient to a receiving hospital because that facility is also overwhelmed with boarding patients, full units, or insufficient staff. This has resulted in patients succumbing to traumatic wounds or serious illnesses and conditions due to the inability to transfer those patients in a timely fashion. As the resolution also notes, this has been exacerbated as hospitals and facilities have not implemented emergency or crisis standards of care protocols to override nursing ratios or other resource scarcity issues.

A June 2024 article published in *ACEPNow* by James Augustine, MD, FACEP, sheds additional light on this issue. Dr. Augustine notes:

> "The additional lengthy ED stays for transfer patients are equally resource-intense for emergency physicians and especially emergency nurses. Some hospital systems have developed transfer centers or flow centers, which attempt to coordinate patient movement to the best site of care within the system. But for independent, and particularly smaller and rural hospitals, the process of finding an accepting hospital for patients needing transfer is a huge burden that involves placing one phone call or digital request at a time. Once a patient is accepted somewhere, the facility must then begin the process of finding a transport resource, coordinating the right time of transfer with the receiving facility, and completing the required documentation."
>
> This points to a need for centers that may specialize in regional patient movement, to include all hospitals and systems. In regions like San Antonio, Texas, this innovation has taken place already and serves needs across a large geographic region and many patient types (https://www.strac.org/). The state of Georgia has developed and funded a coordinating center for patient movement and EMS communications on hospital capabilities (https://georgiarcc.org/). These coordinating centers have been advantageous when patient surges occurred, such as those experienced during the most stressful days of the COVID-19 pandemic."

There are ongoing efforts outside of amending EMTALA requirements aimed at reducing barriers to patient transfers. Some stakeholders like Apprise Health Insights and others have implemented automated, real-time statewide and regional bed tracking and capacity management systems to facilitate quicker transfer of patients to appropriate facilities that have the ability and capacity to provide care. ACEP is also in the process of working with legislators to draft federal legislation to help expand the proliferation of these systems throughout the country. Additionally, ACEP has partnered with the American College of Surgeons (ACS) and the ACS Committee on Trauma (COT) to help develop a National Trauma Emergency Preparedness System (NTEPS) blueprint, which envisions a system that provides awareness of resources and surge capacity throughout the health care system, as well as the ability to load balance the system to match patients with appropriate resources and specialty expertise. This coordinated effort should be built upon a framework of an interconnected network of Regional Medical Operations Coordination Centers (RMOCCs) to improve regional care delivery by facilitating the most appropriate level of care based on individual patient acuity, while also maintaining patient safety and keeping patients in local facilities that are capable of providing high quality care.

RMOCCs are envisioned as having the following essential functions:

- Operationalize the regional plan for patient distribution and health system load balancing for any mass casualty or large public health event;
- Facilitate clinical expertise and consultation for all health-related hazards and coordinate the expertise into the regional plan through current hazard vulnerability assessments;
- Integrate all levels of healthcare leadership (public health, administrative, physician and nursing) from the regional health systems and hospitals into the framework of the emergency operations center and operational plans;
- Provide real-time situational awareness of health care capability and capacity to all regional healthcare systems and other salient healthcare entities. This function includes data collection, analysis, and dissemination (i.e., hospital and EMS capacity data);
- Support dynamic movement of patients when required and load balance the medical facilities to mitigate the need for crisis standards implementation and resource rationing;
- Provide a single point of contact at both the RMOCC and at each hospital/health system for referral requests and life-saving resource sharing;
- Align and coordinate regional resources (e.g., supplies, equipment, medications, etc.) and personnel with the goal of maintaining regional systems for time sensitive care such as cardiac, stroke and trauma that may or may not be directly impacted by the surge event; and
- Provide a communication link to other RMOCCs to lead or participate in a broader coordinated multi-regional, state, or national effort. This includes both a multi-state response and nationwide network integration.

Some of these concepts are included in the Draft Guidelines Regional Health Care Emergency Preparedness and Response Systems issued by the Administration for Strategic Preparedness and Response (ASPR), but ACEP and our partners in this effort continue to encourage ASPR to make RMOCCs the centerpiece of the regionalized approach. ACEP also continues to advocate to Congress to implement this approach as part of our nation's larger emergency preparedness infrastructure.

**ACEP Strategic Plan Reference**

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

**Fiscal Impact**

Budgeted committee and staff resources and current advocacy initiatives. Alternatively, utilizing a consulting firm with specific legislative drafting expertise and services would incur unbudgeted costs ranging from $10,000 – $50,000 depending on the scope of services needed and the timeline for completion.

**Prior Council Action**

Substitute Resolution 36(24) EMTALA Reform to Improve Patient Access to Necessary Care adopted. Directed ACEP to collaborate with the Arizona and Connecticut Chapters and others to develop model state policy, regulation, and legislation, that requires reporting of ED/Hospital Crowding & Inter-Hospital Transfer data to a relevant state entity (e.g., State Dept of Health) and develop a statewide system to facilitate inter-facility transfers.

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted. Directed ACEP to work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA and support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs referred to the Board of Directors. Requests ACEP to: 1) work with state and federal agencies to advocate for state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems and to report their activities publicly; 2) advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not available at the referring hospital; 3) advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined as patient catchment areas rather than jurisdictional boundaries; and 4) support research to strengthen the evidence base regarding rural hospital transfer processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes and experience and include investigation of common challenges experienced by all small, non-networked hospitals.

Amended Resolution 23(11) EMTALA adopted. Directed ACEP to submit recommendations to CMS regarding uniform interpretation and fair application of EMTALA; work with CMS to institute confidential, peer-reviewed process for complaints; work with CMS and others to require that complaints be investigated consistently according to ACEP-developed standards and investigators required to adhere to principles of due process and fairness during investigations; and provide a report to the 2012 Council on this issue.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed ACEP to solicit member input to formulate and submit recommendations for the CMS EMTALA advisory process and other appropriate bodies, including recommendations for clarifying medical staff on call responsibilities, obtaining greater consistency of EMTALA enforcement among all the CMS regional offices, protection of peer review confidentiality, and utilizing consultative peer review for issues involving medical decision making.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA and for the Board to provide a report to members in 2001.

**Prior Board Action**

Substitute Resolution 36(24) EMTALA Reform to Improve Patient Access to Necessary Care adopted.

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs assigned to the ACEP Federal Government Affairs Committee and State Legislative/Regulatory Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution.

January 2022, approved the revised policy statement, "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with current title; revised and approved February 2009, February 2002, June 1997, September 1992 titled, "Appropriate Inter-hospital Patient Transfer;" originally approved September 1989 as position statement "Principles of Appropriate Patient Transfer."

January 2019, reaffirmed the policy statement "EMTALA and On-Call Responsibility for Emergency Department Patients;" revised and approved June 2013, April 2006 replacing "Hospital, Medical Staff, and Payer Responsibility for Emergency Department Patients" (1999),"Medical Staff Responsibility for Emergency Department Patients" (1997), and "Medical Staff Call Schedule."

Amended Resolution 23(11) EMTALA adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

**Background Information Prepared by:** Laura Wooster, MPH
Associate Exec Director, Advocacy & Practice Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 50(25)

SUBMITTED BY: Louisiana Chapter
Maine Chapter
New Jersey Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Emergency Department Staffing Transparency

PURPOSE: Advocate for strict enforcement of federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including explanation of how emergency medical needs will be addressed when a physician is not present.

FISCAL IMPACT: Budgeted committee and staff resources for current advocacy initiatives.

WHEREAS, Recent data indicate that 1 in 13 emergency departments operate at times without a physician physically on-site and on duty; and

WHEREAS, The American College of Emergency Physicians (ACEP) affirms that, regardless of geographic location, all patients who present to emergency departments (EDs) deserve access to high-quality, patient-centered care delivered by emergency physician-led teams; and

WHEREAS, The ACEP Emergency Department Accreditation Program promotes transparency to help patients make informed decisions when seeking emergency care; and

WHEREAS, The general public reasonably expects that a visit to an "Emergency Department" will involve being evaluated by a physician; and

WHEREAS, A March 2022 ACEP public opinion survey found that 72% of respondents would be concerned if no physician were available during their medical emergency; and

WHEREAS, The Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 489, Subpart B.489.20 - Basic Commitments. Section w (5) states:

> "Each dedicated emergency department, as that term is defined in § 489.24(b), in a hospital in which a doctor of medicine or doctor of osteopathy is not present 24 hours per day, 7 days per week must post a notice conspicuously in a place or places likely to be noticed by all individuals entering the dedicated emergency department. The posted notice must state that the hospital does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the hospital will meet the medical needs of any patient with an emergency medical condition, as defined in § 489.24(b), at a time when there is no doctor of medicine or doctor of osteopathy present in the hospital."; therefore be it

RESOLVED, That ACEP advocate for strict enforcement of the federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present.

**Background**

This resolution calls for the College to advocate for strict enforcement of federal regulation requiring hospitals without 24/7 on-site physician coverage to post notices informing patients there is not a physician on site, and how the

hospital will meet the emergency medical needs of any patient when a physician is not present. This is in compliance with the Code of Federal Regulation, Title 42, Chapter IV, Subchapter G, Part 489, Subpart B.489.20 - Basic Commitments. Section w (5).

Section 1866(N)(iii) of the Social Security Act details the EMTALA-required signage for all Medicare-participating hospitals offering emergency services. Additionally, the Centers for Medicare & Medicaid Services (CMS) and the Office of the Inspector General (OIG) within the U.S. Department of Health and Human Services (HHS) have indicated that some signs are *not allowed* under the law.

ACEP staff contacted the EMTALA compliance office within CMS about what signs are permitted/prohibited in response to Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians and received the following response.

> "CMS, along with our colleagues in the Office of Inspector General of Health & Human Services, has discouraged hospitals from placing additional signage in the ED or other required hospital locations that may in any way act to deter or discourage individuals from staying for medical screening examinations and stabilizing treatment. This does not mean that all signage is prohibited. If signage is identified as a concern, hospitals would be expected to demonstrate how it is in compliance with CMS requirements and does not deter or discourage individuals from staying for statutorily required medical screening examinations."

CMS also notes that signs posted in an ED are evaluated on a case-by-case basis. If an individual surveyor finds that signs "deter or discourage" patients from seeking emergency care, facilities would be subject to EMTALA related penalties/fines. Resolution 39(22) was amended by the Council to "encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered."

The 2022 National ED Inventory (NEDI)-USA survey found that 7.4%, or one in every 13, EDs did not have an attending physician on duty 24/7. This phenomenon was more frequent in critical access hospitals (89%) and rural locations (72%) with an annual visit volume greater than 10,000.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" most recently updated in October 2024 states:

> "Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety. Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment."

ACEP released the Physician Staff Requirement in Emergency Departments Model Legislation and Toolkit in 2023 that includes key considerations when crafting and lobbying for a bill or regulation related to the topic. This toolkit, along with support from ACEP's Advocacy team, was instrumental in helping states pass legislation that requires a physician in the ED at all times.

In the 2024-25 legislative session, South Carolina joined Indiana (2023) and Virginia (2024) in passing a law requiring all hospitals with emergency departments to have at least one physician physically onsite while the ED is open. Both Virginia and South Carolina chapters were able to use model legislation and receive direct support from ACEP's State Legislative team, including assistance with drafting the legislation, and providing expert-level support during the legislative process.

ACEP advocated at the AMA House of Delegates for a resolution that adopts much of the model legislation used in Indiana and Virginia. The AMA adopted resolution 204 in June 2024 that compels the AMA to seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and that the AMA seek federal legislation or regulation that would require all emergency departments to be staffed 24/7 by a qualified physician.

CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet to begin and continue participating in Medicare and Medicaid. This action would have the effect of creating a federal mandate that EDs in Critical Access Hospitals (CAH) and Rural Emergency Hospitals (REH) be staffed 24/7 by a qualified physician. This would parallel the requirement in Indiana, Virginia, and ACEP's model legislation, but does not require a board certified emergency physician in the rural setting.

ACEP has continually promoted and advocated the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians and for physician-led care teams in the emergency department at both the national and state level. ACEP's Advocacy and Practice Affairs staff have advocated for this standard to the Centers for Medicare and Medicaid Services as well as Health and Human Services and the U.S. Congress.

ACEP's Legislative and Regulatory Priorities for the First Session of the 119th Congress include:

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs. (Legislative)
- Identify innovative staffing, payment, and reimbursement models, such as potential global budgeting for emergency physician professional services to maintain viability of ED coverage in rural and underserved areas. (Legislative)
- Develop and propose federal legislation to address unique challenges for the current and future EM workforce, with special consideration for solutions to promote access to board-certified EPs in rural and underserved communities. (Legislative)
- Monitor the willingness of critical access hospitals and rural hospitals to convert to Rural Emergency Hospitals and develop policy suggestions that would make this a more attractive option. (Regulatory)

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

**Fiscal Impact**

Budgeted committee and staff resources for current advocacy initiatives.

**Prior Council Action**

Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments referred to the Board. Requested ACEP to collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician is immediately available for on-site care of emergency department patients at all times.

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted. Directed ACEP to adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

Resolution 68(21) Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth) not adopted. Asked ACEP to support legislation to require all facilities who have an ED or designate an area as an ED or emergency room to have a board eligible/certified emergency physician onsite or via telehealth at all times (with a limited exception) to market to the public and bill for emergency services; and to impose requirements on facilities to address shortcomings or to limit their ability to name themselves as emergency departments, etc.

Substitute Resolution 66(21) ACEP Promotion of the Role of Emergency Physician Led Teams referred to the Board of Directors. Called for ACEP to publish and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an ABEM/AOBEM board certified emergency physician; and support the standard that board-certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process and provide findings to the Council by July 1, 2022.

Resolution 27(19) Ensuring Public Transparency and Safety by Protecting the Terms "Emergency Department" and "Emergency Room" as Markers of Physician-Led Care not adopted. Directed ACEP to oppose the use of the terms "emergency" or "ER" by a facility if a physician is not onsite at all times and to draft state and federal legislation mandating that those terms indicate physician led care.

**Prior Board Action**

April 2025 approved the policy statement "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners."

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants

and Advanced Practice Registered Nurses in the Emergency Department", originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" and replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department.

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

April 2023, approved the revised policy statement "Definition of an Emergency Physician;" reaffirmed April 2017; originally approved June 2011.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

**Background Information Prepared by:** Brianna Hanson, MPH
Reimbursement and State Legislative Manager

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 51(25)

SUBMITTED BY: Kansas Chapter

SUBJECT: Supporting Board Certified Physicians in Every Emergency Department

PURPOSE: Support state and federal legislative and regulatory efforts that require a board-certified or eligible emergency physician be physically present and available in every emergency department at all times, and develop draft legislation.

FISCAL IMPACT: Budgeted committee and staff resources for current and ongoing federal and state advocacy initiatives.

WHEREAS, Emergency departments (EDs) serve as critical access points for medical care, often providing life-saving treatment for patients experiencing acute medical emergencies; and

WHEREAS, The complexity and urgency of emergency care require the knowledge, training, and decision-making skills unique to board-certified emergency physicians; and

WHEREAS, ACEP asserts that the gold standard for ED care is provided by emergency physicians certified or eligible for certification by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM); and

WHEREAS, Board certification through the ABEM or AOBEM ensures that physicians have met rigorous standards of competency and excellence in emergency care; and

WHEREAS, ACEP acknowledges the integral role of Physician Assistants (PAs) and Nurse Practitioners (NPs) in the ED care team, it maintains that these professionals do not possess the specialized training and expertise of emergency physicians; and,

WHEREAS, ACEP guidelines stipulate that PAs and NPs should not perform independent, unsupervised care in the ED. Supervision by a board-certified emergency physician is required, with the supervising physician having real-time involvement in patient care decisions; and

WHEREAS, The presence of board-certified emergency physicians in EDs enhances patient safety, improves clinical outcomes, and ensures the highest standards of care; and

WHEREAS, Many hospitals and systems, particularly in rural or underserved areas, increasingly rely on non-board-certified physicians or non-physician providers without physician oversight, potentially compromising the quality of emergency care; and,

WHEREAS, Indiana and Virginia have recently enacted legislation requiring that a licensed physician be physically present and on duty in every hospital ED at all times, setting a precedent for ensuring physician-led emergency care and reinforcing the standard of high-quality, accountable medical oversight in emergency settings; therefore be it

RESOLVED, That ACEP support state and federal legislative and regulatory efforts to require that a physician, ideally a board-certified or eligible emergency physician, be physically present and available in every emergency department at all times, which includes but is not limited to developing draft legislation on this topic.

**Background**

This resolution directs ACEP to support state and federal legislative and regulatory efforts to require that a physician, ideally a board-certified or eligible emergency physician, be physically present and available in every emergency department at all times, and for ACEP to develop draft legislation on this topic.

ACEP has continually promoted and advocated the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians and for physician-led care teams in the emergency department at both the national and state level. ACEP's Advocacy and Practice Affairs staff have advocated for this standard to the Centers for Medicare and Medicaid Services as well as Health and Human Services and the U.S. Congress.

ACEP's Legislative and Regulatory Priorities for the First Session of the 119th Congress include:

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs. (Legislative)
- Identify innovative staffing, payment, and reimbursement models, such as potential global budgeting for emergency physician professional services to maintain viability of ED coverage in rural and underserved areas. (Legislative)
- Develop and propose federal legislation to address unique challenges for the current and future EM workforce, with special consideration for solutions to promote access to board-certified EPs in rural and underserved communities. (Legislative)
- Monitor the willingness of critical access hospitals and rural hospitals to convert to Rural Emergency Hospitals and develop policy suggestions that would make this a more attractive option. (Regulatory)

ACEP released the Physician Staff Requirement in Emergency Departments Model Legislation and Toolkit in 2023 that includes key considerations when crafting and lobbying for a bill or regulation related to the topic. This toolkit, along with support from ACEP's Advocacy team, was instrumental in helping states pass legislation that requires a physician in the ED at all times.

In the 2024-25 legislative session, South Carolina joined Indiana (2023) and Virginia (2024) in passing a law that requires all hospitals with emergency departments to have at least one physician physically onsite while the ED is open. Both Virginia and South Carolina chapters were able to use model legislation and receive direct support from ACEP's State Legislative team, including assistance with drafting the legislation, and providing expert-level support during the legislative process.

ACEP advocated at the AMA House of Delegates for a resolution that adopts much of the model legislation used in Indiana and Virginia. The AMA adopted resolution 204 in June 2024 that compels the AMA to seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and that the AMA seek federal legislation or regulation that would require all emergency departments to be staffed 24/7 by a qualified physician.

The State Legislative/Regulatory Committee developed a toolkit on strategies to combat scope of practice expansion by non-physicians. Additionally, the committee drafted template language requiring all EDs to have a physician on-site and on-duty 24/7/365 days of the year; and that no non-physician practitioner should be allowed to work independently and without supervision in an ED.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" most recently updated in October 2024 states:

> "Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American

> Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety. Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment."

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

**Fiscal Impact**

Budgeted committee and staff resources for current and ongoing federal and state advocacy initiatives.

**Prior Council Action**

Resolution 69(24) Updating ACEP's Position on PA and NP Supervision in the ED referred to the Board of Directors. The resolution sought to amend the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to remove reference to workforce limitations in specific CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "offsite" by telehealth means for Critical Access Hospitals (CAHs) and Rural Emergency Hospitals (REHs).

Resolution 52(24) Delegation of Critical Care to Non-Physician Practitioners referred to the Board of Directors. Revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement to include that: emergency physicians should retain primary responsibility for performing critical care activities within EDs to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care scenarios effectively; credentialing processes must prioritize patient safety and quality of care, ensuring that physicians and non-physician practitioners are granted privileges to manage patients commensurate with their training; the scope of practice for nurse practitioners and physician assistants in EDs should be clearly defined, focusing on roles where their training and expertise can complement but not substitute for the specialized skills of emergency physicians in critical care

Substitute Resolution 29(24) Minimum Standards for Freestanding Emergency Departments adopted. Directed ACEP to promote the maintenance of more specific minimum standards for freestanding emergency departments (FSEDs)

pertaining to appropriate staffing, lab, security, service availability, and imaging capabilities, and update the FSED policy statement accordingly.

Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments referred to the Board. Requested ACEP to collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician is immediately available for on-site care of emergency department patients at all times.

Resolution 49(23) Enhancing Rural Emergency Medicine Patient Care not adopted. Directed ACEP to support initiatives that encourage the placement of emergency medicine-trained and board certified medical directors in all U.S. EDs, whether in person or virtual; support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-emergency medicine physicians, physician assistants, and nurse practitioners already working in rural EDs.

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted. Directed ACEP to adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted. Directed ACEP to make recommendations on the minimum staffing ratios of physicians to nurse practitioners and physician assistants.

Amended Resolution 45(22) Offsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department," so that onsite emergency physician presence to supervise nurse practitioners and physicians be stated as the gold standard for staffing all emergency departments.

Resolution 44(22) Competencies of Independent Emergency Medicine Nurse Practitioners and Physician Assistants not adopted. Requested that ACEP: 1) Revise current policy statements regarding the role of NPs and PAs working in the ED; 2) Advocate with CMS and other third-party payers to exclude care provided by NPs and PAs where there is not in-person, real-time physician supervision from an emergency physician (as defined by ACEP) for billing and reimbursement purposes.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 68(21) Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth) not adopted. Asked ACEP to support legislation to require all facilities who have an ED or designate an area as an ED or emergency room to have a board eligible/certified emergency physician onsite or via telehealth at all times (with a limited exception) to market to the public and bill for emergency services; and to impose requirements on facilities to address shortcomings or to limit their ability to name themselves as emergency departments, etc.

Substitute Resolution 66(21) ACEP Promotion of the Role of Emergency Physician Led Teams referred to the Board of Directors. Called for ACEP to publish and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an ABEM/AOBEM board certified emergency physician; and support the standard that board-certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

Amended Resolution 65(21) Rural Provider Support and a Call for Data adopted. Directed ACEP to: 1) recognize that patients presenting to rural emergency departments are a vulnerable ED patient population in the U.S. and deserve increased support; 2) support the Rural Section in collecting survey data from rural emergency departments to investigate volumes, clinician staffing patterns, and common barriers of care and staffing based on defined volumes; 3) recognize that ABEM/AOBEM-certified or eligible physicians are underrepresented in rural emergency departments and that very low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; 4) encourage rural emergency departments to retain ABEM/AOBEM-certified physicians to serve as emergency department medical directors so there will be physician-led teams in all U.S. EDs; and 5) support and endorse rural-specific tools including telemedicine initiatives, the development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process and provide findings to the Council by July 1, 2022.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to: 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 27(19) Ensuring Public Transparency and Safety by Protecting the Terms "Emergency Department" and "Emergency Room" as Markers of Physician-Led Care not adopted. Directed ACEP to oppose the use of the terms "emergency" or "ER" by a facility if a physician is not onsite at all times and to draft state and federal legislation mandating that those terms indicate physician led care.

Amended Resolution 25(10) Definition of an Emergency Physician referred to the Board of Directors. Directed ACEP to define an "emergency physician" as someone who has either completed ACGME or AOA residency training in Emergency Medicine or fellowship in Pediatric Emergency Medicine, or is ABEM or AOBEM certified in Emergency Medicine or Pediatric Emergency Medicine, or began practicing emergency medicine in the 20th century and therefore is eligible to be a member of the American College of Emergency Physicians.

**Prior Board Action**

April 2025 approved the policy statement "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners."

Substitute Resolution 29(24) Minimum Standards for Freestanding Emergency Departments adopted.

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

April 2023, approved the revised policy statement "Definition of an Emergency Physician;" reaffirmed April 2017; originally approved June 2011.

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted.

Amended Resolution 45(22) Offsite Supervision of Nurse Practitioners and Physician Assistants adopted.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted.

Amended Resolution 65(21) Rural Provider Support and a Call for Data adopted.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

**Background Information Prepared by:** Brianna Hanson, MPH
Reimbursement and State Legislative Manager

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 52(25)

SUBMITTED BY: Gary Gaddis, MD, PhD, FACEP
Sonya Naganathan, MD, MPH, FACEP

SUBJECT: Investigation of State Licensure Requirement for Hospital Administrators

PURPOSE: 1) Investigate the potential advantages, disadvantages, feasibility, and practical aspects if states require licensure of health care administrators. 2) If investigation finds that health care administrators should be licensed, develop model state legislation and ask NEMPAC and chapters PACs to support enactment of appropriate state legislation. 3) If investigation supports licensure of health care administrators, collaborate with other stakeholders to advocate for state licensure. 3) Consider adding a course at a future Scientific Assembly to inform members about the case to be made in support of state licensure of health care administrators.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort. Use of an outside consultant could be utilized to perform the investigation. Costs could range in excess of a minimum of $50,000 depending on the scope of work and the timeline for completion.

WHEREAS, Physicians, Nurses, Advanced Nurse Practitioners, Physician Assistants, and practitioners of the Allied Health fields (Radiology Technology, Ultrasound Technology, Physical Therapy, Occupational Therapy, and others) are all required to maintain an active license from the state(s) in which they practice, as a prerequisite to their ability to provide patient care; and

WHEREAS, This requirement for licensure is rational, because it is in the interest of the various states and their citizens that those who provide health care meet the various standards required by the various states for licensure as a health care worker; and

WHEREAS, Among the underlying reasons for licensure is to minimize the potential for harm that might be caused to patients because of acts by underqualified, undertrained, compromised or underprepared clinicians; and

WHEREAS, Hospital and health care facilities must also be licensed by the state in which they are located, to enable them to function as sites that provide patient care; and

WHEREAS, These hospitals and health care facilities are all managed by various administrators, who are currently free of any licensure obligations by the state in which they work, despite their decisions also having great potential to help or harm patients' interests, and despite that administrators' decisions can impact patients on a much larger scale than any decision made by any single clinician about any individual patient; and

WHEREAS, If hospital administrators were licensed by the various states, those states would obtain a new means to intervene against administrators who persistently make patient-adverse decisions, toward safeguarding the interests of patient care and safety; and

WHEREAS, Model legislation advocating for licensure of health care administrators has been crafted for introduction to the legislatures of the States of Washington and Connecticut, and

WHEREAS, We were unable to find any current ACEP policy that addresses the matter of a requirement for state licensure of hospital administrators; therefore be it

RESOLVED, That ACEP investigate the potential advantages, disadvantages, feasibility, and practical aspects that would be inherent if states were to require licensure of health care administrators; and be it further

RESOLVED, That if investigation supports that health care administrators should be licensed, ACEP will develop model state legislation and advocate for such licensure, while asking the National Emergency Medicine Political Action Committee (NEMPAC) and the various state chapters' political action committees (PACs) to support enactment of appropriate state legislation on this matter; and be it further

RESOLVED, That if investigation supports that health care administrators should be licensed, ACEP will collaborate with other stakeholders, such as but not limited to the American Medical Association, to advocate for state licensure of health care administrators; and be it further

RESOLVED, That ACEP consider adding a course at a future Scientific Assembly to inform members about the case to be made in support of state licensure of health care administrators.

**Background**

This resolution calls for ACEP to investigate the potential advantages, disadvantages, feasibility, and practical aspects of state licensure of health care administrators and, based on favorable investigation, develop model state legislation and advocate for such licensure at the state level in collaboration with other stakeholders. Additionally, the resolution requests ACEP to consider adding a course at a future Scientific Assembly to inform members about the potential advantages of state licensure of health care administrators.

Neither the federal government nor any states currently require licensure for hospital administrators. According to the American College of Health Care Administrators, while hospital administrators do not require a license, as a federal requirement, every nursing home in the U.S. that provides Medicare and Medicaid services must operate under the supervision of a licensed administrator. Nursing Home Administrators are licensed by the states. Applicants are required to have at least a bachelor's degree from an accredited institution, complete an Administrator-in-Training program, and pass the national licensing exam administered by the National Association of Long-Term Care Administrator Boards (NAB).

Health care administrators voluntarily receive certification through the fellowship program such as those offered by the American College of Healthcare Executives (ACHE). Membership is only offered after obtaining an undergraduate or master's degree and being employed in a training role. Applicants are required to complete coursework and pass a certifying examination. Continuing education is required to maintain certification. Other options include the Healthcare Administration and Leadership and Management (HALM) offered through the American Board of Emergency Medicine.

States have considered further regulation of health care administrators, with the most recent attempt being Connecticut SB 7, introduced in the 2025 state legislative session. This legislation would create a new licensure requirement for hospital administrators, with minimum qualifications for education and work experience as well as passing a certifying examination and establishing actions administrators could be held liable for.

Advocating for certification of health care administrators by individual states would require a significant multi-year investment from the College as well as establishing strategic partnerships with other specialties, the American Medical Association (AMA), and identifying legislator champions in key states. Further investigation by the College would also be needed to determine if nursing home administrator licensing has resulted in improved outcomes as expansion of the current NAB model to include hospital administrator certification is the most realistic option for the majority of states to pursue.

Including a course at a future Scientific Assembly in support of state licensure of health care administrators could be accomplished by submitting a course proposal for consideration by ACEP's Education Committee.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort. Use of an outside consultant could be utilized to perform the investigation. Costs could range in excess of a minimum of $50,000 depending on the scope of work and the timeline for completion

**Prior Council Action**

None

**Prior Board Action**

None

**Background Information Prepared by:** Adam Krushinskie, MPA
Senior Director, State Legislative and Reimbursement

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 53(25)

SUBMITTED BY: Kansas Chapter

SUBJECT: Prior Authorization Reform to Reduce Delays in Care and Emergency Department Burden

PURPOSE: Advocate for federal and state legislative and regulatory efforts to reform prior authorization processes, with the goal of reducing care delays that result in emergency department visits or hospitalizations, and advocate for real-time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Prior authorization requirements imposed by insurance companies frequently delay access to medically necessary care, contributing to disease progression, care fragmentation, and patient harm; and

WHEREAS, Although emergency physicians are generally not directly engaging in prior authorizations, they frequently care for patients whose conditions have worsened due to delayed access to diagnostic tests, specialist evaluations, medications, or procedures requiring prior authorization; and

WHEREAS, Such delays disproportionately affect patients with chronic illnesses, cancer, mental health conditions, and social vulnerabilities, many of whom ultimately present to emergency departments in avoidable crisis due to inability to obtain timely outpatient care; and

WHEREAS, Unnecessary ED visits and admissions driven by prior authorization delays contribute to ED crowding, increased health care costs, resource strain, and clinician burnout, ultimately compromising the quality and timeliness of emergency care; and

WHEREAS, Emergency physicians are uniquely positioned to advocate for system reforms that reduce preventable ED visits, improve care coordination, and support timely access to appropriate outpatient services; therefore be it

RESOLVED, That ACEP support federal and state legislative and regulatory efforts to reform prior authorization processes, with the goal of reducing care delays that result in emergency department visits or hospitalizations; and be it further

RESOLVED, That ACEP advocate for real-time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings.

**Background**

This resolution asks ACEP to advocate for time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings and advocate for real-time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings

Emergency physicians frequently care for patients whose conditions have worsened due to delayed access to diagnostic tests, specialist evaluations, medications, or procedures requiring prior authorization, which disproportionately affect patients with chronic illnesses, cancer, mental health conditions, and social vulnerabilities.

Prior authorization is a form of utilization management that requires physicians and other providers to obtain advance approval from a health plan before a specific service is delivered to the patient to qualify for payment coverage. Through Prudent Layperson (PLP) laws have largely eliminated the issue of prior authorization for emergency services, emergency medicine is not immune from the negative effects of overly restrictive prior authorization requirements. Patients are often unable to receive services in other care locations because of prior authorization denials and delays are forced to come to the ED specifically to receive those services. In the 2024 American Medical Association Prior Authorization Physician Survey, 93 percent of physicians surveyed responded that prior authorization sometimes, often, or always results in care delays.

Prior authorization is frequently utilized by Medicare Advantage Organizations (MAOs), but unfortunately, it delays necessary care, instead of preventing unnecessary care. According to the Kaiser Family Foundation, there were 35 million Medicare Advantage (MA) prior authorization requests in 2021. Over two million prior authorization requests were fully or partially denied by MA plans, and 11 percent of those denials were appealed. The vast majority (82 percent) of appeals resulted in fully or partially overturning the initial prior authorization denial. Since MAOs are not required to indicate the reason a denial was issued in the reporting to CMS, it is unclear why claims are being denied. The fact that the majority of prior authorization appeals are fully or partially overturned gives credence to the argument that prior authorization is simply a delay tactic.

Prior authorization also contributes to ED boarding. In a March 2022 American Hospital Association (AHA) letter to the Centers for Medicare & Medicaid Services (CMS), the AHA stated that the use of prior authorization among MA plans is "especially problematic when general acute-care hospital beds have been filled to capacity and while healthcare providers contend with the demands of vaccine distribution and workforce shortages," and "The absence of prior authorization waivers also resulted in unintended consequences for patients who were then forced to stay in acute care settings unnecessarily while waiting for health plan administrative processes to authorize the next steps of their care."

ACEP's Prior Authorization Policy Statement maintains that prior authorization rules instituted by third party payers must not pose a barrier to patients seeking access to timely emergency care, and that an insured patient should be granted the expectation of coverage when seeking emergency care. ACEP further asserts that insurance companies have an obligation to pay for necessary evaluation, stabilizing treatments, and/or appropriate consultation, admission, or transfer.

ACEP's legislative and regulatory priorities include:

- Oppose efforts by insurers to create unnecessary barriers to care, including through use of prior authorization, etc.
- Monitor regulatory changes in Medicare that promote Medicare Advantage and potential increased patient burdens via prior authorization requirements, narrow networks, increased cost-sharing, step therapy, and others.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

**Fiscal Impact**

Budgeted resources for current advocacy initiatives.

**Prior Council Action**

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted. The resolution directed ACEP to commission an independent study on the financial influence exerted by health insurers to leverage EMTALA mandates and withhold appropriate reimbursement and work with other allied organizations to better understand their impact on physician delivery of emergency care.

Amended Resolution 38(19) Standards for Insurance Denials adopted. Directed ACEP to work with legislators to enact legislation that makes it illegal for a payor to engage in automatic denials; allow a physician who is board certified and remains clinically active in a field related to the claim, carefully review the denial, and attest to the cause of the denial; patients have the legal right under EMTALA to seek emergency care and that their claims are not denied by payors; and work towards getting an affirmation in writing from payors that they will adopt this as policy.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts and work to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in states that have the definition in law.

Amended Resolution 25(87) Prior Authorization Requirements adopted. Directed ACEP to recognize the concept of prior authorization imposes barriers to patient care, reaffirm the principles that patients should receive prompt emergency care regardless of payment source or ability to pay, patient who requests emergency medical care establishes a relationship with the physician, and develop strategies to address the ramifications of prior authorization.

**Prior Board Action**

June 2023, approved the revised policy statement "Fair Reimbursement When Services are Mandated" with the current title; revised and approved April 2017 titled "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005; revised and approved June 1999 titled "Compensation When Services Are Mandated;" originally approved September 1992.

June 2023, approved the revised policy statement "Prior Authorization;" revised and approved April 2017, April 2010, February 2003; originally approved October 1998.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted.

October 2020, approved the revised policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved April 2014, June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

February 2020, approved prudent layperson model state legislation stipulating that "the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway."

Amended Resolution 38(19) Standards for Insurance Denials adopted.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.
Resolution 43(97) Prudent Layperson Legislation adopted.

Amended Resolution 25(87) Prior Authorization Requirements adopted.

**Background Information Prepared by:** Jessica Adams
Reimbursement Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 54(25)

SUBMITTED BY: Nevada Chapter

SUBJECT: Reassessment and Potential Restructuring of the HCAHPS Survey and Its Role in Medicare Reimbursement

PURPOSE: Study the feasibility and potential impact of a complete restructuring or replacement of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to develop recommendations that focus on patient-centered care, physician autonomy, and sustainable health system payment.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort and would require a minimum of unbudgeted costs of $30,000 including for staff time, $15,000 for outside consultants (e.g. statistician, survey developer), and $5,000 for development, formatting, and distribution of findings.

WHEREAS, The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey has been a core component of Medicare's Value-Based Purchasing (VBP) program since 2007, influencing up to 25% of a hospital's performance-based reimbursement[1]; and

WHEREAS, The original intent of HCAHPS was to promote patient-centered care through standardized measurement of patient experience, but its integration into payment systems has led to unintended consequences, including administrative burden and potential manipulation or gaming of survey results[2]; and

WHEREAS, The survey includes controversial components, such as questions related to pain management, which have been criticized by the American Medical Association for potentially encouraging opioid overprescription and undermining appropriate clinical judgment[3]; and

WHEREAS, Response rates to the HCAHPS survey have declined over time, and the current design may disadvantage patients with low health literacy and hospitals serving vulnerable populations, potentially exacerbating health disparities[4]; and

WHEREAS, International models of patient experience measurement, such as those used in the United Kingdom and Canada, prioritize quality improvement and public accountability without direct financial penalties or rewards, offering potential lessons for U.S. policy[5]; and

WHEREAS, Proposed cuts to Medicaid will likely lead to hospital closures in rural and underserved areas, which are also the hospitals that are likely to benefit from restructuring of the HCAHPS survey[6]; and

WHEREAS, ACEP has an interest in promoting evidence-based performance measures that do not inadvertently compromise clinical care; therefore be it

RESOLVED, That ACEP study the feasibility and potential impact of a complete restructuring or replacement of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and specifically its linkage to Medicare reimbursement, with the aim of developing recommendations that better balance the goals of patient-centered care, physician autonomy, and sustainable health system payment.

**References**

[1] https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey#:~:text=CMS%20implemented%20the%20HCAHPS%20survey,results%20occurred%20in%2 0March%202008.
[2] https://www.who.int/health-topics/integrated-people-centered-care#tab=tab_1

[3]https://www.ama-assn.org/delivering-care/nation-s-overdose-epidemic/patient-satisfaction-surveys-need-better-address-pain
[4]https://pmc.ncbi.nlm.nih.gov/articles/PMC8478166/#:~:text=Perhaps%20a%20larger%20problem%20with,HCAHPS%20responses%20rates%20after%20TKA.
[5]https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly#:~:text=Goal:%20To%20compare%20the%20performance,children%20and%20working%2Dage%20adults
[6]https://sph.umich.edu/news/2025posts/what-proposed-medicaid-cuts-could-mean-for-rural-communities-hospital-access.html

**Background**

This resolution asks ACEP to develop a study and offer recommendations for a replacement or restructuring of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

The HCAHPS Survey is a national, standardized, publicly-reported survey of patients' perspectives of hospital care. The 32-item instrument and data collection methodology allow valid comparisons to be made across hospitals. The original survey was nationally implemented in 2006, and public reporting of hospital scores began in 2008. Since 2012, HCAHPS scores have also played a role in hospital payment through the Hospital Value-Based Purchasing (VBP) program.

Beginning January 1, 2025, CMS made several changes to survey administration and content. The HCAHPS Survey asks recently discharged patients about aspects of their hospital experience that they are uniquely suited to address: 22 questions that ask how often or whether patients experienced a critical aspect of hospital care, 3 screener items that direct patients to relevant questions, and 7 questions to adjust for the mix of patients across hospitals or support Congressionally-mandated reports. Hospitals are permitted to add up to 12 supplemental items; CMS does not review, approve, or receive data from supplemental items. Of note, the updated HCAHPS does not include items related to pain management. It is unlikely that CMS will modify or replace the current HCAHPS in the near future as they very recently revamped the survey and its administration.

In 2012, CMS worked with the RAND Corporation on the Emergency Department Patient Experience of Care (EDPEC) survey, now renamed the Emergency Department Consumer Assessment of Healthcare Providers & Systems (ED CAHPS) survey. ACEP members were appointed to the Technical Expert Panel that modified the original ED PEC survey, making it more physician friendly. CMS has decided not to make the ED CAHPS survey mandatory; however, it allows EDs to collect information about their patients' experience of care and identify aspects of care that could be improved. ACEP could work with CMS to utilize the ED CAHPS as a replacement for the HCAHPS in the ED setting.

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort and would require a minimum of unbudgeted costs of $30,000 including for staff time, $15,000 for outside consultants (e.g. statistician, survey developer), and $5,000 for development, formatting, and distribution of findings.

**Prior Council Action**

Resolution 55(24) Patient Experience Reporting not adopted. Directed the College to work with relevant stakeholders to change reporting for ED patient experience scores to be based on mean score rather than percentile score and revise ACEP's "Patient Experience of Care" policy statement to advocate for mean score rather than percentile scores.

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted. Directed ACEP to advocate for alignment with current ACEP policy and previous recommendations that patient experience surveys be extended to all appropriate categories of emergency department patients to attempt to improve validity; oppose reimbursement metrics and employment decisions correlated with or dependent on patient experience surveys; and work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

Amended Resolution 55(21) Patient Experience Scores adopted. Directed ACEP to acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy; define standardized inclusion and exclusion criteria for patient experience survey populations; define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias, and appropriate power calculations such that sufficient surveys are collected to yield more statistically valid results; and advocate for patient experience survey validity and work with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Resolution 39(15) Patient Satisfaction Surveys in Emergency Medicine referred to the Board. Called for the College to acknowledge that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, many components of medical care not under physician control, and to oppose the use of patient satisfaction surveys for physician credentialing or for emergency medicine financial incentives or disincentives.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non -evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Resolution 43(13) Patient Satisfaction Scores referred to the Board. Called for the College to take a clear public stance to reject the continued use of non-valid patient satisfaction scoring tools in emergency medicine and that current patient satisfaction surveys should not be used to determine ED physician compensation and reimbursement.

Resolution 26(12) Patient Satisfaction Scores and Pain Management not adopted. Called for the College to work with appropriate agencies and organizations to exclude complaints from ED patients with chronic non-cancer pain from patient satisfaction surveys; oppose new core measures relating to chronic pain management in the ED; continue to promote timely, effective treatment of acute pain while supporting treating physicians' rights to determine individualized care plans for patients with pain; and bring patient satisfaction scores and pain management to the AMA for national action.

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted. Directed ACEP to disseminate information to educate members about patient satisfaction surveys including how emergency physicians armed with more knowledge can assist hospital leaders with appropriate interpretation of the scores and encourage hospital and emergency physician partnership to create an environment conducive to patient satisfaction.

Substitute Resolution 12(98) Benchmarking adopted. Directed ACEP to study and develop appropriate criteria for methodology and implementation of statistically valid patient satisfaction surveys in the ED.

Resolution 51(95) Criteria for Assessment of EPs adopted. States that ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by an individual emergency physician.

**Prior Board Action**

January 2025, March 2024, February 2023, and January 2022, approved legislative and regulatory priorities that include advocating for patient experience validity and working with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted.

February 2023, approved the revised policy statement "Patient Experience of Care Surveys;" revised and approved June 2016 with the current title; originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 55(21) Patient Experience Scores adopted.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

February 2013, approved "Crowding" policy statement. Originally approved January 2006.

June 2011, reviewed the information paper "Emergency Department Patient Satisfaction Surveys."

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted.

Substitute Resolution 12(98) Benchmarking adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

**Background Information Prepared by:** Erin Grossmann
Regulatory and External Affairs Manager

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 55(25)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Reduce Non-Beneficial Regulation by The Joint Commission and other Health Care Regulatory Bodies

PURPOSE: Identify The Joint Commission's and other health care regulatory bodies' mandates and standards that do not improve patient care in the ED setting and advocate for the elimination or modification of such requirements.

FISCAL IMPACT: Budgeted staff resources for ongoing communications with TJC and other regulatory bodies. Potential unbudgeted travel costs of $3,000-5,000 for each in-person meeting with TJC and/or CMS, NQF, or other regulatory bodies. Potential unknown and unbudgeted costs for longitudinal studies of all requirements promulgated by TJC and other regulatory bodies and accrediting organizations.

WHEREAS, The Joint Commission (TJC) is a major accrediting body for hospitals and health care facilities, with its standards intended to improve patient safety, quality of care, and operational efficiency; and

WHEREAS, Regulatory compliance is essential to maintaining high standards of care, but excessive and unnecessary regulations can divert valuable time and resources away from direct patient care; and

WHEREAS, Emergency departments (EDs) face significant operational challenges, including overcrowding, increasing patient volumes, and staff shortages, all of which are exacerbated by excessive regulatory burdens; and

WHEREAS, Many emergency physicians report that compliance with non-beneficial accreditation requirements increases administrative workload, contributes to burnout, and reduces the time available for patient care; and

WHEREAS, Certain TJC standards have been criticized for being overly prescriptive or redundant with existing federal and state regulations, leading to unnecessary duplication of efforts; and

WHEREAS, Studies have shown that administrative burden is a leading cause of physician dissatisfaction and contributes to physician burnout, which is linked to decreased quality of care, increased medical errors, and physician workforce attrition; and

WHEREAS, Some TJC documentation and process requirements do not have strong evidence linking them to improved patient outcomes, yet failure to comply with these mandates can still result in citations or financial penalties; and

WHEREAS, Emergency departments, due to their fast-paced and unpredictable nature, require regulatory flexibility to adapt to emergent situations, and overly rigid standards can interfere with real-time clinical decision-making; and

WHEREAS, Through ACEP's advocacy efforts, emergency departments are now permitted to allow beverages with lids and food to be consumed within the department, promoting a more flexible and supportive work environment for health care staff while maintaining patient safety and infection control standards; and

WHEREAS, The Centers for Medicare & Medicaid Services (CMS) and other regulatory bodies have recognized the need to reduce administrative burdens in health care and have implemented measures to streamline requirements in various areas; and

WHEREAS, Collaborative efforts between medical organizations and accrediting bodies have successfully led to the revision or removal of overly burdensome requirements in the past, demonstrating the potential impact of physician-led advocacy; and

WHEREAS, ACEP, as the leading organization representing emergency physicians, is uniquely positioned to advocate for the elimination of non-beneficial accreditation requirements (e.g., sedation documentation, pain assessments, etc.) that do not improve patient outcomes but increase administrative burden; therefore be it

RESOLVED, That ACEP conduct a comprehensive review of The Joint Commission and other health care regulatory bodies' regulatory requirements to identify mandates and interpretations of standards that do not demonstrably improve patient care in the emergency department setting; and be it further

RESOLVED, That ACEP collaborate with The Joint Commission and other health care regulatory bodies to advocate for the elimination or modification of such non-beneficial requirements, aiming to streamline processes, reduce administrative burdens on emergency physicians, and allow more time for direct patient care.

**Background**

This resolution requests the College to review existing mandates and standards promulgated by the Joint Commission (TJC) and other regulatory bodies that do not improve patient care in the emergency department setting and advocate for the elimination of such standards.

The resolution does not reference specific mandates and standards to advocate for appeal and asks for a comprehensive review of all standards. The resolution also does not delineate or define how something "demonstrably improve[s] patient care," which could necessitate longitudinal studies of all requirements promulgated by TJC and other regulatory bodies and accrediting organizations.

Independently, TJC is making efforts to reduce complexities and streamline and simplify requirements. TJC announced on June 30, 2025, significant updates to its standards used by hospitals and critical access hospitals to guide compliance with accreditation requirements and the Centers for Medicare & Medicaid Services' (CMS) Conditions of Participation. This new accreditation process includes an updated Accreditation Manual that more clearly identifies CMS-directed Conditions of Participation, while the remaining requirements and National Patient Safety Goals are being merged into Joint Commission National Performance Goals (NPGs). This includes a reduction of 713 requirements from the hospital accreditation program.

Reducing administrative burden and advocating for the modification or elimination of detrimental policies is at the forefront of the College's regulatory affairs agenda. In May 2025, ACEP responded to a Request for Information (RFI) on deregulation issued by the White House Office of Management and Budget, where we suggested potential repeal or modification of several redundant, clinically inconsistent, or overly burdensome federal regulations including prescription drug monitoring program (PDMP) checking requirement reform, repeal of onerous methadone prescribing regulations, deregulation of the 21st Century Cures Act, removal of barriers to adding codes to the Medicare Telehealth Services List, deregulation of the acute hospital-at-home program requirements, and the repeal of the SEP-1 measure. ACEP again responded in June 2025 to a deregulatory RFI specific to Medicare regulations issued by CMS. ACEP's comments were reiterated in the RFI related to Medicare requirements and also advocated for the modification of critical care time reporting policies, streamlining of Medicare signature requirements, and deregulation of overly complex Merit-based Incentive Payment Systems (MIPS) requirements for qualified clinical data registries.

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

**Fiscal Impact**

Budgeted staff resources for ongoing communications with TJC and other regulatory bodies. Potential unbudgeted travel costs of $3,000-5,000 for each in-person meeting with TJC and/or CMS, NQF, or other regulatory bodies. Potential unknown and unbudgeted costs for longitudinal studies of all requirements promulgated by TJC and other regulatory bodies and accrediting organizations.

**Prior Council Action**

Resolution 54 (23) Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions adopted. Directed ACEP to discuss with TJC ACEP's opposition to credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

Resolution 33(20) Metrics, Measures, and Pay-for-Performance Programs not adopted. Directed the College to seek decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements to alleviate administrative burden.

Resolution 12(16) Collaboration with Non-Medical Entities on Quality and Standards referred to the Board. Called for ACEP to collaborate and build coalitions with non-medical organizations involved in developing quality standards and engage with regulatory entities such as CMS, Joint Commission, and the National Quality Forum.

Amended Resolution 43(15) Required CME Burden adopted. Called for the College to address annual requirements for CME in specific areas that could lead to reduced ongoing education in other clinical area and work with other organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to care for all ED patients.

**Prior Board Action**

Resolution 54(23) Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions adopted.

Amended Resolution 43(15) Required CME Burden adopted.

**Background Information Prepared by:** Laura Wooster, MPH
Associate Exec Director, Advocacy & Practice Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 56(25)

SUBMITTED BY: Michigan College of Emergency Physicians
New Mexico Chapter

SUBJECT: Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions

PURPOSE: 1) Advocate for state and federal legislation requiring AI-assisted reimbursement or coverage decisions be reviewed and approved by qualified human personnel; 2) support prohibiting health insurers from relying solely on AI-based algorithms to deny, delay, or modify health care claims or services and urge both CMS and state regulatory agencies to establish policies requiring human oversight in these decisions; 3) collaborating with relevant stakeholders, including insurers, technology providers, and regulators, to ensure that AI algorithms used in health care decision-making are transparent, accountable, and subject to oversight.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort.

WHEREAS, Artificial intelligence (AI) is increasingly utilized by health insurers to automate reimbursement and coverage decisions, including down-coding and prior authorization processes; and

WHEREAS, The use of AI in these contexts can lead to insurers reducing reimbursement rates through the automation of decision-making processes; and

WHEREAS, Companies such as Cotiviti are employed by insurers to implement AI-driven systems for claims processing, often without disclosing the underlying algorithms to health care entities, thereby limiting transparency and understanding of decision-making criteria; and

WHEREAS, The lack of transparency and potential biases in AI algorithms may result in inappropriate down-coding, claim denials, and delays in patient care, adversely affecting both patients and physicians; and

WHEREAS, Multiple states have recognized the risk associated with AI-driven insurer decision-making and have introduced legislation to regulate its use, including:

- Georgia (HB 887, 2023-4), which aimed to prohibit the use of AI in making certain insurance coverage decisions without human oversight; and
- Arizona (HB 2175, 2025-6), which ensures that AI-driven claim denials are subject to human review by licensed medical professionals; and
- Texas (SB 815, 2025-6), which would prohibit the use of AI-based algorithms as the sole basis of utilization review decisions in health care; and
- Florida (SB 794, 2025-6), which would have mandated that claim denials be reviewed by a qualified human professional and prohibited insurer use of AI as the sole basis for denying or adjusting claims; and
- Michigan (HB 4536 and 4537, 2025-6), which would prohibit health insurers and contracted health plans from denying, modifying, or delaying a claim based on a review using artificial intelligence; and

WHEREAS, AI-driven reimbursement and coverage decisions present significant concerns for patient care and physician autonomy, which may lead to delays, denials, and adverse outcomes for patients due to improper or unchecked AI interventions; therefore be it

RESOLVED, That ACEP advocate for legislation at the state and federal levels requiring that artificial intelligence-assisted reimbursement or coverage decisions be reviewed and approved by qualified human personnel; and be it further

RESOLVED, That ACEP support prohibiting health insurers from relying solely on artificial intelligence-based algorithms to deny, delay, or modify health care claims or services and urge both CMS and state regulatory agencies to establish policies requiring human oversight in these decisions; and be it further

RESOLVED, That ACEP collaborate with relevant stakeholders, including insurers, technology providers, and regulators, to ensure that artificial intelligence algorithms used in health care decision-making are transparent, accountable, and subject to oversight by qualified health care professionals.

**Background**

This resolution asks ACEP to advocate for state and federal legislation that will require artificial intelligence-assisted reimbursement or coverage decisions be reviewed and approved by qualified human personnel by collaborating with relevant stakeholders, including insurers, technology providers, and regulators, to ensure that artificial intelligence algorithms used in health care decision-making are transparent, accountable, and subject to oversight.

In recent years, health insurers have turned to AI decision-making tools to make prior authorization determinations with little or no human review. In October 2024, the U.S Senate Permanent Subcommittee on Investigations issued its report, *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care* which concluded that:

> "The data obtained so far is troubling regardless of whether the decisions reflected in the data were the result of predictive technology or human discretion. It suggests Medicare Advantage insurers are intentionally targeting a costly but critical area of medicine—substituting judgment about medical necessity with a calculation about financial gain."

The version of the 2025 reconciliation bill, also known as the "One Big Beautiful Bill Act," that the U.S. House of Representatives passed on May 22, 2025, initially included language that prohibited states from enforcing any law or regulation governing artificial intelligence (AI) models, systems, or automated decisions systems for a 10-year period. The U.S. Senate removed this language, and the Senate version of the bill was passed on July 3, 2025, leaving AI regulation to the states.

According to the National Conference of State Legislatures, as of 2025 all 50 states, Puerto Rico, the Virgin Islands, and Washington, DC, have introduced legislation to regulate AI. Significant state AI legislation will go into effect in 2026, including:

- California's Artificial Intelligence Training Data Transparency Title 15.2 - Mandates comprehensive transparency of AI training datasets.
- Colorado Consumer Protections for Artificial Intelligence Bill – Allows a consumer to appeal, via human review if technically feasible, an adverse consequential decision from the deployment of a high-risk AI system.
- Texas Responsible AI Governance Act – Provides certain consumer protections, enforcement processes, and created the Artificial Intelligence Council to support innovation and compliance.

ACEP appointed an AI Task Force in June 2024 to determine the current landscape of utilization of AI in emergency medicine practice, to include an assessment of prevalence, practice type, and purpose as well as other objectives to help prepare emergency physicians and their teams for the provision of care using AI. The task force scope of work has evolved and a new Artificial Intelligence Committee will begin its work in September 2025 with the following objectives:

1. Identify relevant opportunities and risks in the application of artificial intelligence in the education and training of emergency medicine for emergency physicians at all career stages. Provide a report to the Board of Directors summarizing these findings.
2. Identify relevant opportunities and risks in the application of artificial intelligence in the practice of emergency medicine for emergency physicians. This scope of work should include activities directly related to clinical practice, including documentation of care, diagnostic testing and evaluation and quality

improvement. Provide a report to the Board of Directors summarizing these findings. The report should advocate for responsible and physician-centric integration of artificial intelligence in emergency care and should support a "human-in-the-loop" model that ensures AI augments rather than replaces physician judgement.

3. Identify relevant opportunities and risks in the application of artificial intelligence in the practice of emergency medicine for emergency physicians related to the operational and administrative practice of emergency medicine including revenue cycle management and risk management. Provide a report to the Board of Directors summarizing these findings including best practices such as safeguards and protective measures for health care professionals who choose to use AI.
4. Identify relevant opportunities and risks in the application of artificial intelligence in the operations and management of the College including identification of opportunities to improve communication with members and other member-facing operations. Provide a report to the Board of Directors summarizing these findings.

Additionally, ACEP is hosting an AI Summit October 21-22, 2025, and will bring together representatives from all major emergency medicine organizations to explore and align on the role of AI in emergency medicine. The summit will focus on three key areas:

- Education – Discussing approaches to the use of AI in the education of emergency physicians across the career spectrum, including AI in formal medical education, research, and publishing.
- Clinical Care – Establishing consensus on how AI should be used in emergency care delivery, including appropriate applications and necessary safeguards.
- Practice Administration / EM Group Management – Identifying the use of AI in administrative and business aspects such as quality improvement, documentation/coding, revenue cycle management, risk management, and more.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Career Fulfillment**:** Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort.

**Prior Council Action**

The Council has discussed and adopted many resolutions pertaining to reimbursement and coverage decisions, although none that are specific to regulating artificial intelligence in health insurance reimbursement and coverage decisions.

Resolution 42(19) Augmented Intelligence in Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to convene an Emergency Medicine Augmented Intelligence (EMAI) Summit and/or a task force to produce an information paper on the issues and concerns surrounding augmented intelligence and make recommendations for the College. Advised the Board of Directors to consider updating the College's Strategic Plan to include augmented intelligence and be include a presentation/session on augmented intelligence in emergency medicine at LAC20 or ACEP20.

**Prior Board Action**

January 2025, approved the revised policy statement "Medical Services Coding;" revised and approved January 2019;

reaffirmed June 2013; revised and approved April 2006 with the current title; reaffirmed June 1999; originally approved September 1986 titled "Coding Reform."

October 2020, approved the revised policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved April 2014, and June 2007 with current title; revised and approved July 2000, January 1999, and March 1993 titled "Managed Health Care Organizations and Emergency Care;"" originally approved September 1987 titled "Managed Health Care Plans and Emergency Care."

July 2019, hosted the "HIT SUMMIT: *Evolving Emergency Care with Technology*" in Dallas, TX, attended by 100 participants from a broad spectrum of Health Information Technology stakeholders, with a breakout session dedicated to Artificial (Augmented) Intelligence (AI) and Clinical Decision Support. The event proceedings resulted in a comprehensive Vision Paper, including a section on AI with seven related detailed recommendations.

February 2018, reaffirmed the policy statement "Assignment of Benefits;" reaffirmed April 2012; originally approved April 2006.

April 2017, approved the revised policy statement "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005 with the title "Compensation When Services are Mandated;" originally approved September 1992.

May 2016, ACEP filed suit against the federal government. Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are "out of network" because of a medical emergency.

April 2016, approved the revised policy statement "Fair Payment for Emergency Department Services;" originally approved April 2009.

April 2014, revised and approved the policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Amended Substitute Resolution 15(00) EMTALA adopted. A report was distributed at the 2001 Leadership/ Legislative Issues Conference.

**Background Information Prepared by:** Jessica Adams
Reimbursement Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 57(25)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Repeal Certificate of Need Laws to Expand Access and Improve Patient Care

PURPOSE: Advocate for the repeal of Certificate of Need (CON) laws in states where such laws exist, develop a toolkit to support legislative action aimed at eliminating these laws, and collaborate with other health care organizations to raise public awareness and educate state policymakers on the negative impacts of CON laws.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other advocacy work to support this effort.

WHEREAS, Certificate of Need (CON) laws were originally enacted in the 1970s to control health care costs, manage the supply of health care resources, and ensure access to care; and

WHEREAS, CON laws often result in limited health care access, especially in underserved and rural areas, by restricting the ability of health care providers to expand services or facilities based on demand; and

WHEREAS, CON laws create artificial barriers to entry for new health care providers, limiting competition and preventing the development of essential services, such as diagnostic equipment and inpatient beds, which could reduce wait times and improve patient access to care; and

WHEREAS, CON laws contribute to inefficiencies in health care delivery, including overcrowding and longer wait times in emergency departments (EDs), as well as delays in patient care due to a lack of available inpatient beds; and

WHEREAS, The repeal of CON laws can foster competition among health care providers, encouraging innovation, improving efficiency, and expanding patient access to high-quality care; and

WHEREAS, Many states that have reformed or eliminated CON laws have experienced improvements in health care access, competition, and lower health care costs, without compromising the quality of care; and

WHEREAS, ACEP recognizes the critical role that timely access to diagnostic services and inpatient beds plays in improving emergency care outcomes, including reducing patient morbidity and mortality; and

WHEREAS, ACEP advocates for a health care system that promotes timely access to care, reduces regulatory burdens that impede effective care delivery, and ensures that patients receive the appropriate services when needed; therefore be it

RESOLVED, That ACEP advocate for the repeal of Certificate of Need (CON) laws in states where such laws exist and develop a toolkit to support legislative action aimed at eliminating these laws, including evidence-based arguments and strategies for engaging policymakers; and be it further

RESOLVED, That ACEP collaborate with other health care organizations to raise public awareness and educate state policymakers on the negative impacts of Certificate of Need (CON) laws on patient access to emergency care, including overcrowding, boarding, and limited capacity, and advocate for the removal of these regulatory barriers to improve patient flow and health care access.

## Background

This resolution calls ACEP to advocate for the repeal of Certificate of Need (CON) laws in states where such laws exist, and develop a toolkit to support legislative action aimed at eliminating these laws, and to collaborate with other health care organizations to raise public awareness and educate state policymakers on the negative impacts of CON laws.

Certificate of need, or CON, laws require a health agency or entity to approve the creation of a new health facility, or the expansion of an existing facility. The goal of CON laws are to control health care costs by restricting duplicative services.[1] As of January 2025, 35 states and Washington, DC have CON programs/laws.

ACEP's Physicians' Guide to State Legislation, Fourth Edition, most recently updated in 2012, states, "Traditionally, the health-related activities of state and local government are public health, including health monitoring, sanitation, and disease control; the financing and delivery of health services, including Medicaid, mental health, and direct delivery through public hospitals and health departments; environmental protection, including protection against manmade environmental and occupational hazards; and the regulation of the providers of medical care, through certificate-of-need, state rate-setting, and licensing functions."

ACEP's Freestanding Emergency Centers (FEC) Section has had previous discussions regarding certificate of need designation.

A 2020 empirical investigation on emergency departments found that CON programs "have a statistically significant impact on increasing the median wait time for medical examination, pain medication administration, hospital admittance, and hospital discharge."[2]

A 2007-2009 national study found that Emergency Departments in CON states have reduced length of stays. The study also found that stringency surrounding equipment expenditure lessens the positive impacts CON laws have on ED length of stay[3].

**Background References**

1. National Conference of State Legislatures. (2025, April 29). Certificate of Need State Laws. https://www.ncsl.org/health/certificate-of-need-state-laws
2. Myers, M. S., & Sheehan, K. M. (2020). The impact of certificate of need laws on emergency department wait times. *Journal of Private Enterprise*, *35*(1), 59-75.
3. Paul, J. A., Ni, H., & Bagchi, A. (2014). Effect of certificate of need law on emergency department length of stay. *The Journal of Emergency Medicine*, *47*(4), 453-461.

## ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

## Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other advocacy work to support this effort.

## Prior Council Action

Amended Resolution 32(24) Preventing Harmful Health Care Deals adopted. Directed ACEP to advocate for legislation that would require health systems to file notice with regulatory agencies before completing critical transactions – including but not limited to sale-leaseback agreements, purchases or sales of health system facilities or real estate, dividend recapitalization, private practice rollups, and changes in majority owner equity stakes – to protect the integrity of health systems and maintain competitive markets.

**Prior Board Action**

Amended Resolution 32(24) Preventing Harmful Health Care Deals adopted.

**Background Information Prepared by:** Brianna Hanson, MPH
Reimbursement and State Legislative Manager

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 58(25)

SUBMITTED BY: Michael J. Bresler, MD, FACEP
Nicole E. Exeni McAmis, MD
Gus M. Garmel, MD, FACEP
California Chapter
Colorado Chapter
Montana Chapter
Ohio Chapter

SUBJECT: Role of EDs in Interactions with U.S. Immigration and Customs Enforcement

PURPOSE: 1) Acknowledge ACEP's prior guidance on ICE in the ED and recognize the continuing potential impact of ICE enforcement actions within EDs on patient care and public health. 2) Advocate for development and dissemination of guidelines and training programs for ED staff to manage interactions with ICE officials, ensuring the protection of patient rights and the provision of uncompromised medical care. 3) Support collaboration with legal experts, hospital administrations, and community organizations to establish policies delineating the role of EDs in relation to ICE activities, emphasizing the importance of patient trust, safety, and confidentiality.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Hospitals and emergency departments (EDs) have traditionally been considered places of refuge, providing medical care to all individuals regardless of immigration status; and

WHEREAS, Recent changes in U.S. immigration enforcement policies have led to increased instances of Immigration and Customs Enforcement (ICE) officials entering hospitals to conduct enforcement actions, including the detention of patients[1]; and

WHEREAS, Such enforcement actions within healthcare settings can deter individuals from seeking necessary medical care due to fear of deportation, thereby compromising public health and patient safety[2]; and

WHEREAS, Emergency department personnel may lack clear guidelines on how to respond to ICE presence while upholding patient confidentiality, legal obligations, and institutional policies[3]; and

WHEREAS, The American College of Emergency Physicians (ACEP) has previously issued guidance titled "Navigating Immigration Enforcement in the Emergency Department[4]" which offers a foundational framework for EDs in responding to ICE activities, but many hospitals have yet to adopt or operationalize this guidance into formal policies; and

WHEREAS, The Emergency Medicine Residents' Association (EMRA) has developed resources[5,6] to assist health care providers in navigating interactions with ICE, including guidelines and sample institutional policies; therefore be it

RESOLVED, That ACEP acknowledge its prior guidance on U.S. Immigration and Customs Enforcement (ICE) in the emergency department as a valuable foundation, and recognize the continuing potential impact of ICE enforcement actions within emergency departments on patient care and public health; and be it further

RESOLVED, That ACEP advocate for the development and dissemination of clear guidelines and training programs for emergency department staff to manage interactions with U.S. Immigration and Customs Enforcement officials, ensuring the protection of patient rights and the provision of uncompromised medical care; and be it further

RESOLVED, That ACEP support collaboration with legal experts, hospital administrations, and community organizations to establish policies that delineate the role of emergency departments in relation to U.S. Immigration and Customs Enforcement activities, emphasizing the importance of patient trust, safety, and confidentiality.

**Resolution References**

1. Exeni McAmis N. Responding to ICE in Emergency Departments: Protecting Patients and Navigating Legal Obligations. EM Resident. February 11, 2025.
2. American Civil Liberties Union (ACLU). Know Your Rights: What to Do if ICE Comes to Your Workplace, Home, or Public Space.
3. National Immigration Law Center. Protecting Access to Health Care: Guidelines for Medical Providers. Available at: https://www.nilc.org/health-care-access. Accessed 2/18/25.
4. American College of Emergency Physicians. Navigating Immigration Enforcement in the Emergency Department.
5. Emergency Medicine Residents' Association. Responding to ICE in the Emergency Department [Flyer]. Available at: https://www.emra.org/siteassets/emresident/documents/emra---ice-flyer---2025-final.pdf. Accessed 2/18/25.
6. Emergency Medicine Residents' Association. Managing ICE Interactions in Emergency Departments: Sample Institutional Policy. Available at: https://www.emra.org/siteassets/emresident/images/articles/2025/02-feb/ice---sample-policy.pdf. Accessed 2/18/25. Exeni McAmis N.

## Background

This resolution calls for ACEP to: 1) Acknowledge it's prior guidance on U.S. Immigration and Customs Enforcement (ICE) in the ED and recognize the continuing potential impact of ICE enforcement actions within EDs on patient care and public health. 2) Advocate for development and dissemination of guidelines and training programs for ED staff to manage interactions with ICE officials, ensuring the protection of patient rights and the provision of uncompromised medical care. 3) Support collaboration with legal experts, hospital administrations, and community organizations to establish policies delineating the role of EDs in relation to ICE activities, emphasizing the importance of patient trust, safety, and confidentiality

In 2021, the director of ICE issued an internal memo directing ICE officers to generally avoid conducting enforcement activities (such as arrests, interviews, searches, and surveillance) at protected areas, including hospitals, churches, and schools. Housed under the Department of Homeland Security (DHS), ICE is the federal agency responsible for identifying and eliminating border, economic, transportation, and infrastructure security vulnerabilities. On January 20, 2025, this internal ICE policy was rescinded by DHS. Therefore, ICE officers are no longer discouraged from conducting enforcement activities in these areas, and the change has led to increased instances of officials entering hospitals to conduct enforcement actions, including the detention of patients.

As a result, ACEP developed the resource "Navigating Immigration Enforcement in the Emergency Department" detailing what this change means for emergency departments and guidance on what emergency physicians or other ED staff should do if ICE officers present themselves in the ED. ACEP consulted with outside legal experts with a background in hospital-specific issues, as well as other impacted stakeholders, to inform the development of this resource. As the ACEP resource notes, while ICE officers are no longer discouraged from conducting enforcement activities at protected areas including hospitals, how a hospital responds to ICE should be no different today than it was previously. Hospitals should already have policies and procedures in place for interacting with ICE officials as well as sufficient staff training to ensure they are appropriately followed.

ACEP has heard reports of hospitals that either lack such clear policies or guidelines or (to similar effect) have not trained ED and other relevant staff about the policies/guidelines or made them aware of their existence. ACEP's resource encourages emergency physicians to request such guidance from their hospital as well as training for all staff on several specific areas, including:

- How to inform immigration or other law enforcement officers that only the designated authorized staff member(s) is authorized to review a warrant or to consent to their entry into private areas.
- Declining to answer questions agents pose about a patient unless authorized to do so by the designated staff member.
- Avoiding any action that could be interpreted as consent by an officer.
- Being cautious of what is in "public view".

Development of further guidance via collaboration with legal experts, hospital administrations, and community organizations can be useful, although it is complicated by the fact that state and local laws (for example, Florida and

Texas[1] require hospitals to ask patients about their immigration status for aggregate reporting of amounts of uncompensated care provided to undocumented patients) can vary, so national-level guidance must be appropriately caveated and can therefore potentially be limited in level of specificity.

The State Legislative/Regulatory Committee, in collaboration with the Diversity, Equity, & Inclusion Committee (now Access, Belonging, & Community Committee) developed the toolkit "Law Enforcement Presence in the Emergency Department" to assist with navigating encounters with law enforcement personnel beyond ICE.

ACEP's policy statement "Understanding the Effects of Law Enforcement Presence in the Emergency Department" states:

- No legal or law enforcement process should interfere with patient care in the ED absent immediate safety threats or specific applicable laws.

**Background Reference**

[1]Potential Impacts of New Requirements in Florida and Texas for Hospitals to Request Patient Immigration Status

## ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

## Fiscal Impact

Budgeted committee and staff resources.

## Prior Council Action

Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presence in the Emergency Department adopted. Directed ACEP to support the research, development, and adoption of best practices regarding law enforcement and security personnel presence in the hospital environment, including but not limited to the ED and collaborate with other interested organizations to create easily accessible transparent toolkits outlining state-specific policies and laws regarding law enforcement presence in the hospital environment, including but not limited to the ED.

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted. Required revisions to the existing policy statement on "Law Enforcement Information Gathering in the Emergency Department" to reflect the recent relevant court decisions regarding consent for searches with or without a warrant to provide clarification and guidance to emergency physicians on their ethical and legal obligations on this issue.

Resolution 35(18) ACEP Policy Related to Immigration referred to the Board of Directors. The resolution sought for ACEP to affirm the right for all patients to receive emergency medical care; encourage establishment of policies of non-collaboration between hospital staff and immigration authorities, unless required by warrant; and oppose modifications to U.S. public charge policies, referred.

Resolution 33(17) Immigrant and Non-Citizen Access to Care referred to the Board of Directors. The resolution requested that ACEP develop model hospital policy language similar to the "Delivery of Care to Undocumented Persons" policy statement for physicians to access and present to their hospital systems for implementation and make available online for public use, in multiple languages, a "Safe Zone" statement that notifies patients of an implemented hospital policy regarding immigrant and non-citizen access to care so that physician can ensure the policy is communicated in the language most relevant to their patient populations.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Directed ACEP to develop a paper addressing the impact of foreign nationals on the American health care safety net and develop proposals seeking legislative, regulatory, and/or judicial remedies for uncompensated health care services provided to foreign nationals in U.S. emergency departments.

**Prior Board Action**

September 2024, reaffirmed the policy statement "Delivery of Care to Undocumented Persons;" revised and approved June 2018; reaffirmed February 2018, April 2012, October 2005, July 2000; originally approved January 1995.

September 2024, approved the policy statement "Understanding the Effects of Law Enforcement Presence in the Emergency Department."

June 2023, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" revised and approved June 2017 and April 2010; originally approved September 2003.

February 2022, Reviewed the Policy Resource & Education Paper (PREP) "Law Enforcement Information Gathering in the Emergency Department: Legal and Ethical Background and Practical Approaches."

Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presence in the Emergency Department adopted.

June 2019, approved the Medical-Legal Committee's recommendation to take no further action on Resolution 35(18) ACEP Policy Related to Immigration. The committee noted that policies already exist throughout the health care community to protect patient information, unless disclosure is required by law, and creating additional policy specific to providing information to immigration authorities would essentially be superfluous. Further, the committee noted the Fourth Amendment provides patients with a reasonable expectation of privacy and protects against unreasonable search and HIPAA requires patient information to be protected unless by a court order or in special circumstances not relevant to this issue. The U.S. Immigration and Customs Enforcement Agency also has policy stating that hospitals are included in the definition of "sensitive zones" where access by immigration officials is severely limited except in extraordinary circumstances.

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted.

**Background Information Prepared by:** Laura Wooster, MPH
Associate Exec Director, Advocacy & Practice Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 59(25)

SUBMITTED BY: Michigan College of Emergency Physicians
New Mexico Chapter

SUBJECT: Support Interstate Telemedicine Practice for Physicians with Permanent Licensure

PURPOSE: Advocate for regulatory changes at both federal and state levels to allow physicians with a permanent, unrestricted medical license in one U.S. state to provide telemedicine services to patients in any state without requiring additional state-specific licensure; work with relevant stakeholders to establish a national telemedicine licensure framework modeled after Florida's successful telehealth registration system to expand access to emergency telemedicine services across state lines while ensuring patient safety and physician accountability.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Current state-based medical licensure requirements create barriers to telemedicine by restricting physicians from providing care across state lines unless they obtain multiple state licenses; and

WHEREAS, Telemedicine has proven to be an effective and efficient way to expand access to emergency and acute care, particularly in underserved and rural areas, and to reduce unnecessary emergency department visits; and

WHEREAS, State licensure barriers prevent patients from accessing timely care from qualified physicians, especially in cases where specialists or emergency physicians could provide critical virtual consultation or ongoing care management; and

WHEREAS, The COVID-19 pandemic demonstrated the necessity and feasibility of interstate telemedicine, with temporary waivers allowing physicians to practice across state lines improving healthcare access and outcomes; and

WHEREAS, The Interstate Medical Licensure Compact (IMLC) was created to streamline the licensure process for physicians across state lines, but remains burdensome to complete, requiring substantial paperwork, time, and effort for physicians; and

WHEREAS, Despite the intent to simplify licensure, the IMLC continues to involve significant costs for both the states and the physicians, undermining its intended purpose of reducing barriers to medical practice across state lines; and

WHEREAS, Many states still face difficulties in efficiently implementing and maintaining the IMLC, resulting in delays and complications for physicians who wish to practice across multiple states; and

WHEREAS, The IMLC has not yet achieved widespread adoption or effectiveness in alleviating the challenges associated with state-by-state medical licensure processes; and

WHEREAS, Unlike the Interstate Medical Licensure Compact, which still imposes significant costs, administrative burdens, and delays, driver's licenses are universally recognized and accepted across state lines without such barriers, serving as a more efficient model for multi-state credentialing; and

WHEREAS, The current system requiring physicians to obtain multiple state licenses is burdensome, costly, and does not improve patient safety, as U.S. physicians undergo standardized medical education, residency training, and board certification processes; and

WHEREAS, Florida has implemented a streamlined telemedicine registration process that allows out-of-state physicians with a permanent license in another state to provide telemedicine services without requiring full licensure in Florida, thus improving access to care while maintaining patient safety and regulatory oversight; and

WHEREAS, The Florida telehealth model has demonstrated that such licensure reforms can increase patient access to care without compromising quality, and similar approaches could be adopted nationwide; and

WHEREAS, The current patchwork of state regulations disproportionately impacts vulnerable populations, including those with mobility limitations, patients in rural or physician shortage areas, and those seeking follow-up care with out-of-state specialists; and

WHEREAS, Allowing physicians with a permanent and unrestricted medical license in one U.S. state to provide telemedicine services nationwide would improve healthcare access while maintaining high standards of care and medical accountability; therefore be it

RESOLVED, That ACEP support and advocate for federal and state legislative efforts to allow physicians with a permanent and unrestricted medical license in one U.S. state to provide telemedicine services to patients in any state without requiring additional state-specific licensure; and be it further

RESOLVED, That ACEP work with relevant stakeholders to establish a national telemedicine licensure framework modeled after Florida's successful telehealth registration system; and be it further

RESOLVED, That ACEP advocate for permanent regulatory changes at both federal and state levels to expand access to emergency telemedicine services across state lines while ensuring patient safety and physician accountability.

**Background**

This resolution calls for the College to support and advocate at the federal and state levels for legislative to allow physicians with a permanent, unrestricted medical license in one U.S. state to provide telemedicine services to patients in any state without requiring additional state-specific licensure, and work with relevant stakeholders to establish a national telemedicine licensure framework modeled after Florida's telehealth registration system to expand access to emergency telemedicine services across state lines while ensuring patient safety and physician accountability.

The Interstate Medical Licensure Compact is an agreement among participating U.S. states and territories to work together to streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify and enables states to share investigative and disciplinary information. As of July 2025, the Compact includes 40 states, the District of Columbia and the Territory of Guam. Applicants are charged a non-refundable $700 fee when requesting to participate in the Compact and must submit fingerprints to the designated criminal justice agency in their State of Principal License for a criminal background check.

In 2019, Florida passed into law section 456.47, Florida Statutes, which established standards of practice for telehealth services and authorized out-of-state health care practitioners to perform telehealth services for patients in Florida. Out-of-state physicians must register with the Florida Department of Health to perform telehealth services for patients in Florida. Telehealth providers must practice in a manner consistent with his or her scope of practice and the prevailing professional standard of practice for in-person health care services to patients in Florida.

ACEP has advocated for both regulatory and legislative changes to advance the use of telehealth in emergency medicine and implement more consistent payment policies. Even before the COVID-19 public health emergency (PHE) began, ACEP sent a letter to the Centers for Medicare & Medicaid Services (CMS) formally requesting that CMS add the five emergency department (ED) evaluation and management (E/M) codes to the list of approved Medicare telehealth services. During the PHE, CMS temporarily added many codes, including all five ED E/M codes, to the list of approved telehealth services and allowed emergency physicians to perform medical screening exams – a component of the Emergency Medical Treatment and Labor Act (EMTALA) – a via telehealth. CMS also used its

unique "1135" waiver authority that only exists during a national emergency to temporarily waive two existing telehealth restrictions in Medicare: the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home) and the geographic requirement (which restricts telehealth in Medicare to only rural areas). Waiving these requirements during the PHE allows clinicians to perform telehealth services regardless of where they or their patient are located, in both urban and rural areas.

However, CMS does not have the legal authority to permanently waive the originating site and geographic restrictions. Eliminating these telehealth restrictions requires legislation from Congress. ACEP sent a letter calling on Congress to take action immediately. Specifically, ACEP called on Congress to enact S.2741, the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act. This vital legislation sets the stage for permanent reforms to telehealth that would advance care delivery, improve preparedness and capacity, and improve patient outcomes. In the letter to Congress and in a separate opinion article, ACEP also called on state Medicaid programs and health plans to embrace telehealth with the same enthusiasm as Medicare and align their telehealth policies with Medicare's to ensure consistent regulation, licensure, billing, and coding for emergency telehealth services. Different billing rules and state regulations make reimbursement inconsistent and adds administrative challenges that hinder the sustainability of these new and vital telehealth programs.

ACEP's "Practice Guidance for Emergency Telehealth and Acute Unscheduled Care Telehealth" states, "Emergency physicians are uniquely qualified to leverage acute care medical decision making via telehealth, unscheduled or scheduled, to provide medical care across the spectrum of conditions and severity." The Guidance also supports national telemedicine licensure framework:

> "ACEP's Emergency Telehealth Section supports a national licensing standard that would allow physicians to practice in all 50 states and all US territories which would ease the burden qualified and willing EPs and NEPs face in order to provide telehealth services. Such a licensing standard would increase access to specialty care and help provide emergency telehealth services from board-certified physicians to residents of rural areas and other underserved communities that currently are unable to receive such services in a timely manner, if at all."

A Telehealth Task Force was appointed in 2021 to define a vision for the impact of telehealth on emergency medicine and identify ACEP resources necessary to position emergency physicians to be the leaders in acute unscheduled telehealth. Substitute Resolution 36(20) Telehealth Free Choice, which was referred to the Board, called on ACEP to address a wide variety of issues in Emergency Telehealth including who should provide emergency care. The Taskforce recommended that ACEP take the position that emergency medicine and board-certified emergency physicians are appropriate and well suited to practice acute unscheduled telehealth, while recognizing that other specialties practice within certain care models (Direct-to-Consumer, remote home monitoring, etc.); and that ACEP advocate that the practice of emergency telehealth is an extension (via an additional modality) of emergency medicine and clinical practice within the scope of a Board-Certified Emergency Physician.

ACEP remains engaged in advancing the use of telehealth in emergency medicine. In accordance with ACEP's policy statement "Emergency Medicine Telehealth," ACEP supports, "the development of interstate medical licenses, which would be offered based on reciprocity among the states. As interstate licenses evolve, ACEP further supports the development of uniform rules governing the practice of medicine, physician discipline, and laws concerning malpractice throughout the United States to provide uniform, safe, and quality urgent and emergent patient care."

The Legislative and Regulatory Priorities for First Session of 119th Congress, as approved by the ACEP Federal Government Affairs (FGA) Committee and the Board of Directors, include the following initiatives regarding telehealth:

- Encourage the use of waivers to restrictive payment policies such as telehealth and the 3-day SNF rule, as appropriate, based on experience from waivers granted during the COVID-19 public health emergency.
- Support innovative models of care that enable or promote access to emergency care, such as Rural Emergency Hospitals, digital health, Free Standing Emergency Departments, telehealth, etc.
- Track private sector, Medicare, and Medicaid coverage of telehealth initiatives.

- Monitor regulations regarding telehealth in which CMS has extended waivers through the end of 2025 through the CY 2025 Physician Fee Schedule.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

**Fiscal Impact**

Budgeted resources for current advocacy initiatives.

**Prior Council Action**

Resolution 40(24) Telehealth Emergency Physician Standards referred to the Board of Directors. Requested the College to affirm that physicians providing telehealth emergency medicine or urgent care services be board certified or board eligible in emergency medicine.

Substitute Resolution 36(20) Telehealth referred to the Board of Directors. Called for ACEP to support legislation to allow patients to be at any location, allow emergency medicine physicians or other clinicians that are supervised by emergency medicine physicians, to be at any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that reflects the service provided; support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer's network, or outside of insurer's network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; that ACEP, in collaboration with other medical organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and, oppose restrictions to tele-health care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Amended Resolution 51(19) Stimulating Telemedicine Researchers and Programs adopted. Directed ACEP to advocate for telehealth research in emergency medicine.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

**Prior Board Action**

January 2025, approved the Legislative and Regulatory Priorities for First Session of 119th Congress.

September 2022 approved the revised policy statement "Emergency Medicine Telehealth;" revised and approved February 2020 with the current title; originally approved January 2016 titled "Emergency Medicine Telehealth."

June 2022 reviewed the reimbursement recommendations from the Telehealth Task Force report, and approved the recommendations except for number 4, number 8, and number 12.

January 2022, approved the revised policy statement "Ethical Use of Telehealth in Emergency Care;" originally approved June 2016, titled "Ethical Use of Telehealth in Emergency Care."

January 2022 reviewed the recommendations from the Telehealth Task Force Report and referred the reimbursement recommendation to the Coding & Nomenclature Advisory Committee and the Reimbursement Committee to provide further analysis and submit their recommendations to the Board on appropriate advocacy action regarding telehealth reimbursement.

October 2021 filed the Telehealth Task Force Report and assigned subgroups of the Board to review each of the recommendations contained in the report and provide their analysis to the Board.

April 2021 approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

January 2021 approved the policy statement "Telehealth Inclusion."

May 2020 reviewed the information paper "COVID-19: Rapid Application of Technology for Emergency Department Tele-Triage."

Amended Resolution 52 (19) Telehealth Emergency Physician Inclusion adopted.

Amended Resolution 51 (19) Stimulating Telemedicine Researchers and Programs adopted.

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.

June 2015 approved the revised policy statement "Definition of Emergency Medicine;" revised April 2008 and April 2001; reaffirmed October 1998; revised April 1994 with current title; originally approved March 1986 as "Definition of Emergency Medicine and the Emergency Physician."

Resolution 36(14) Development of Telemedicine Policy for Emergency Medicine adopted.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

**Background Information Prepared by:** Jessica Adams
Reimbursement Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 60(25)

SUBMITTED BY: Minnesota Chapter

SUBJECT: Tele-Emergency Medicine Oversight of Non-Board-Certified/Board-Eligible Emergency Medicine EDs

PURPOSE: 1) Engage with chapters to encourage and support legislation promoting the minimum requirement of board certified/board eligible emergency physician-led care for all EDs noting that care can be led and supported virtually for sites designated as small rural, frontier, or extreme frontier in the ACEP Rural Emergency Care Task Force 2020 Report. 2) Provide clarification to Amended Resolution 42(23) On-Site Physician Staffing in Emergency Departments that all medium rural, medium/large rural, or greater sized EDs are expected to maintain a minimum of 24/7 on-site and on-duty board certified/board eligible emergency physician coverage, as endorsed through the ACEP Rural Emergency Care Task Force 2020 Report to the ACEP Board of Directors.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, ACEP believes that all patients who present to emergency department (EDs) should have access to high-quality, patient-centered care delivered by Board Certified/Board Eligible (BC/BE) EM physician-led care teams; and

WHEREAS, ACEP Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments (as amended) was referred to the Board, calling for critical access and rural emergency hospitals to have "a qualified, state-licensed (MD/DO/MBBS) physician be required to be immediately available for on-site and available for care of emergency department patients at all times", regardless of their specialty; and

WHEREAS, Recent advocacy initiatives have led to state legislation mandating on-site and on-duty physician coverage at all EDs, regardless of volume, without a requirement of BC/BE status; therefore be it

RESOLVED, That ACEP engage with state chapters to encourage and support legislation promoting the minimum requirement of board certified/board eligible emergency physician-led care for all EDs noting that care can be led and supported virtually for sites designated as small rural, frontier, or extreme frontier in the ACEP Rural Emergency Care Task Force 2020 Report; and be it further

RESOLVED, That ACEP provide clarification to Amended Resolution 42(23) On-Site Physician Staffing in Emergency Departments that all medium rural, medium/large rural, or greater sized emergency departments are expected to maintain a minimum of 24/7 on-site and on-duty board certified/board eligible emergency physician coverage, as endorsed through the ACEP Rural Emergency Care Task Force 2020 Report to the ACEP Board of Directors.

**Background**

The resolution calls for ACEP to engage with state chapters to encourage and support legislation promoting the minimum requirement of board certified/board eligible emergency physician-led care for all EDs noting that care can be led and supported virtually for sites designated as small rural, frontier, or extreme frontier in the ACEP Rural Emergency Care Task Force 2020 Report. Additionally, the resolution seeks clarification to Amended Resolution 42(23) On-Site Physician Staffing in Emergency Departments that all medium rural, medium/large rural, or greater sized emergency departments are expected to maintain a minimum of 24/7 on-site and on-duty board certified/board eligible emergency medicine physician coverage, as endorsed through the ACEP Rural Emergency Care Task Force 2020 Report to the ACEP Board of Directors.

Amended Resolution 42(23) On-Site Physician Staffing in Emergency Departments, as adopted by the Council and the Board of Directors:

> RESOLVED, That ACEP work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments; and be it further
>
> RESOLVED, That ACEP continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician certified by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, or certified by the American Board of Pediatrics in pediatric emergency medicine.

The resolution was assigned as an objective to the State Legislative/Regulatory Committee (SLRC) to "Monitor legislative and regulatory efforts by nurse practitioners and physician assistants to expand their scope of practice in emergency medicine in a way that is inconsistent with ACEP policy and develop resources to assist state chapter advocacy on this issue." The committee developed a toolkit after the successful passage of the Indiana legislation and used the language from that legislation (HOUSE BILL No. 1199) along with other model provisions, drafting notes and definitions, as well as current regulatory language to consider.

The second resolved of Amended Resolution 42(23) was assigned to ACEP's communications staff to include in ongoing communications regarding ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." The policy statement was most recently revised in October 2024, in response to other resolutions submitted to the 2024 Council seeking revisions to the policy statement. The policy states:

> "Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in emergency medicine or pediatric emergency medicine or an equivalent international certifying body recognized by ABEM or AOBEM in emergency medicine or pediatric emergency medicine."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

The ACEP Rural Emergency Care Task Force 2020 Report made several recommendations to address the needs of ACEP's rural members, including the development of a model for onboarding for physician assistants (PAs) and nurse practitioners (NPs) practicing without emergency medicine (EM) board-certified emergency physician presence in rural EDs, to include EM specific knowledge and procedural skills training, and to facilitate the use of telemedicine in rural sites to enable supervision by EM board-certified physicians for initial onboarding supervision of PAs and NPs, as well as ongoing telemedicine availability.

ACEP has consistently advocated for physician-led care teams in the emergency department at both the national and state level. ACEP's Advocacy & Practice Affairs staff have advocated for this standard to the Centers for Medicare and Medicaid Services (CMS) as well as Health and Human Services and the U.S. Congress.

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The

> facility management must provide sufficient support to ensure high-quality emergency care and patient safety. Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

ACEP's current "Emergency Medicine Telehealth" policy statement addresses this with respect to supervision requirements for nurse practitioners (NPs) and physician assistants (PAs):

> "Physician assistants (PAs) and nurse practitioners (NPs) can serve an integral role as members of the emergency care team, but do not replace the medical expertise provided by emergency physicians. With the aim of ensuring that all patients seeking telehealth services receive high quality care, the American College of Emergency Physicians (ACEP) endorses the utilization of PAs and/or NPs who are supervised by an American Board of Emergency Medicine/American Osteopathic Board of Emergency Medicine (ABEM/AOBEM) board-certified or board-eligible emergency physician according to ACEP guidelines."

ACEP's policy statement "Rural Emergency Medical Care" states:

> "As rural emergency departments (EDs) provide a safety net for some of the country's most vulnerable and underserved communities, the American College of Emergency Physicians (ACEP) believes that all emergency care should be provided, directed, and/or supervised by a board-certified/board-eligible (BC/BE) emergency physician."

These principles are also widely affirmed throughout other ACEP policy statements, such as "Role of the Emergency Physician in the Care of Trauma Patients," which states that "…patients presenting for care in an emergency department are best served by receiving care from board-eligible or board-certified emergency physicians…"

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

**Fiscal Impact**

Budgeted committee, section, and staff resources.

**Prior Council Action**

Resolution 69(24) Updating ACEP's Position on PA and NP Supervision in the ED referred to the Board of Directors. The resolution sought to amend the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to remove reference to workforce limitations in specific CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "offsite" by telehealth means for Critical Access Hospitals (CAHs) and Rural Emergency Hospitals (REHs).

Resolution 40(24) Telehealth Emergency Physician Standards referred to the Board of Directors. The resolution sought to affirm that physicians providing telehealth emergency medicine or urgent care services be board-certified or board-eligible.

Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments referred to the Board of Directors. The resolution sought to collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified,

state-licensed (MD/DO/MBBS) physician be required to be on-site and available for care of emergency department patients at all times.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an ED is a board-certified/board-eligible emergency physician.

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Substitute Resolution 36(20) Telehealth referred to the Board of Directors. Called for ACEP to support legislation to allow patients to be at any location, allow emergency medicine physicians or other clinicians that are supervised by emergency medicine physicians, to be at any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that reflects the service provided; support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer's network, or outside of insurer's network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; that ACEP, in collaboration with other medical organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and, oppose restrictions to tele-health care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

**Prior Board Action**

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing two policy statements. "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

September 2022, approved the revised policy statement "Emergency Medicine Telehealth;" revised and approved February 2020 with the current title; originally approved January 2016 titled "Emergency Medicine Telehealth."

June 2022, approved the revise policy statement "Rural Emergency Medical Care" with the current title; originally approved June 2017 titled "Definition of Rural Emergency Medicine."

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

April 2020, approved the policy statement "Role of the Emergency Physician in the Care of Trauma Patients."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments.

**Background Information Prepared by:** Ryan McBride, MPP
Congressional Affairs Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 Council Meeting
# Reference Committee Members

**Reference Committee C – Emergency Medicine Practice**
Resolutions 61-80

Angela P. Cornelius, MD, FACEP (TX) – Chair
Greg Gafni-Pappas, DO, FACEP (MI)
Puneet Gupta, MD, FACEP (CA)
Amanda Irish, MD, MPH, MS (IA)
Jeffrey F. Linzer, MD, FACEP (GA)
Aaron Snyder, MD (NM)

Travis Schulz, MLS, AHIP
George Solomon, MHS, FP-C, CCP-C, TP-C

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 61(25)

SUBMITTED BY: Juliana Chang, MD
Gayle Galletta, MD, FACEP
Hillary Irons, MD, FACEP
Emily Sbiroli, MD, FACEP
Tushara Surapanemi, MD
Massachusetts College of Emergency Physicians

SUBJECT: Acknowledging and Mitigating the Environmental Impact of Metered-Dose Inhalers

PURPOSE: 1) Acknowledge the environmental impact of metered-dose inhalers and supports efforts to reduce their carbon footprint through sustainable practices; 2) encourage the education of emergency physicians, other medical personnel, pharmacists, and patients regarding the environmental impact of metered-dose inhalers, including the differences among canister weights and associated propellant volumes; the availability and appropriateness of dry powder inhalers as an alternative, when clinically indicated; and proper disposal and recycling protocols for metered-dose inhalers, including the importance of incineration to deactivate remaining hydrofluoroalkane propellants; and 3) support collaboration with health care systems, manufacturers, insurers, and public health organizations to promote policies that facilitate lower-emission alternatives to metered-dose inhalers and inhaler recycling.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

WHEREAS, Climate change has been recognized by leading health organizations as a public health emergency, with the United States healthcare sector contributing approximately 8.5% of domestic greenhouse gas (GHG) emissions; and one quarter of global health care GHG emissions[1]; and

WHEREAS, Metered-dose inhalers (MDIs), commonly used in emergency medicine for acute asthma and chronic obstructive pulmonary disease (COPD), contain hydrofluoroalkane (HFA) propellants, which are potent hydrofluorocarbon (HFC) greenhouse gases with global warming potentials (GWPs) thousands of times that of carbon dioxide[2]; and

WHEREAS, There are varying canister weights of MDIs on the market – each containing an equivalent amount of medication but varying amounts of HFA propellant – resulting in significantly different environmental impacts[3]; and

WHEREAS, Dry powder inhalers (DPIs) are a clinically effective alternative to MDIs for many patients and are associated with significantly lower carbon footprints because DPIs do not use propellants, making them a more environmentally sustainable treatment option;[4,5]; and

WHEREAS, MDIs are often disposed of in general waste streams despite containing recyclable materials such as aluminum and residual HFA propellants that can only be deactivated by incineration[6]; and

WHEREAS, Education of emergency physicians, allied health professionals, pharmacists, and patients regarding environmentally sustainable prescribing practices, inhaler choice, and proper disposal methods can reduce environmental harm without compromising patient care; and

WHEREAS, Other nations such as the United Kingdom have taken substantial steps to reduce the environmental impact of healthcare delivery, including the establishment of the *Greener NHS* initiative and the

*GreenED* (Green Emergency Departments) program, a model for environmental sustainability in emergency medicine,[7,8]; therefore be it

RESOLVED, That ACEP acknowledge the environmental impact of metered-dose inhalers and supports efforts to reduce their carbon footprint through sustainable practices; and be it further

RESOLVED, That ACEP encourage the education of emergency physicians, other medical personnel, pharmacists, and patients regarding:

- the environmental impact of metered-dose inhalers, including the differences among canister weights and associated propellant volumes;
- the availability and appropriateness of dry powder inhalers as an alternative, when clinically indicated; and
- proper disposal and recycling protocols for metered-dose inhalers, including the importance of incineration to deactivate remaining hydrofluoroalkane propellants; and be it further

RESOLVED, That ACEP support collaboration with health care systems, manufacturers, insurers, and public health organizations to promote policies that facilitate lower-emission alternatives to metered-dose inhalers and inhaler recycling.

**References**

1. Eckelman MJ, et al. Health Care Pollution and Public Health Damage in the United States: An Update. *Health Affairs*, December 2020. doi.org/10.1377/hlthaff.2020.01247
2. Woodcock A, Beeh KM, Sagara H, Aumônier S, Addo-Yobo E, Khan J, Vestbo J, Tope H. The environmental impact of inhaled therapy: making informed treatment choices. *Eur Respir J*. 2022 Jul 21;60(1):2102106. doi: 10.1183/13993003.02106-2021.
3. Wilkinson AJK, Braggins R, Steinbach I, Smith J. Costs of switching to low global warming potential inhalers. *BMJ Open*. 2019;9(10):e028763.
4. British Thoracic Society. *Position Statement on the Environment and Lung Health*. 2020.
5. Feld J, Lowering Inhalers' Carbon Footprint: Climate-Friendly pMDI Alternatives. https://pulmonaryadvisor.com (Accessed June 2025).
6. Pharmaceutical Services Negotiating Committee (PSNC). *Guidance on the disposal of inhalers*. Available from: https://psnc.org.uk (Accessed May 2025).
7. NHS England. *Delivering a Net Zero National Health Service*. 2020. Available at: [https://www.england.nhs.uk/greenernhs].
8. Royal College of Emergency Medicine Green ED. https://greened.rcem.ac.uk (Accessed May 2025).

## Background

This resolution directs ACEP to: 1) acknowledge the environmental impact of metered-dose inhalers and supports efforts to reduce their carbon footprint through sustainable practices; 2) encourage the education of emergency physicians, other medical personnel, pharmacists, and patients regarding the environmental impact of metered-dose inhalers, including the differences among canister weights and associated propellant volumes; the availability and appropriateness of dry powder inhalers as an alternative, when clinically indicated; and proper disposal and recycling protocols for metered-dose inhalers, including the importance of incineration to deactivate remaining hydrofluoroalkane propellants; and 3) support collaboration with health care systems, manufacturers, insurers, and public health organizations to promote policies that facilitate lower-emission alternatives to metered-dose inhalers and inhaler recycling.

Climate change has been formally recognized as a public health emergency by leading health bodies, and the United States health care sector plays a significant role in this crisis by accounting for approximately 8.5% of national greenhouse gas emissions and nearly 25% of the global healthcare sector's emissions. Notably, Scope 3 emissions, generated by the health care supply chain – including pharmaceuticals, medical devices, and energy usage – comprise over 80% of the sector's carbon footprint. Moreover, these emissions have increased by 6% between 2010 and 2018, underscoring the urgent need for decarbonization efforts. The health care sector's substantial contribution to carbon emissions mandates urgent mitigation, particularly in emergency care where metered-dose inhalers (MDIs) are used routinely. Transitioning toward dry powder inhaler (DPI) use when appropriate, adopting education on inhaler carbon footprints, and implementing sustainable prescribing and disposal practices are critical steps. Coupled with broader commitment from institutions and policymakers, these efforts support climate resilience, public health, and cost-effective care.

In the context of emergency medicine, MDIs are frequently used to manage acute asthma and COPD exacerbations and have significant environmental impact. MDIs utilize hydrofluoroalkane (HFA) propellants, which are potent greenhouse gases with global warming potentials (GWPs) thousands of times greater than $CO_2$. Even the lowest-emission MDI may produce approximately 10 kg $CO_2$-equivalent over its lifetime, while the highest emit over 36 kg $CO_2$-equivalent. By contrast, DPIs, which do not rely on propellants, typically produce only 1.5–6 kg $CO_2$-equivalent per use. Improper disposal of MDIs further exacerbates environmental harm. Many devices are discarded in general waste, despite containing recyclable materials (e.g., aluminum) and residual HFAs that require incineration for safe deactivation.

Medical professionals can play a pivotal role in mitigating this environmental burden through education and practice transformation. Strategies include selecting DPIs when clinically appropriate, prescribing MDIs with lower environmental impact where necessary, instituting safe disposal and recycling protocols, and engaging colleagues, pharmacists, and patients on sustainable inhaler use. Such measures enable reductions in carbon emissions without compromising patient care.

International analogues offer instructive models. The United Kingdom's Greener NHS and Green Emergency Departments (GreenED) programs have systematically integrated sustainability into healthcare operations. The NHS aims to achieve net-zero emissions by 2045 and has successfully phased out high-GWP anesthetics like desflurane. Many U.S. health systems have followed suit and realizing substantial cost savings and emission reductions by eliminating desflurane and other volatile anesthetics. Collective efforts are also underway in the U.S.: in 2022, more than 650 hospitals and health sector organizations signed the HHS Health Sector Climate Pledge, committing to reduce greenhouse gas emissions by 50% by 2030 and reach net-zero by 2050. Academia, policy groups, and the National Academy of Medicine are collaborating to establish decarbonization metrics, standardized reporting, and scalable solutions for healthcare sustainability.

Currently, in the U.S., dry powder inhalers, particularly brand name products, are more expensive.

The use of MDIs has limited scope within emergency medicine and aligning and supporting efforts led by broader agencies and organization such as the National Academy of Medicine and the American Medical Association would have greater impact on addressing the problem.

**ACEP Strategic Plan Reference**

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

**Prior Council Action**

Resolution 59(24) Tap Water is Sufficient Treatment adopted. Directed ACEP to: 1) advocate to transition to hospital tap water in the U.S. for wound irrigation to decrease the carbon footprint of ED; 2) emphasize the importance of research and education within the emergency medicine community and raise awareness of the financial and environmental benefits of tap water for wound irrigation; and 3) urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted. Directed ACEP to: 1) encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and 2) work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

**Prior Board Action**

Resolution 59(24) Tap Water is Sufficient Treatment adopted.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted.

September 2024, approved the revised policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine;" originally approved June 2018.

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 62(25)

SUBMITTED BY: Kansas Chapter

SUBJECT: Promoting Environmental Sustainability and Waste Reduction in the ED

PURPOSE: 1) Support efforts to reduce unnecessary waste and carbon emissions in EDs through education, policy development, and support for sustainable clinical practices. 2) Encourage hospitals and EDs to implement environmentally responsible practices, including but not limited to proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate. 3) Develop resources to help emergency physicians and EDs achieve the aim of reducing waste and carbon emissions from the ED.

FISCAL IMPACT: Budgeted committee and staff resources to continue working on a similar resolution from 2024.

WHEREAS, The health care sector contributes approximately 8–10% of greenhouse gas emissions in the United States, with a significant portion attributed to wasteful practices and energy use in hospital and emergency department (ED) settings; and

WHEREAS, EDs generate large volumes of waste, including improperly sorted biohazard and sharps materials, which unnecessarily increase both environmental impact and disposal costs; and

WHEREAS, The use of disposable and single-use medical products – while often clinically necessary – can contribute to excessive resource use when not employed judiciously, and opportunities exist to reduce low-value or unnecessary interventions without compromising patient safety; and

WHEREAS, Board certification through the ABEM or AOBEM ensures that physicians have met rigorous standards of competency and excellence in emergency care; and

WHEREAS, Environmentally sustainable practices such as implementing recycling programs, proper waste segregation, minimizing overuse of disposable supplies, and substituting sterile water or saline with tap water for wound cleaning (when clinically appropriate) have been shown to reduce waste, lower carbon emissions, and save costs; and

WHEREAS, As stewards of both public health and health system resources, emergency physicians are uniquely positioned to lead and model environmental responsibility in acute care settings; therefore be it

RESOLVED, That ACEP support efforts to reduce unnecessary waste and carbon emissions in emergency departments (EDs) through education, policy development, and support for sustainable clinical practices; and be it further

RESOLVED, That ACEP encourage hospitals and emergency departments to implement environmentally responsible practices, including but not limited to proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate; and be it further

RESOLVED, That ACEP develop resources to help emergency physicians and emergency departments achieve the aim of reducing waste and carbon emissions form the emergency department.

**Background**

This resolution calls for ACEP to support efforts to reduce unnecessary waste and carbon emissions in emergency departments (EDs) through education, policy development, and support for sustainable clinical practices; encourage hospitals and EDs to implement environmentally responsible practices, including but not limited to proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate; and develop resources to help emergency physicians and EDs achieve the aim of reducing waste and carbon emissions from the ED.

The Council and the Board of Directors adopted Amended Resolution 58(24) Reducing Waste in Our Emergency Departments last year. The resolution directed ACEP to encourage and support comprehensive research efforts to facilitate data collection of the measurements of ED waste and energy consumption and work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste. The resolution was assigned to the Public Health Committee for implementation. The committee recently updated the policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine" and is working on a policy resource and education paper (PREP) as an adjunct to the updated policy statement. Additionally, the committee is working to develop on a policy statement highlighting the importance to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, biohazard/medical waste, as well as advocating for a transition to hospital tap water in the United States for wound irrigation to decrease the carbon footprint of emergency departments contributing to global efforts to combat climate change.

The U.S. health care sector continues to be a major contributor to environmental degradation through its substantial waste generation, heavy use of single-use devices, pharmaceuticals, and energy-intensive operations. American hospitals produce approximately 29 pounds of waste per bed per day, equating to roughly 5 million tons annually, with the operating rooms alone responsible for 70% of that waste. Health care operations account for 8-8.5% of U.S. greenhouse gas emissions, surpassing many national emitters and resulting in an estimated 655 million metric tons.

Single-use medical devices represent approximately 80% of the sector's carbon footprint, given their entire lifecycle from manufacture to disposal. However, initiatives like reusable textiles and device reprocessing demonstrate substantial environmental and economic benefits. Reusable gowns can reduce energy use by up to 64%, cut greenhouse gas emissions by 66%, and reduce solid waste generation by 84% compared to disposables. Additionally, FDA-regulated reprocessing of single-use devices can divert thousands of pounds from landfills and save hospitals up to $462 million annually across the U.S., while lowering device purchase costs by 60–75%

Adopting broad climate-smart health care practices, such as low-carbon procurement, energy and water efficiency, waste minimization, and climate resilience strategies, can yield significant financial savings. Energy efficiency and renewable energy transitions have already reduced emissions by over 95% in some systems (e.g., Gundersen Health) and saved hundreds of thousands of dollars annually in operating costs. Nationwide, comprehensive sustainability efforts could save health care institutions up to $15 billion over ten years, with up to $5.4 billion saved in five years through waste reduction and operational efficiency measures.

Clinical inefficiencies and waste represent a major economic burden as well and account for 5.4% to 15.7% of U.S. health care spending, or approximately $760 to $935 billion annually, with potential savings of $191 to $282 billion per year if addressed through low-value care reduction and improved coordination. These data underscore the urgent need for the health care sector, including emergency departments, to prioritize sustainable supply chains, waste reduction, decarbonization, and resilience strategies—not only to reduce environmental harm but to improve public health and reduce costs.

In 2022, ACEP joined the Medical Society Consortium on Climate and Health, aligning with 25 state networks and 56 major medical societies (representing over one million health professionals) to advocate for public and policy awareness of climate change as a health threat and promote sustainable health practices.

**ACEP Strategic Plan Reference**

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

**Fiscal Impact**

Budgeted staff and committee resources to continue working on a similar resolution from 2024.

**Prior Council Action**

Resolution 59(24) Tap Water is Sufficient Treatment adopted. Directed ACEP to: 1) advocate to transition to hospital tap water in the U.S. for wound irrigation to decrease the carbon footprint of ED; 2) emphasize the importance of research and education within the emergency medicine community and raise awareness of the financial and environmental benefits of tap water for wound irrigation; and 3) urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted. Directed ACEP to: 1) encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and 2) work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste.

Resolution 21(20) Medical Society Consortium on Climate & Health adopted. The resolution directed ACEP to become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

**Prior Board Action**

Resolution 59(24) Tap Water is Sufficient Treatment adopted.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted.

September 2024, approved the revised policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine;" originally approved June 2018.

Resolution 21(20) Medical Society Consortium on Climate & Health adopted.

**Background Information Prepared by:** Sam Shahid, MD, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 63(25)

SUBMITTED BY: Michael J. Bresler, MD, FACEP
Gus M. Garmel, MD, FACEP
Nicole E. Exeni McAmis, MD
Colorado Chapter
Montana Chapter

SUBJECT: Addressing Bullying in the ED – Role of Emergency Physicians in Identification and Intervention

PURPOSE: 1) Recognize the critical role of emergency physicians in identifying and addressing victims of bullying; 2) advocate for the development and implementation of evidence-based screening tools and protocols within emergency departments to identify victims of bullying and provide appropriate resources and referrals; and 3) support the integration of education and training on bullying recognition, intervention, and trauma-informed care into emergency medicine residency programs and continuing medical education courses.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Bullying is a pervasive issue that affects individuals of all ages, leading to significant physical, psychological, and emotional harm[1]; and

WHEREAS, Victims of bullying often present to emergency departments (EDs) with both acute and chronic physical injuries, as well as mental health concerns including depression, anxiety, and suicidal ideation[2]; and

WHEREAS, Emergency medicine physicians are uniquely positioned to identify victims of bullying due to their role in treating a diverse patient population, including children, adolescents, and adults who may not otherwise seek help[3]; and

WHEREAS, Early identification and intervention by emergency medicine physicians can help mitigate the long-term health consequences of bullying through appropriate screening, counseling, and referrals to mental health and social support services[4]; and

WHEREAS, There is a growing need for increased education and training among emergency medicine providers to recognize the signs of bullying and provide trauma-informed care to affected individuals[5]; therefore be it

RESOLVED, That ACEP recognize the critical role of emergency medicine physicians in identifying and addressing victims of bullying; and be it further

RESOLVED, That ACEP advocate for the development and implementation of evidence-based screening tools and protocols within emergency departments to identify victims of bullying and provide appropriate resources and referrals; and be it further

RESOLVED, That ACEP support the integration of education and training on bullying recognition, intervention, and trauma-informed care into emergency medicine residency programs and continuing medical education courses.

**References**

1. Centers for Disease Control and Prevention. Violence Prevention: Bullying Research. Available at: https://www.cdc.gov/violenceprevention/youthviolence/bullyingresearch/index.html. Accessed 2/18/25.
2. StopBullying.gov. Federal Government Resource. Available at: https://www.stopbullying.gov/. Accessed 2/18/25.

3. American Academy of Pediatrics. Bullying Prevention Strategies. Available at: https://www.aap.org/en/patient-care/bullying/. Accessed 2/18/25.
4. National Suicide Prevention Lifeline. Dial 988 for 24/7 support. Available at: https://988lifeline.org/. Accessed 2/18/25.
5. American College of Emergency Physicians. Trauma-Informed Care Guidelines. Available at: [insert ACEP guideline link]. Accessed 2/18/25.
6. National Institutes of Health. Recognizing and Addressing Mental Health Consequences of Bullying. Available at: https://www.nih.gov/news-events/news-releases/recognizing-mental-health-consequences-bullying. Accessed 2/18/25.
7. American Psychological Association. Understanding and Preventing Bullying. Available at: https://www.apa.org/topics/bullying. Accessed 2/18/25.
8. U.S. Department of Education. Protecting Students from Harassment and Bullying. Available at: https://www2.ed.gov/about/offices/list/ocr/letters/colleague-bullying-201010.html. Accessed 2/18/25.

**Background**

This resolution calls for ACEP to recognize the critical role of emergency medicine physicians in identifying and addressing victims of bullying; advocate for the development and implementation of evidence-based screening tools and protocols within emergency departments to identify victims of bullying and provide appropriate resources and referrals; and support the integration of education and training on bullying recognition, intervention, and trauma-informed care into emergency medicine residency programs and continuing medical education courses.

Bullying continues to be a significant public health concern in the United States, impacting individuals across a wide range of age groups and social settings. Victims of bullying may suffer from both physical injuries and psychological effects, including anxiety, depression, post-traumatic stress, and, in severe cases, suicidal ideation or self-harm. Emergency physicians could play a vital role in the identification, management, and prevention of the health consequences associated with bullying. Emergency departments often serve as the initial point of contact for individuals experiencing acute physical or emotional distress related to bullying. Emergency physicians may be uniquely positioned to recognize clinical and behavioral signs of victimization, provide timely medical and psychological care, and facilitate referrals to appropriate mental health and social support services. Through interdisciplinary collaboration with schools, behavioral health professionals, and community organizations, emergency medicine can contribute to a broader, coordinated response aimed at early intervention, prevention, and the reduction of bullying-related harm.

ACEPs policy, "Emergency Department Triage" states, "Screening information may be best obtained after the initial prioritization process is complete and should not delay timely access to the medical screening exam and stabilizing treatment." ACEPs policy, "Screening for Disease and Risk Factors in the Emergency Department" and related Policy Resource and Education Paper, "Principles of Screening for Disease and Health Risk Factors in the Emergency Department" state that "screening should rely on evidence-based strategies drawn from the United States Preventive Services Task Force (USPSTF), the Centers for Disease Control and Prevention, peer-reviewed emergency medicine literature, and other trusted sources." The Screening policy also states that "Screening with inadequate or inappropriate follow-up systems available for the targeted disease or risk factor may lead to unintentional harm."

ACEP's policy statement "The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies" highlights strategies, resources, and recommendations for improving emergency care delivery for pediatric mental and behavioral health emergencies, including presentations related to bullying.

Additionally, the Pediatric Emergency Medicine Committee has developed multiple resources addressing this topic, including information papers: "Role of Emergency Physicians in Identifying Bullying in the Emergency Department," and "Suicide Contagion in Adolescents: The Role of the Emergency Department".

The Pediatric Emergency Medicine Committee is currently developing a point-of-care tool addressing suicide in the pediatric population, as well as a policy statement on trauma informed care.

The tenets of this resolution have been met by prior and ongoing work.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

None

**Prior Board Action**

January 2025, approved the revised policy statement, "Emergency Department Triage;" revised and approved June 2024, June 2023 with the current title, January 2017, and October 2010; originally approved September 2023 titled "Triage Scale Standardization."

January 2022, approved the revised ACEP/AAP/ENA joint policy statement "The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies;" revised and approved September 2018 titled "Pediatric Mental Health Emergencies in the Emergency Department;" reaffirmed April 2012; originally approved April 2006 titled "Pediatric Mental Health Emergencies in the Emergency Medical Services System."

April 2021, approved the policy statement, "Screening for Disease and Risk Factors in the Emergency Department."

April 2021, reviewed the Policy Resource and Education Paper (PREP), "Principles of Screening for Disease and Health Risk Factors in the Emergency Department."

October 2015, reviewed the information paper "Role of Emergency Physicians in Identifying Bullying in the Emergency Department."

February 2019, reviewed the information paper "Suicide Contagion in Adolescents: The Role of the Emergency Department."

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 64(25)

SUBMITTED BY: Juliana Chang, MD, NY ACEP
Gayle Galletta, MD, FACEP, MA ACEP
Hillary Irons, MD, FACEP, MA ACEP
Tushara Surapaneni, MD, CT ACEP
Massachusetts College of Emergency Physicians
New Jersey Chapter

SUBJECT: Endorsement of Electronic Discharge Instructions for Patients with Electronic Medical Records

PURPOSE: Endorse and promote the use of electronic discharge instructions for patients with access to electronic medical records and communication tools, leveraging the widespread adoption of EMRs in hospitals and EDs to transition from paper-based to more efficient and secure electronic processes.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The majority of hospitals and emergency departments in the United States have implemented electronic medical records (EMRs)[1]; and

WHEREAS, The use of printed discharge instructions consumes significant amounts of paper and ink, contributing to environmental waste[2]; and

WHEREAS, Electronic discharge instructions can be securely delivered to patients via patient portals, email, or text message, enabling faster discharge processes and improving ED throughput and operational efficiency[3]; and

WHEREAS, Electronic discharge instructions reduce costs associated with printing materials, maintenance of printers, and staff time spent printing, collating, and distributing physical documents[4]; and

WHEREAS, The manual distribution of paper instructions poses a risk of human error, including the possibility of handing a patient another patient's discharge summary, thereby violating the Health Insurance Portability and Accountability Act (HIPAA)[5]; and

WHEREAS, Electronic delivery mechanisms tied to unique patient identifiers reduce the risk of such privacy breaches and enhance the accuracy and safety of information delivery[6]; therefore be it

RESOLVED, That ACEP endorse the use of electronic discharge instructions for patients with access to electronic medical records and electronic communication capabilities; and be it further

RESOLVED, That ACEP encourage emergency departments to adopt policies and technologies that support the secure, timely, and environmentally responsible electronic delivery of discharge instructions in compliance with HIPAA regulations and best practices.

**References**

1. Office of the National Coordinator for Health Information Technology. *Non-federal Acute Care Hospital Electronic Health Record Adoption*. HealthIT.gov. 2021. https://www.healthit.gov/data/quickstats/non-federal-acute-care-hospital-ehr-adoption
2. Environmental Paper Network. *State of the Global Paper Industry Report*. 2018. https://environmentalpaper.org
3. Liu, B., et al. *Improving Emergency Department Discharge Process with an EMR-Based Solution*. AMIA Annu Symp Proc. 2019;2019:1138–1147.

4. Kruse, C. S., et al. *The Impact of Electronic Health Records on Healthcare Quality: A Systematic Review and Meta-analysis*. JMIR Med Inform. 2018;6(2):e10234.
5. U.S. Department of Health & Human Services. *Health Information Privacy: HIPAA Violations*. https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
6. Patel, V. & Johnson, C. *Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2020*. ONC Data Brief, No. 56. The Office of the National Coordinator for Health IT. May 2021.

**Background**

This resolution asks the College to endorse and encourage the use of electronic discharge instructions for patients who have access to electronic medical records and electronic communication capabilities.

The widespread adoption of electronic medical records (EMRs) in the majority of hospitals and emergency departments across the United States has created an opportunity to transition from traditional paper-based discharge processes to more efficient and secure electronic methods. The current reliance on printed discharge instructions contributes to significant paper and ink consumption, impacting environmental sustainability. In contrast, electronic discharge instructions can be delivered securely through various digital channels, including patient portals, email, or text messages. This electronic delivery facilitates faster discharge processes, which in turn improves emergency department throughput and overall operational efficiency.

A critical advantage of electronic delivery is the reduction of human error inherent in manual distribution, such as the risk of inadvertently providing a patient with another patient's discharge summary, which constitutes a violation of the Health Insurance Portability and Accountability Act (HIPAA). Electronic mechanisms, by being tied to unique patient identifiers, significantly reduce the risk of such privacy breaches and enhance the accuracy and safety of information dissemination. Furthermore, electronic discharge instructions offer substantial cost reductions by minimizing expenses associated with printing materials, printer maintenance, and the staff time traditionally allocated to printing, collating, and distributing physical documents.

**ACEP Strategic Plan Reference**

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.
- Identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.
- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

**Fiscal Impact**

Budgeted committee and staff resources. The primary activities involved would include developing and disseminating advocacy statements, creating communication materials to encourage adoption, and potentially collaborating with relevant committees or sections to provide guidance and best practices.

**Prior Council Action**

None

**Prior Board Action**

None

**Background Information Prepared by:** Dhruv Sharma, MS
Lead Data Scientist

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 65(25)

SUBMITTED BY: Louisiana Chapter
Maine Chapter
New Jersey Chapter

SUBJECT: Emergency Physicians and Collaborative Practice Agreements

PURPOSE: Develop a policy statement regarding collaborative practice agreements that provides protection for emergency physicians.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy statement.

WHEREAS, Emergency physicians are frequently required to supervise non-physician practitioners (NPPs) as a condition of employment; and

WHEREAS, Emergency physicians are often excluded from the credentialing, hiring, privileging, or training processes of the nonphysician practitioners they are assigned to supervise; and

WHEREAS, Physicians are sometimes asked to sign blanket authorization forms – occasionally with the names of NPPs left blank – granting their employer, hospital, or contract medical group the authority to enter into collaborative practice agreements (CPAs) on their behalf; and

WHEREAS, Some physicians have discovered that CPAs have been established or maintained under their medical license without their explicit knowledge or consent; and

WHEREAS, In certain cases, CPAs may have been initially authorized but later:

- Automatically renewed for years without the physician's awareness;
- Continued without proper reauthorization;
- Remained in effect even after the physician had changed jobs or had not worked with the NPP in many years; and

WHEREAS, The collaborative relationship defined in a CPA represents a legal and professional obligation designed to ensure patient safety and must not be treated as a mere administrative formality; and

WHEREAS, CPAs can expose physicians to professional and legal liability; therefore be it

RESOLVED, That ACEP develop a policy statement opposing the following practices:

- the establishment of collaborative practice agreements without the specific and informed authorization of the supervising physician;
- the execution of collaborative practice agreements by employers, hospitals, or contract groups on behalf of emergency physicians;
- the imposition of collaborative practice agreements as a mandatory condition of employment for emergency physicians.

**Background**

This resolution asks that ACEP develop a policy statement regarding collaborative practice agreements that provides protection for emergency physicians by opposing: establishing collaborative practice agreements without the specific and informed authorization of the supervising physician; the execution of collaborative practice agreements by

employers, hospitals, or contract groups on behalf of emergency physicians; and the imposition of collaborative practice agreements as a mandatory condition of employment for emergency physicians.

When physicians work with non-physician practitioners, most states require a practice agreement outlining the relationship. Traditionally, these practice agreements were called supervision agreements, which delineate the scope of practice, level of supervision required, and roles and responsibilities. Some states have shifted from a supervision model to collaborative practice models, allowing for non-physician practitioners to operate with less supervision and oversight. CPAs are more commonly associated with nurse practitioners and in states that have expanded their scope of practice and independence.

Physicians who enter collaborative practice agreements face potential risks including liability for the actions of those they supervise, challenges in maintaining adequate oversight, and legal and compliance issues. These agreements can also lead to increased administrative burden and potential conflicts within the collaborative relationship.

Risks and Concerns for Physicians:

- **Liability Exposure:** Physicians can be held liable for the actions of NPs and PAs working under a CPA, even if they were not directly involved in the specific case. This liability can stem from malpractice claims or board complaints.
- **Maintaining Adequate Oversight:** Providing sufficient oversight and guidance to multiple NPPs can be challenging, especially in busy or complex settings. This is particularly true when collaborating with a large number of NPPs, when the collaborative agreement involves complex cases, or don't build in appropriate oversight processes.
- **Legal and Compliance Issues:** Collaborative practice agreements must comply with state laws and regulations, including scope of practice, prescribing authority, and other requirements. Failure to comply with these regulations can result in legal and financial consequences, especially if the physicians don't have input into the agreements
- **Administrative Burden:** Managing collaborative agreements, including record-keeping, communication, and oversight activities, can add to the administrative workload for physicians.
- **Potential for Conflict:** Disagreements may arise between the physician and the supervisee regarding treatment plans, patient care, or other aspects of the collaborative relationship. This can be especially challenging if the physician does not have clear and defined supervision responsibilities./
- **Difficulty Defending Claims:** If a lawsuit arises, it may be difficult for the physician to defend against claims if they did not have direct involvement in the case or if there are discrepancies in documentation or communication.

The CPAs are often standardized by employers across multiple types of relationships, roles, and types of NPPs. Employed physicians may not have the autonomy to provide input and determine the terms of the CPAs based on the relationship with the NPPs.

ACEP is actively engaged in addressing scope of practice issues to protect physician-led care in emergency medicine by advocating for policies that prioritize emergency physician-led teams at both the state and federal levels. ACEP has developed a toolkit with model state legislation and best practices for scope of practice, while simultaneously fighting against legislation that would expand the scope of non-physician practitioners.

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional**.**

**Fiscal Impact**

Budgeted committee and staff resources to develop a policy statement.

**Prior Council Action**

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted. Directed ACEP to make recommendations on the minimum staffing ratios of physicians to nurse practitioners and physician assistants.

Amended Resolution 72(21) Fair Compensation to Emergency Physicians for Collaborative Practice Agreements & Supervision adopted. The amended resolution directed ACEP to support emergency physicians being fairly compensated to supervise ABEM/AOBEM board certified/eligible physician led teams.

**Prior Board Action**

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" and replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department.

June 2023, approved the policy statement "Fair Compensation to Emergency Physicians to Supervise ABEM/AOBEM Board Certified/Board Eligible Led Teams."

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted.

Amended Resolution 72(21) Fair Compensation to Emergency Physicians for Collaborative Practice Agreements & Supervision adopted.

April 2021, approved the revised policy statement, "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, August 1993. Originally approved October 1984 titled, "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, and June 2001; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

April 2020, approved the policy statement "Staffing Models and the Role of the Emergency Department Medical Director."

July 2018, reviewed the Policy Resource & Education Paper (PREP) "Emergency Physician Contractual Relationships."

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 66(25)

SUBMITTED BY: Sean Vanlandingham, MD, MBA, FACEP
Alabama Chapter

SUBJECT: Endorsing a Realistic Door-to-Doctor Standard

PURPOSE: Endorse a national door-to-doctor benchmark of no less than 30 minutes to prevent increasingly unrealistic targets that undermine clinical judgment and operational sustainability and oppose practices that encourage unsafe or unsustainable door-to-doctor expectations without adequate staffing or clear evidence of improved patient care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Timely care is a core principle of emergency medicine, and a door-to-doctor benchmark has historically helped balance patient flow, staffing, and safety; and

WHEREAS, Until recently the long-standing industry standard for door-to-doctor time had been 30 minutes, providing a realistic target that accounted for variability in patient volume and workforce limitations; and

WHEREAS, Some health systems and staffing companies are now enforcing artificially aggressive door-to-doctor targets while neglecting to strengthen the core staffing, systems, and processes that enable safe emergency care; and

WHEREAS, These reduced targets often serve financial incentives (e.g., to ensure patients are billed) rather than improving patient outcomes, and may contribute to physician burnout, resource overuse, and fragmented care; and

WHEREAS, Physician-in-triage (PIT) models used to achieve these metrics frequently involve brief, superficial encounters that increase diagnostic testing, cloud subsequent decision-making, and introduce risks of diagnostic anchoring, communication failures, and medical error; and

WHEREAS, Studies have shown that PIT models are minimally effective in addressing the root causes of the ED boarding crisis; and

WHEREAS, Nursing led triage processes (without PIT) are sufficient to identify patients requiring immediate care utilizing proven protocols for Stroke, STEMI, and the Emergency Severity Index (ESI) model; therefore be it

RESOLVED, That ACEP endorse a national door-to-doctor benchmark of no less than 30 minutes to prevent increasingly unrealistic targets that undermine clinical judgment and operational sustainability; and be it further

RESOLVED, That ACEP oppose practices that encourage unsafe or unsustainable door-to-doctor expectations without adequate staffing or clear evidence of improved patient care.

**References**


- Franklin BJ, Li KY, Somand DM, Kocher KE, Kronick SL, Parekh VI, Goralnick E, Nix AT, Haas NL. Emergency department provider in triage: assessing site-specific rationale, operational feasibility, and financial impact. *J Am Coll Emerg Physicians Open.* 2021 May 24;2(3):e12450. doi: 10.1002/emp2.12450. PMID: 34085053; PMCID: PMC8144283.vhttps://pmc.ncbi.nlm.nih.gov/articles/PMC8144283/
- Kelen GD, Wolfe R, D'Onofrio G, Mills AM, Diercks D, Stern SA, Wadman MC, Sokolove PE. Emergency department crowding: the canary in the health care system. *NEJM Catalyst Innov Care Deliv.* 2021 Sep 28;2(5). doi: 10.1056/CAT.21.0217.vhttps://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217

- Marshall ADA, Diercks DB, McGeorge NM, Meurer WJ, Sharp SC. The effect of a physician in triage on number of orders placed. *Ann Emerg Med.* 2019 Oct;74(4 Suppl):S47.https://www.annemergmed.com/article/S0196-0644(19)30794-2/fulltext

**Background**

The resolution calls for ACEP to endorse a national door-to-doctor benchmark of no less than 30 minutes to prevent increasingly unrealistic targets that undermine clinical judgment and operational sustainability and oppose practices that encourage unsafe or unsustainable door-to-doctor expectations without adequate staffing or clear evidence of improved patient care. The median door-to-doctor time was once part of the CMS quality reporting requirements for Timely and Effective Care in the Emergency Department and it was removed several years ago; however, it is still used in many benchmarking processes.

ACEPs policy statement, "Standards for Measuring and Reporting Emergency Department Wait Times*" recommends standard terms for reporting of ED patient waiting times for initial evaluation. The policy states:

- ED patient "wait time" should be defined as "door to provider contact time." [1,2]
- Provider is defined as physician (MD, DO), advanced practice nurse, or physician assistant (PA).
- Measurement of the "door to provider contact time" should be the sole metric used in public advertising to describe ED patient "wait time."
- Provider contact time is defined by either the face-to-face evaluation of the patient by the provider or the initiation by the provider of specific diagnostic and/or therapeutic orders.
- The calculation of wait time should be the longest amount of time that a patient is currently waiting to see a provider.
- Public advertising of ED patient "wait time" should include a time stamp of the last moment the metric was updated or refreshed.
- Ideally, advertised times should be accurate and reflect real-time waits. However, posted wait times should be updated at least hourly to be meaningful to patients.

**Note: This policy is undergoing review in the 2025-26 committee year as part of ACEP's Policy Sunset Review Process. One change to the policy will be to remove the word "provider."*

ACEP's policy statement "Patient Experience of Care Surveys" reviews the methodological and statistical issues with existing patient experience surveys. It states that many factors that lead to poor patient experience scores, such as wait times and boarding, are beyond the control of the individual emergency physician. The policy specifically states that patient experience of care survey scores should not be used for credentialing, contract renewal, or incentive bonus programs, and that rank-ordered percentiles should be abandoned.

Quality metrics are used as a means to measure "quality." While every attempt is made to make these metrics as fair as possible, often there are ways to "game" the measure. Additionally, there can be obstacles outside of the physician's control that interfere with the ability to meet a metric, such as boarding.

A December 2023 article in *ACEPNow*, A Sobering Year for Emergency Departments and Their Patients, included data from the Emergency Department Benchmarking Alliance (EDBA) 2022 report on data from 938 EDs reflecting 46 million patient visits which was roughly one-third of all patients seen in US EDs in 2022. Compared to data from the previous year, "Patient intake remained steady with median "Door to Bed" time decreasing to about eight minutes and "Door to Doctor" time to about 20 minutes."

Door-to-doctor time is a commonly tracked emergency department (ED) metric intended to evaluate the timeliness of patient assessment. For many years, the standard benchmark for this metric had been set arbitrarily at 30 minutes. This timeframe acknowledged that emergency departments operated under unpredictable and variable volumes, often with constrained staffing and limited physical space.

Recently, some hospital systems and contract management groups have sought to reduce door-to-doctor times, using PIT models where a physician or advanced practitioner briefly evaluates the patient in triage. While marketed as

patient-centered, this practice is often driven by financial motivations – ensuring patients are "seen" before they can leave – and does not necessarily improve care quality.

The PIT model leads to several downstream challenges:

- **Fragmented care**: Patients are seen by multiple physicians, NPs, or PAs, sometimes with inconsistent or duplicative evaluations and limited communication.
- **Increased costs**: Hasty workups in triage can result in over-testing and overuse of resources.
- **Clinical risk**: The initial impression based on a quick and limited history may bias the second physician's decisions, introducing cognitive errors.
- **Physician dissatisfaction**: Many emergency physicians find these systems inefficient, demoralizing, and operationally disruptive.
- **Educational**: In residency settings, having patients pre-worked can have a significant impact on learners.

Studies suggest that PIT models, while effective at reducing door-to-doctor time, do little to resolve emergency department crowding and may introduce unintended negative consequences.

- PIT models have been shown to **increase laboratory and imaging orders** for ESI 3 and 4 patients (Marshall et al. 2019)
- PIT models **do not reduce overall length of stay for admitted patients** (Franklin et al. 2021)
- PIT models have been found to be **ineffective in alleviating the ED crowding crisis** (Kelen et al. 2021)

Physicians, NPs, and PAs in triage are often underutilized and relegated to observing the triage nurse, jotting down brief notes, and initiating a few orders, all while practicing far below their level of capability. Despite the added expense of staffing these clinicians in triage, health systems deem it worthwhile because of the increased revenue from early billing capture. The result is that many patients are effectively seen by two "half" doctors instead of one fully engaged physician, which is a model that, as previously outlined, undermines continuity, inflates costs, and compromises the quality and efficiency of care.

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Amended Resolution 50(23) Metric Shaming referred to the Board of Directors. The referred resolution requested ACEP to develop practices and policies to prevent the public or external publication, transmission, and/or release unblinded metric-related information about individual emergency physician performance..

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non-evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Amended Resolution 19(09) Defining Boarding Time in the Nation's Emergency Departments adopted. Directed development of policy statement to define "boarded patient" and continue involvement with national organizations

developing measurements on patient through-put.

Amended Resolution 25(06) : Redefining the Front End Process to Optimize Emergency Department & Hospital Flow adopted. This resolution called for ACEP to develop a position paper defining optimal emergency care related to the "Front End" processing of ED patients and specifying that individuals with clinical expertise are the first personnel to interact with ED patients.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will reduce crowding by placing the burden on hospitals to manage their resources more effectively.

Substitute Resolution 18(04) Caring for Emergency Department "Boarders" adopted. The resolution called for ACEP to endorse the concept of inpatient nurse staffing assigned to care for patients that been admitted but are classified as "boarders" in the ED and develop a relevant policy to which ED medical directors and hospital administrators may refer.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. Directed ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards that are consistent with ACEP's policy "Boarding of Admitted and Intensive Care Patients in the Emergency Department." The standard should address the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision.

**Prior Board Action**

June 2024, approved the revised policy statement, "Boarding of Pediatric Patients in the Emergency Department." Previously revised September 2018; originally approved January 2012.

February 2023, approved the revised policy statement, "Patient Experience of Care Surveys." Previously revised June 2016; originally approved September 2010 with the title, "Patient Satisfaction Surveys"

February 2023, approved the revised policy statement, "Boarding of Admitted and Intensive Care Patients in the Emergency Department," revised June 2017, April 2011, April 2008, and January 2007; originally approved October 2000.

September 2018, reaffirmed the policy statement, "Standards for Measuring and Reporting Emergency Department Wait Times;" originally approved October 2012.

May 2016, reviewed the report, "Emergency Department Crowding: High Impact Solutions."

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

Amended Resolution 19(09) Defining Boarding Time in the Nation's Emergency Departments adopted.

January 2008, reviewed the information paper, "Optimizing Emergency Department Front-End Operations."

Amended Resolution 25(06) Redefining the Front End Process to Optimize Emergency Department & Hospital Flow adopted.

June 2006, approved adopting a quality measure requiring hospitals to report the time of presentation to the ED to the time of disposition (admission or leaving the ED) within six hours for all patients.

Substitute Resolution 18(04) Caring for Emergency Department "Boarders" adopted.

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
Manager, Clinical Ultrasound Accreditation Program

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 67(25)

SUBMITTED BY: Forensic Medicine Section
Illinois College of Emergency Physicians

SUBJECT: Forensic Programs in Trauma Centers

PURPOSE: Work with other organizations to implement a standard of forensic programs at all Level 1 and Level 2 trauma centers.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort as well as resources to provide support for collaborative work with external stakeholders.

WHEREAS, Traumatic injuries are a frequent cause of Emergency Department visits and they affect all patient populations and include injuries from multiple causes such as gunshot wounds, motor vehicle accidents, pedestrians injured by vehicles, assaults, sexual assault, strangulation, intimate partner and domestic violence, assaults, child and elder abuse, and human trafficking; and

WHEREAS, A significant fraction of those visits will prompt law enforcement investigation and subsequent court proceedings and this process will rely on medical records for the documentation of injuries and the physical evidence collected during the initial patient visit; and

WHEREAS, Medical treatment always takes precedence over forensic aspects of care, and trauma and emergency physicians providing lifesaving care may not be able to provide comprehensive forensic documentation; and

WHEREAS, Detailed description and photographic documentation of pattern injuries, gunshot wounds, evidence of abuse, patient's appearance and clothing, and trace evidence can determine the outcome of a court case; and

WHEREAS, Medical providers are often not familiar with the correct process of evidence collection and preserving chain of custody, putting the evidence at risk of being dismissed in court; and

WHEREAS, Forensic nurses have specialized training that would allow them to collect photos and evidence during medical evaluation and comply with legal requirements; therefore be it

RESOLVED, That ACEP work with stakeholders including the Forensic Medicine Section, American College of Surgeons – Committee on Trauma (ACS-COT), International Association of Forensic Nursing (IAFN), Academy of Forensic Nursing (AFN), and Emergency Nurses Association (ENA), to implement a standard of forensic programs at all Level 1 and Level 2 trauma centers.

**Resources**


1. International Association of Forensic Nurses: SANEs in Level 1 and 2 Trauma Centers Policy Paper https://forensicnurses.org/wp-content/uploads/2021/11/sanes_in_trauma_centers_poli.pdf
2. 24/7 Forensic Trauma Nurses: How we Did It And What We Learned. An interview with Heather DeVore, MD, ACEP Now September 18, 2017 https://www.acep.org/forensicmedicine/newsroom/fm-newsroom-articles/sept2017/247-forensic-trauma-nurses-how-we-did-it-and-what-we-learned

**Background**

This resolution calls for the College to work with stakeholders including ACEP's Forensic Medicine Section, American College of Surgeons-Committee on Trauma (ACS-COT), International Association of Forensic Nursing (IAFN), Academy of Forensic Nursing (AFN), and the Emergency Nurses Association (ENA) to implement a standard of forensic programs at all Level 1 and Level 2 trauma centers.

The ACS-COT establishes and verifies trauma center criteria. ACEP has a long history of working with ACS on trauma issues that affect emergency medicine, but ACEP does not set the criteria.

The College has historically been involved in various aspects of evidence collection within the emergency department, primarily around patients in police custody, requests from law enforcement, and sexual assault. However, this resolution seeks to require forensic programs be incorporated into Level 1 and Level 2 trauma criteria.

A forensic program within a trauma center plays a crucial role in providing comprehensive and specialized care to patients who have experienced trauma, particularly when those injuries may be related to violence, abuse, or other criminal activity. The purpose of such a program is to address the unique needs that arise at the intersection of health care and the legal system. Care in forensic programs is generally delivered at the bedside by specially trained and dedicated nurses whose primary role is to care for victims of violence and other crimes.

Key elements and functions of a forensic program at a trauma center include:

- Bridging health care and the legal system: Forensic programs aim to provide specialized medical care to those affected by trauma while also collecting and preserving crucial evidence that can be used in legal investigations.
- Trauma-informed care: Prioritize a trauma-informed approach, ensuring patients feel safe, respected, and supported throughout the process. This includes being sensitive to the emotional and psychological impact of trauma and providing appropriate referrals for ongoing support.
- Specialized care: Provide specialized care for victims of sexual assault, domestic violence, child abuse, elder abuse, and other forms of interpersonal violence. This includes both physical and emotional support, as well as addressing immediate and long-term health consequences of the trauma.
- Forensic medical examinations and evidence collection: Conduct meticulous examinations to document injuries and collect potential evidence such as DNA, hair, fibers, and other trace materials. Proper documentation, photography, and adherence to chain-of-custody protocols are essential to ensure the evidence's admissibility in court.
- Collaboration with law enforcement and the legal system: Working with police, attorneys, and other legal professionals, which may include providing expert testimony in court
- Advocacy and support: Providing emotional and psychological support to patients and connecting them with victim services and community resources.
- Education and training: Forensic programs often contribute to the education and training of other healthcare professionals on forensic principles, trauma-informed care, and the proper handling of forensic evidence in order to ensure all staff are familiar with best practices.
- Violence prevention and public health: By identifying patterns of violence and collaborating with community partners, forensic programs contribute to violence prevention efforts and promoting public health and safety.

A standardized training program focusing on forensic training for trauma centers does not currently exist. ACEP would need to work with ACS-COT to develop a curriculum to incorporate a forensic program into all trauma centers. Once such a curriculum was developed, dissemination of the material by either online or in person instruction would need to be developed.

ACEP's policy statement "Sexual Assault Nurse Examiner Programs and Facilities" supports the collection of forensic evidence (performance of evidentiary examinations) by specially educated and clinically trained personnel development and funding of additional Sexual Assault Nurse Examiner (SANE)/Sexual Assault Response Team (SART) programs and facilities.

ACEP's policy statement *"*Law Enforcement Information Gathering in the Emergency Department*"* specifies that evidence collection for law enforcement purposes must occur only with patient consent, under a legal mandate, or pursuant to a court order, and must never delay or interfere with the provision of medical care. The Policy Resource and Education Paper (PREP) "Law Enforcement Information Gathering in the Emergency Department – Legal and Ethical Background and Practical Approaches," was developed as an adjunct to the policy statement and provides detailed legal and ethical background with practical approaches to balancing clinical care and forensic responsibilities.

The "Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department" policy statement recommends that ED staff receive training to properly preserve physical evidence and maintain the chain of custody when caring for incarcerated patients. The PREP "Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department" provides additional guidance.

Additionally, ACEP disseminated the e-book "Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient, 2nd edition," developed by the Forensic Medicine Section, in June 2016. This resource provides standardized recommendations for forensic evaluation and evidence collection for sexual assault victims.

**ACEP Strategic Plan Reference**

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort as well as resources to provide support for collaborative work with external stakeholders

**Prior Council Action**

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted. Directed ACEP to expand the "Law Enforcement Information Gathering in the Emergency Department" policy statement to reflect recent relevant course decisions regarding consent for searches with or without a warrant, providing clarification and guidance to emergency physicians on their ethical and legal obligations in this issue.

Resolution 22(16) Court-Ordered Forensic Evidence Collection in the ED adopted. Directed ACEP to study the ethical and moral implications for emergency physicians acting in compliance with court orders that require the collection of evidence from a patient in the absence of consent, and to develop a policy statement addressing the issue.

Amended Resolution 30(14) Sexual Assault Victims' DNA Bill of Rights adopted. Directed ACEP to encourage members to be familiar with and comply with all local laws, policies, and procedures regarding the collection and submission of DNA evidence to law enforcement agencies and support state legislative "Sexual Assault Victims' DNA Bill of Rights" and other initiatives regarding the timely submission and processing of DNA evidence.

Amended Resolution 36(11) Sexual Assault Training in Emergency Medicine Residency adopted. Directed ACEP to work with the Council of Emergency Medicine Residency Directors and other organizations to develop sexual assault examination curricular tools that can be adopted by emergency medicine programs and practicing emergency physicians.

Amended Resolution 21(06) Selective Triage for Victims of Sexual Assault to Designated Exam Facilities adopted. Directed ACEP to support the collection of forensic evidence by specially educated and clinically trained personnel when available and appropriate and the development and funding of additional SANE/Sexual Assault Response Team (SART) programs.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Directed the College to amend the policy statement, "Management of the Patient with the Complaint of Sexual Assault.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Directed the College to assume a leadership role in organizing formal collaboration with key stakeholders including clinical, legal, forensic, judicial, advocacy, and law enforcement organizations to establish areas of cooperation, mutual training, standardization, and continuous quality improvement for the benefit of the sexually assaulted patient.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted. Directed ACEP to take the lead in the development of a national multidisciplinary model protocol that would include training programs and standards for the collection of evidence, examination, and treatment of sexually assaulted patients and that funding sources for the project be sought.

Substitute Resolution 10(91) Sexual Assault adopted. Directed ACEP to develop a recommended list of equipment/supplies for evidence collection kits for victims of sexual assault and address the special needs of pediatric sexual assault patients in its guidelines for management of sexual assault patients.

Substitute Resolution 34(89) Sexual Assault adopted. Directed ACEP to develop a position paper on the appropriate management of sexual assault victims of all ages and act as a clearinghouse of resource materials concerning issues on the management of sexual assault victims.

**Prior Board Action**

August 2023, approved the policy statement "Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department."

August 2023, reviewed the Policy Resource & Education Paper (PREP) "Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department."

April 2024, approved the revised policy statement "Sexual Assault Nurse Examiner Programs and Facilities;" reaffirmed February 2018 and April 2012; originally approved October 2006 titled "Selective Triage for Victims of Sexual Assault to Designated Exam Facilities."

June 2023, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" revised and approved June 2017 and April 2010; originally approved September 2003.

June 2023, reviewed the Policy Resource & Education Paper (PREP) "Law Enforcement Information Gathering in the Emergency Department – Legal and Ethical Background and Practical Approaches"

February 2020, reaffirmed the policy statement "Management of the Patient with the Complaint of Sexual Assault;" reaffirmed February 2020, April 2014 and October 28; revised and approved October 2002; reaffirmed June 1999; revised and approved December 1994; originally approved January 1992.

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted.

Resolution 22(16) Court-Ordered Forensic Evidence Collection in the ED adopted.

Amended Resolution 30(14) Sexual Assault Victims' DNA Bill of Rights adopted.

Amended Resolution 36(11) Sexual Assault Training in Emergency Medicine Residency adopted.

Amended Resolution 21(06) Selective Triage for Victims of Sexual Assault to Designated Exam Facilities adopted.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.

Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

**Background Information Prepared by:** George Solomon, MHS, FP-C, CCP-C, TP-C, LSSBB
Director of EMS, Disaster Medicine, and Accreditation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 68(25)

SUBMITTED BY: Halleh Akbarnia, MD, MPH, FACEP
Kristen Donaldson, MD, MPH, FACEP
Illinois College of Emergency Physicians

SUBJECT: Integrating Firearm Safety Counseling into Emergency Medicine Education and Practice

PURPOSE: 1) Amend ACEP's policy statement "Firearm Safety and Injury Prevention" to include support for the integration of firearm injury prevention, safe storage, and counseling education into emergency medicine residency training and continuing medical education programs. 2) Develop or identify and disseminate a physician-facing clinical guide to support emergency physicians in conducting brief, trauma-informed firearm safety counseling.

FISCAL IMPACT: Budgeted committee and staff resources for current and ongoing initiatives.

WHEREAS, Firearm violence remains the leading cause of death for children and teens in the United States, affecting hundreds of lives daily – including the 327 people shot each day – and emergency physicians, as front-line responders, have both the responsibility and privilege to care for victims and to advocate for prevention, consistent with ACEP's established policies supporting a public health approach to firearm injury prevention; and

WHEREAS, Emergency physicians are often the first and only point of contact in high-risk encounters such as suicidal ideation, domestic violence, or pediatric injury, yet most residency programs and continuing medical education (CME) offerings lack standardized training on firearm safety counseling and education; and

WHEREAS, ACEP's 2020 policy on "The Role of the Emergency Physician in Injury Prevention and Control" and the 2019 policy on "Violence Free Society" affirm that emergency physicians have both the right and responsibility to provide injury prevention counseling and education to patients and families, and emphasize the need to teach the next generation of physicians about injury prevention through formal education and leadership development; and

WHEREAS, Studies show that firearm safety counseling is underutilized despite patient risk, and a 2024 study by Ladines-Lim et al. conducted in primary care clinics found no documentation of firearm safety counseling even when patients reported access to firearms and had psychiatric risk factors; and

WHEREAS, Brief, nonjudgmental counseling about safe firearm storage has been shown to increase the use of secure storage practices, which reduces the risk of suicide, unintentional injury - particularly among youth - and limits unauthorized access, including firearm theft and diversion to community violence (Carter and Cunningham, 2024); and

WHEREAS, A 2022 study by Pallin et al. found that fewer than half of medical trainees asked patients about firearm access, stating barriers exist such as lack of training, time, and confidence; yet over 90% expressed interest in receiving firearm injury prevention education, and those who had prior training were significantly more likely to engage in counseling behavior; therefore be it

RESOLVED, That ACEP amend its policy statement "Firearm Safety and Injury Prevention" to include support for the integration of firearm injury prevention, safe storage, and counseling education into emergency medicine residency training and continuing medical education programs; and be it further

RESOLVED, That ACEP develop or identify and disseminate a physician-facing clinical guide to support emergency physicians in conducting brief, trauma-informed firearm safety counseling, particularly for high-risk patients, alongside both printable and digital format, evidence-based patient handouts suitable for emergency

department use, potentially leveraging existing materials and partnerships where appropriate and consistent with ACEP's firearm safety policies.

**Related ACEP Policies/Resolutions**
Firearm Safety and Injury Prevention Policy (Policy revised June 2024)
Declaring Firearm Violence a Public Health Crisis (2023 Council Resolution 35)
Role of the Emergency Physician in Injury Prevention and Control for Adult and Pediatric Patients (Policy revised June 2020)
Violence-Free Society (Policy 2019)

**References**
1. Carter PM, Cunningham RM. Clinical Approaches to the Prevention of Firearm-Related Injury. N Engl J Med. 2024;391(10):926-940. doi:10.1056/NEJMra2306867
2. Ladines-Lim J, Secrest K, Pu A, et al. Firearm Screening and Counseling in General Medicine Primary Care Clinics at an Academic Medical Center. *J Gen Intern Med.* 2024;39(1):147-149. doi:10.1007/s11606-023-08379-x
3. Pallin R, Teasdale S, Agnoli A, et al. Talking about firearm injury prevention with patients: a survey of medical residents. *BMC Med Educ.* 2022;22(1):7. doi:10.1186/s12909-021-03024-9

## Background

This resolution calls for ACEP to amend its policy statement "Firearm Safety and Injury Prevention" to include support for the integration of firearm injury prevention, safe storage, and counseling education into emergency medicine residency training and continuing medical education programs; and that ACEP develop or identify and disseminate a physician-facing clinical guide to support emergency physicians in conducting brief, trauma-informed firearm safety counseling - particularly for high-risk patients - alongside both printable and digital format, evidence-based patient handouts suitable for emergency department use, potentially leveraging existing materials and partnerships where appropriate and consistent with ACEP's firearm safety policies.

In 2023, firearms remained the leading cause of death among U.S. youth, surpassing motor vehicle crashes and other causes. Among children and adolescents aged 0–17, there were approximately 2,581 firearm-related deaths, reflecting a 50% increase since 2019; this equates to nearly four deaths per 100,000 children. Nationwide, total firearm fatalities reached 46,728 in 2023, an average of 14.0 deaths per 100,000 people—including 27,300 firearm suicides (8.2 per 100,000) and 17,927 firearm homicides. Among youth firearm deaths in 2023, 63% were homicides, 29% suicides, and 5% attributed to unintentional incidents. Firearm suicides remain particularly urgent: firearms were involved in 47% of all youth suicides, and across all ages, 55% of suicides utilized firearms. This data underscores the vital importance of prevention strategies. Evidence strongly links access to firearms, especially unsecured weapons in the home, with increased risk of both suicide and homicide. Research shows that approximately 80% of youth firearm suicides involve a firearm from the home, and nearly 40% of households with children store at least one weapon loaded and unlocked.

Safe firearm storage is a critical and evidence-based strategy for reducing gun-related injuries and deaths, with broad support from researchers, healthcare professionals, and many firearm owners. Studies have consistently shown that storing firearms securely, unloaded, locked, and separate from ammunition, significantly reduces the risk of suicide, particularly among adolescents, and helps prevent unintentional injuries and deaths. In addition, secure storage decreases the likelihood that firearms will be stolen, diverted into illegal markets, or used in criminal activity. Child-protective firearm safety practices include a range of security measures, such as lockboxes and safes for handguns and long guns, trigger and cable locks, and separate locked containers for ammunition. A growing body of research supports the effectiveness of safe storage laws and policies, which have been associated with meaningful reductions in firearm suicides, accidental shootings, and homicides, including among youth and young adults.

Lethal means safety counseling in the emergency department (ED) is a crucial evidence-based suicide prevention intervention aimed at reducing the risk of suicide and self-harm among patients. This recommended practice involves healthcare providers assessing patients' access to means that could be used for self-injury, such as firearms, medications, or other harmful substances, with the goal is to create a supportive environment that helps patients develop coping strategies and access mental health resources, ultimately minimizing the risk of suicide. Effective lethal means safety counseling not only addresses immediate safety concerns but also contributes to long-term mental health support and recovery.

Unfortunately, earlier studies involving emergency physician self-reports found that lethal means assessment was not routine; less than 50% of providers 'almost always' or 'often' ask about suicidal patients' access to firearms, even though more than half thought that this assessment is important. Additionally, it is not uniformly implemented across all facilities, and its frequency can vary based on several factors, including institutional policies, physician training, and the specific protocols of the ED. Training programs and guidelines that emphasize the importance of this counseling can increase its implementation. However, not all EDs may have comprehensive training or resources available. Overall, while there is growing recognition of the importance of lethal means safety counseling, its frequency of implementation in EDs varies, and efforts are ongoing to standardize and improve its application across different healthcare settings.

Various studies have shown a strong correlation between firearm safety instruction to children and a reduction in dangerous interactions with firearms. A study published July 2023 in JAMA Pediatrics found that children ages 8-12 were three times more likely to avoid touching a discovered firearm when they had been shown a single one-minute firearm safety video a week prior. They were also three times more likely to tell an adult.

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements. Two firearms-related resolutions were adopted by the Council and the Board of Directors last year:

- Amended Resolution 61(24) Safe Storage of Firearms directed ACEP to create education to raise awareness that secure gun storage, (storing guns locked, unloaded and separate from ammunition) can save lives, prevent theft, and prevent access by unauthorized users who may pose a danger to themselves or others; and encourage emergency physicians and/or departments to function as messengers to patients about safe gun storage. The Public Health Committee is developing strategies to address this resolution.

- Amended Resolution 60(24) Lethal Means Firearm Safety Counseling directed ACEP to develop resources to provide evidence-based firearm-related lethal means safety counseling to at risk youth and work with other organizations to develop training for health care providers in firearm-related lethal means safety training. The Public Health Committee is investigating available resources and enhance their availability to ACEP members.

The 2023 Council and the Board of Directors adopted Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems directing ACEP to support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems. ACEP's policy statement "Firearm Safety and Injury Prevention" was revised in June 2024 in response to Resolution 36(23) Mandatory Waiting Period for Firearm Purchases and Resolution 35(23) Declaring Firearm Violence a Public Health Crisis.

The provisions of the "Firearm Safety and Injury Prevention" policy statement include:

- ACEP supports legislative and regulatory efforts that:
  - Actively support both private and public funding into firearm safety and injury prevention research.
  - Protect the duty of physicians to discuss firearm safety with patients.
- ACEP supports public health and health care efforts that:
  - Provide health care providers with information on the most effective ways to counsel patients and families on proper firearm safety, emphasizing evidence-based methods that are shown to reduce intentional and unintentional injuries.
  - Support research into public policies that may reduce the risk of all types of firearm-related injuries, including risk characteristics that might make a person more likely to engage in violent and/or suicidal behavior.

The policy statement "Violence-Free Society" notes that "ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives." The Public Health Committee (PHC) is currently revising and updating this policy statement.

The PHC developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" that provides information on prevention of firearm injuries, including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs, and listings of community-based firearm violence prevention programs by state. Additionally, the PHC is developing a patient centered resource addressing gun safety and providing information on best practices and available resources. The Pediatric Emergency Medicine Committee is developing an information paper on Safety Planning for Youth in the Emergency Department who have Suicide Risk, and this paper addresses firearms and provides guidance on evidence based best practices related to firearms.

In addition to the College's own specific efforts, ACEP member representatives and staff also continue to work with the American Medical Association (AMA), American College of Surgeons (ACS) and the ACS Committee on Trauma, the American Academy of Pediatrics (AAP), and other stakeholders to address firearm injury prevention and research.

**ACEP Strategic Plan Reference**

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Career Fulfillment: Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients

**Fiscal Impact**

Budgeted committee and staff resources for current and ongoing initiatives.

**Prior Council Action**

Amended Resolution 61(24) Safe Storage of Firearms adopted. Directed ACEP to create education to raise awareness that secure gun storage, (storing guns locked, unloaded and separate from ammunition) can save lives, prevent theft, and prevent access by unauthorized users who may pose a danger to themselves or others; and encourage emergency physicians and/or departments to function as messengers to patients about safe gun storage.

Amended Resolution 60(24) Lethal Means Firearm Safety Counseling adopted. Directed ACEP to develop resources to provide evidence-based firearm-related lethal means safety counseling to at risk youth and work with other organizations to develop training for health care providers in firearm-related lethal means safety training.

Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems adopted. Directed that ACEP support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted. Directed ACEP to declare firearm violence to be a public health crisis in the United States.

Resolution 14(00) Childhood Firearm Injuries referred to the Board of Directors. Directed ACEP to support legislation that requires safety locks on all new guns sold in the USA and support legislation that holds the adult gun owner legally responsible if a child is accidentally injured with the gun.

**Prior Board Action**

Amended Resolution 61(24) Safe Storage of Firearms adopted.

Amended Resolution 60(24) Lethal Means Firearm Safety Counseling adopted.

June 2024, approved the revised policy statement "Firearm Safety and Injury Prevention;" revised and approved October 2019; revised and approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems adopted.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted.

June 2020, approved the revised policy statement "Role of the Emergency Physician in Injury Prevention and Control for Adult and Pediatric Patients;" reaffirmed April 2014; revised and approved June 2008, replacing rescinded policy statement "Role of Emergency Physicians in the Prevention of Pediatric Injury;" reaffirmed October 2002; originally approved March 1998 titled "The Role of the Emergency Physician in Injury Prevention and Control."

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

June 2018, reviewed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention.

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 69(25)

SUBMITTED BY: Kansas Chapter

SUBJECT: Investigating Best Practices and Policy Solutions for Direct Communication When Referring Patients to the ED

PURPOSE: Investigate and report on best practices, operational models, and potential legislative or regulatory approaches to promote timely and direct communication between referring outpatient clinicians and emergency departments when patients are referred for emergency care.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. Unknown and unbudgeted costs for external resources could also be required.

WHEREAS, Emergency departments (EDs) often receive patients referred from urgent care centers, primary care providers, telehealth services, and other outpatient settings without accompanying documentation or direct communication; and

WHEREAS, The lack of direct communication between referring clinicians and emergency physicians can result in incomplete clinical information, unnecessary diagnostic duplication, delayed treatment, and potential patient harm; and

WHEREAS, Emergency physicians are frequently left to reconstruct the clinical reasoning, treatments already administered, or the urgency of the referral, particularly in cases where patients are unable to accurately relay relevant medical history; and

WHEREAS, Direct communication – whether through phone call, secure messaging, or electronic health record transmission – between the referring provider and the emergency physician could improve care coordination, reduce inefficiencies, and enhance patient safety; and

WHEREAS, Poor communication is a leading cause of patient harm, patient safety events and malpractice claims; and,

WHEREAS, While operational and logistical challenges exist, models in certain health systems have demonstrated the feasibility and benefit of streamlined referral communication protocols; therefore be it

RESOLVED, That ACEP investigate and report on best practices, operational models, and potential legislative or regulatory approaches to promote timely and direct communication between referring outpatient clinicians and emergency departments when patients are referred for emergency care.

**Background**

This resolution calls on ACEP investigate and report on best practices, operational models, and potential legislative or regulatory approaches to promote timely and direct communication between referring outpatient clinicians and emergency departments when patients are referred for emergency care.

The prevalence of chronic and behavioral health conditions is rising as the U.S. population ages and people often have multiple, complex underlying conditions. Half of adult Americans have at least one chronic condition and more than two-thirds of Medicare patients have two or more. People with complex, chronic, and behavioral health conditions

contribute to higher health care costs and account for more than 90%t of the nation's $3.3 trillion in health care spending. Patients with serious illness often have a lack of understanding of their disease process and prognosis. Patients are even sent to the ED after critical test results without being informed of the result or diagnosis.

Patient handoffs or transitions of care are dangerous primarily due to communication errors, which can lead to adverse events, delays in treatment, and even death. These errors often stem from missing, incomplete, or inaccurate information during the handoff process, as well as differing perspectives among caregivers. Communication errors have been identified as the root cause in about 70% of sentinel events. Additionally, up to 84% of treatment delays can be attributed to miscommunication.[1]

The risk to patient safety from handoffs is a well-known problem in medicine. Many organizations have taken steps to address the risks of handoffs, including the Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, and The Joint Commission. Structured communication, the use of standardized tools, and a supportive environment is necessary to improve patient safety during handoffs along with prioritizing face-to-face communication, minimizing distractions, and ensuring adequate time for information exchange and questions. Implementing tools such as SBAR (Situation, Background, Assessment, Recommendation) or I-PASS (Illness severity, Patient summary, Action list, Situation awareness, Synthesis by receiver) can help ensure all critical information is conveyed. ACEP has developed resources to improve handoffs in the ED and a Rapid Integration of Care Toolkit. These tools have been primarily applied in the hospital setting.

**Background Reference**

1. Cheung DS, Kelly JJ, Beach C, Berkeley RP, Bitterman RA, Broida RI, Dalsey WC, Farley HL, Fuller DC, Garvey DJ, Klauer KM, McCullough LB, Patterson ES, Pham JC, Phelan MP, Pines JM, Schenkel SM, Tomolo A, Turbiak TW, Vozenilek JA, Wears RL, White ML; Section of Quality Improvement and Patient Safety, American College of Emergency Physicians. Improving handoffs in the emergency department. Ann Emerg Med. 2010 Feb;55(2):171-80. doi: 10.1016/j.annemergmed.2009.07.016. Epub 2009 Oct 2. PMID: 19800711.

## ACEP Strategic Plan Reference

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment

## Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. Unknown and unbudgeted costs for external resources could also be required.

## Prior Council Action

Amended Resolution 50(24) Communication to Established Patients Being Referred to the Emergency Department adopted. The resolution directed ACEP to work with the other stakeholders to develop a strategy to address the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression of which they and their families were not educated by the physicians responsible for doing so.

Adopted Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted. Directed ACEP to rapid integration of care toolkit to focus on transitions of care and care coordination, provide best practices based upon hospital type and location, tools/resources for the design and implementation of rapid integration of care programs, and measures to report success of efforts.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted. Directed ACEP to: 1) define the role of emergency medicine in transitions of care for emergency medicine patients; 2) participate in all significant forums of discussion with regulatory entities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, The Joint Commission, National Quality Forum, related to performance parameters and proposed

standards for emergency medicine transitions of care; 3) monitor and have input into any reimbursement issues tied to transitions of care, including performance incentives and accountable care organization collaboration; and 4) identify resources and educational materials to improve transitions of care for emergency patients.

**Prior Board Action**

January 2015, reviewed the Rapid Integration of Care Toolkit

Adopted Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted.

October 2012, reviewed the Transitions of Care Task Force Report. The information paper recommended strategies for emergency medicine. The 2012 Council Town Hall meeting focused on Transitions of Care and highlighted aspects of the task force report.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted.

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 70(25)

SUBMITTED BY: Colorado Chapter
District of Columbia Chapter
New York Chapter
North Carolina College of Emergency Physicians
Wellness Section

SUBJECT: Mandated Reporting of ED Violence

PURPOSE: Partner with other organizations to develop an ED violence reporting system and facilitate collection of violence prevention initiatives implemented by hospitals and health systems and develop best practices.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives. Unbudgeted costs for creation of a national centralized reporting portal, likely in excess of $100,000, and considerable staff resources to create, analyze, and maintain the data. Collecting violence prevention initiatives from hospitals and health systems to address ED violence and develop best practices is not a current initiative of the College and would require diverting committee and staff resources to address this initiative.

WHEREAS, Violence against physicians in the ED is an epidemic; and

WHEREAS, There is a paucity of data of the occurrence of violence against physicians in the ED; and

WHEREAS, Once we know the true occurrence of this violence, it can be tracked and health systems can be held accountable; therefore be it

RESOLVED, That ACEP work with likeminded organizations, such as the Emergency Nurses Association and the Lorna Breen Foundation, to develop an emergency department violence reporting system; and be it further

RESOLVED, That ACEP facilitate the collection of violence prevention initiatives that hospitals and health systems have implemented to address emergency department violence and develop best practices.

**Background**

This resolution calls for ACEP to partner with other organizations to develop an ED violence reporting system and facilitate collection of violence prevention initiatives implemented by hospitals and health systems and develop best practices.

ACEP has taken a leading role in addressing the growing problem of violence in emergency departments. Surveys conducted by ACEP in 2024, 2022, and 2018 reveal an alarming and escalating trend: nearly half of emergency physicians reported being physically assaulted at work in 2018, with 91% indicating in 2024 that they or a colleague had experienced violence within the past year. Many physicians believe hospitals can do more to enhance safety through increased security measures, such as deploying security personnel, installing surveillance systems, and implementing stricter visitor screening protocols. In response, ACEP has collected more than 800 personal accounts from emergency physicians detailing workplace violence and has advocated for improved local reporting mechanisms. ACEP has advocated for local reporting of violence in the ED. While the development of a national database on emergency department violence could offer valuable insights, ACEP recognizes the significant logistical challenges involved, including the need for standardized terminology, consistent data submission across institutions, and dedicated analytic resources – challenges similar to those encountered with collecting data for the Clinical Emergency Data Registry. ACEP has learned from the implementation of the Clinical Emergency Data Registry, and

even with the CDC, hospitals are reluctant to provide such data outside of state or federal requirements. Despite these barriers, ACEP continues to promote data-driven approaches to reduce violence and protect emergency care teams. Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts and has been featured as one of the key advocacy priorities during several ACEP Leadership & Advocacy Conference (LAC) meetings in Washington, DC, including as recently as 2024.

ACEP's Legislative & Regulatory Priorities for the First Session of the 119th Congress include:

- Advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED and secure new congressional champions.(Legislative)
- Continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department. (Regulatory)
- Support legislation and identify new opportunities to promote comprehensive violence prevention and intervention efforts, such as hospital-based violence intervention programs, increased community-specific resources, research funding, and educational initiatives.(Legislative)

ACEP helped inform and continues to support the "Workplace Violence Prevention Act for Health Care and Social Service Workers" (H.R. 2531/S.1232), introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI). This legislation would compel the Occupational Safety and Health Administration (OSHA) to issue federal standards to require health care and social service employers to create and implement workplace violence prevention plans. ACEP was the first physician organization to ever endorse this legislation and has worked closely with the sponsors for several Congresses. Among the provisions of this bill are:

- The OSHA standard mandates that employers shall investigate each incident of workplace violence as soon as practicable, document the findings, and take corrective measures.
- The OSHA standard requires that employers must record workplace violence incidents in a Violent Incident Log ("Log"). An annual summary of the Log shall be posted in the workplace in the same manner as the posting of the OSHA Annual Summary of Injuries and Illnesses, and similarly shall be transmitted to OSHA. Employers shall maintain records related to the Plan, and employees are provided the right to examine and make copies of the Plan, the Log and related Plan documents, with appropriate protections for patient and worker privacy. Patient names and personal identifying information will be excluded from the Violent Incident Log.
- The OSHA standard prohibits retaliation against a covered employee for reporting a workplace violence incident, threat, or concern to an employer, law enforcement, local emergency services, or a government agency. A violation of this prohibition shall be enforceable as a violation of an OSHA standard.

ACEP has also worked directly with OSHA for many years as they have attempted to develop and issue regulations on this front, efforts that have been in progress since 2015. The agency had hoped to release a proposed rule for a workplace violence prevention in health care and social service facilities in December 2024, however the agency ultimately did not release the proposed rule prior to the end of President Joe Biden's term.

ACEP also helped inform and supports the bipartisan, "Save Healthcare Workers Act" (H.R. 3178/S.1600), previously known as the "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768) in previous Congresses. This bipartisan, bicameral legislation was introduced by Madeleine Dean (D-PA) and Reps. Mariannette Miller-Meeks (R-IA), and Sens. Cindy Hyde-Smith (R-MS) and Angus King (I-ME). This legislation would establish federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP President Alison Haddock, MD, FACEP, was quoted in the press release when the legislation was introduced.

Last year, the Council and the Board of Directors adopted Amended Resolution 41(24) Workplace Violence Data Collection. The resolution directed ACEP to advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem. This tenets of this resolution are addressed in the proposed

"Save Healthcare Workers Act" (H.R. 3178/S.1600).

In early 2024, ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA). ACEP, along with the with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA), hosted another congressional briefing on workplace violence in March 2024. And in July 2024, ACEP and AHA hosted another congressional briefing focused on the Senate, with Senator Joe Manchin (D-WV) attending to deliver remarks to the audience as well. ACEP has also established and leads a coalition of other medical specialties to further amplify these advocacy efforts on Capitol Hill.

ACEP also provided input on The Joint Commission's "Workplace Violence Prevention" project in 2021 and, as a result of that work, TJC announced new requirements for accredited hospitals to ensure safer work environments. The new and revised requirements that went into effect January 1, 2022 include directives for hospitals to have a workplace violence prevention program; conduct annual worksite analysis related to its workplace violence prevention program; establish a process to continually monitor, report, and investigate safety incidents including those related to workplace violence; and to provide training, education and resources to leadership, staff, and licensed practitioners to address prevention, recognition, response and reporting of workplace violence. The Workplace Violence Standards Fact Sheet provides an overview of the new standards.

ACEP began a partnership with ENA in 2019 to launch the "No Silence on ED Violence" campaign to draw more public attention to the problem of violence in the emergency department, to drive policymaker action to address the issue, and to provide resources and support to emergency physicians and emergency nurses. The campaign website, www.stopEDviolence.org, includes fact sheets and advocacy materials highlighting the severity of the issue, as well as resources for members seeking ways to reduce the incidence of violence in the ED. ACEP continues working closely with ENA on this issue. Additionally, ACEP has communicated with the American Nurses Association (ANA) and the National District Attorneys Association (NDAA) to gain a better understanding of the various issues that contribute to the current workplace violence landscape where violence against emergency physicians and other health care workers is either not reported or not prosecuted, and the College continues working to develop a better understanding of the patchwork of state laws related to health care workplace violence. In May 2022, No Silence on ED Violence Press Conference leaders and members of ENA and ACEP, together with Senator Tammy Baldwin (D-WI), held a press conference on Capitol Hill calling on Congress to pass legislation aimed at reducing violence against health care workers." ACEP and ENA hosted a similar press conference on Capitol Hill after LAC2023, and continue closely partnering on related efforts.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of Violence in the Emergency Department" calls workplace violence "a preventable and significant public health problem" and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a page with a wealth of resources entitled "Violence in the Emergency Department: Resources for a Safer Workplace." The site includes links to information papers on the "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED and "Emergency Department Violence: An Overview and Compilation of Resources" and the "How Safe is Your Workplace" sample checklist.

The Public Health Committee is currently working on a one-page/signage template for emergency departments using the "Emergency Department Patient Rights and Responsibilities" policy statement to educate patients that clearly defines acceptable behavior and states that non-medical aggression may result in immediate removal.

ACEP's State Legislative/Regulatory Committee (SLRC) has a work group assigned to address workplace violence issues. Part of their work involves discussions with the law enforcement community to ensure that convictions for workplace violence are not dismissed by district attorney offices. Additionally, the SLRC has advocated for mandatory reporting of workplace violence, similar to legislation in North Carolina, which requires hospitals to track and report such incidents.

**ACEP Strategic Plan Reference**

Career Fulfillment: ACEP supports you in addressing your career frustrations and seeking avenues for greater career fulfillment, and commits to addressing tough issues head on.

Advocacy: ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

**Fiscal Impact**

Budgeted staff resources for ongoing advocacy initiatives. Unbudgeted costs for creation of a national centralized reporting portal, likely in excess of $100,000, and considerable staff resources to create, analyze, and maintain the data. Collecting violence prevention initiatives from hospitals and health systems to address ED violence and develop best practices is not a current initiative of the College and would require diverting committee and staff resources to address this initiative.

**Prior Council Action**

Substitute Resolution 56(24) Patient and Visitor Code of Conduct adopted. Directed ACEP to develop and adopt a universal code of conduct for patients and visitors in the emergency department.

Amended Resolution 41(24) Workplace Violence Data Collection adopted. Directed ACEP to advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state, and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. This resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against healthcare providers , advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital’s emergency department.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on violence prevention issue and encourage the National Institute of Mental Health and Centers for Disease Control and Prevention, among others, to make financial support available for research.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop

recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

**Prior Board Action**

Approved as legislative and regulatory priorities in January 2025, March 2024, February 2023, and January 2022 to continue advocating for reintroduction or passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

Substitute Resolution 56(24) Patient and Visitor Code of Conduct adopted.

Amended Resolution 41(24) Workplace Violence Data Collection adopted.

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved with the title "Protection from Violence in the Emergency Department" April 2016; revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

Resolution 55(17) Workplace Violence adopted.

May 2016, reviewed the information paper "Emergency Department Violence: An Overview and Compilation of Resources."

November 2015, reviewed the information paper "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

August 2014, reviewed the information paper "Hospital-Based Violence Intervention Programs."

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NO
OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 71(25)

SUBMITTED BY: Louisiana Chapter
Pennsylvania College of Emergency Physicians
Vermont Chapter
New Mexico Chapter
Texas College of Emergency Physicians
Emergency Medicine Workforce Section

SUBJECT: Maintenance of Malpractice Tail Coverage in the Setting of Employer Bankruptcy

PURPOSE: Curate educational materials and webinars focused on best practices in employment negotiation, guidance on assessing contract provisions, malpractice insurance fundamentals with particular emphasis on securing tail coverage provisions and responding to employer insolvency and have these resources available in an organized, user-friendly, centralized and a member-accessible hub that is easily identifiable on the ACEP website.

FISCAL IMPACT: Budgeted committee and staff resources. Members and staff are currently working on providing additional resources to members affected by employer bankruptcy and making the resources available in a centralized area of the website.

WHEREAS, Emergency physicians frequently practice under employment agreements with contract management groups (CMGs) and other private entities that are responsible for securing and maintaining malpractice insurance coverage, including tail coverage upon separation or corporate dissolution; and

WHEREAS, Recent high-profile bankruptcies of emergency medicine practice groups, including NES Health and American Physicians Partners, have disrupted the continuity of malpractice insurance coverage for many emergency medicine physicians, placing them at personal financial and legal risk;[1,2] and

WHEREAS, The sudden collapse of such entities can leave physicians without critical malpractice tail coverage, particularly when employer policies do not guarantee or adequately fund tail insurance upon insolvency; and

WHEREAS, ACEP has a vested interest in advocating for the financial security and legal protection of its members, and in equipping emergency medicine physicians with the knowledge and tools necessary to navigate employer-related insurance gaps;[3] and

WHEREAS, Easily accessible educational resources and guidance from ACEP would empower emergency medicine physicians to proactively protect themselves against such vulnerabilities in future employment contracts; and

WHEREAS, ACEP already has various resources available in its Career Center, other locations on the ACEP website, and within the NES Health Discussion Member Interest Group;[4,5,6] therefore be it

RESOLVED, That ACEP curate existing and future educational materials and webinars focused on best practices in employment negotiation, guidance on assessing contract provisions, malpractice insurance fundamentals with particular emphasis on securing tail coverage provisions, and responding to employer insolvency and have these resources available in an organized, user-friendly, centralized and member-accessible hub that is easily identifiable on the ACEP website.

**References**

1. https://www.acepnow.com/article/another-failed-physician-mgmt-company-leaves-ed-staff-dangling/

2. https://www.beckershospitalreview.com/legal-regulatory-issues/physician-staffing-firm-files-for-bankruptcy/
3. https://www.acep.org/news/acep-newsroom-articles/acep-calls-for-stronger-physician-protections-when-employers-break-contracts
4. https://www.acep.org/life-as-a-physician/career-center
5. https://www.acep.org/careertransitionsupport
6. https://engaged.acep.org/communities/community-home?CommunityKey=36175b5e-1ad5-4e56-a03f-0192eadd604b

**Background**

This resolution calls for ACEP to curate educational materials and webinars focused on best practices in employment negotiation, guidance on assessing contract provisions, malpractice insurance fundamentals with particular emphasis on securing tail coverage provisions and responding to employer insolvency and have these resources available in an organized, user-friendly, centralized and a member-accessible hub that is easily identifiable on the ACEP website.

Several prominent emergency physician groups have undergone financial reorganization or bankruptcy recently without always honoring their commitment to provide tail malpractice coverage for their employed physicians. These bankruptcies have exposed emergency physicians to long-term legal and financial risks. Many were faced with the prospect of personally funding expensive tail policies or assuming open-ended legal liability for their prior clinical work having been unaware that their tail coverage was not guaranteed in the event of corporate bankruptcy.

ACEP has multiple resources in various locations on the website to assist members, including the Career Center. Other areas of the website include resources on employment contracts, medical-legal resources, and the Town Hall session on Resources for Physicians Affected by NES Health. Additionally, ACEP in conjunction with EMRA, offers a comprehensive course "Practice Essentials" that is free to EMRA and ACEP members. The course covers many of the topics called for in this resolution including negotiation, contracts, malpractice fundamentals, personal finance, etc.

ACEP President Alison Haddock, MD, FACEP, has appointed a workgroup of members who have been impacted by recent employer groups dissolving, national ACEP Board members, and staff to assist with strategies to pursue and developing resources to assist members. The strategies being discussed include: 1) help prepare physicians by giving them the skills and knowledge needed to best protect themselves up front; 2) consolidate more resources to be able to help immediately when new situations occur; and 3) advocate at both the state and national level for better protections for emergency physicians and patients when employer groups are at risk of dissolution.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

**Fiscal Impact**

Budgeted committee and staff resources. Members and staff are currently working on providing additional resources to members affected by employer bankruptcy and making the resources available in a centralized area of the website

**Prior Council Action**

The Council has discussed and approved many resolutions related to contracts and providing resources to members. Prior resolutions have not been submitted that are specific to curating the resources in a centralized area of the website.

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted. Directed ACEP to adopt a policy statement addressing continuity of fair compensation including monetary payments and malpractice coverage during times of contract transitions.

**Prior Board Action**

The Boad has discussed and approved many policy statements and other resources related to contracts and providing resources to members.

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted. The resolution was formatted as the policy statement "Protecting Emergency Physicians During Contract Transitions."

**Background Information Prepared by:** Adam Krushinskie, MPA
Senior Director, State Legislative & Reimbursement

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 72(25)


SUBMITTED BY:

| | |
|---|---|
| Stephen H. Anderson MD, FACEP | Donald Stader, MD, FACEP |
| John Bibb, MD, FACEP | Jessica Wall, MD, MPH, FACEP |
| Nida Degesys, MD, FACEP | Scott Weiner, MD, FACEP |
| Ramnik Dhaliwal, MD, JD | California Chapter |
| Alicia Gonzalez, MD, FACEP | Missouri Chapter |
| Alexis LaPietra, DO, FACEP | New Mexico Chapter |
| Aimee Moulin, MD, FACEP | Pain Management & Addiction Medicine Section |
| Evan Schwarz, MD, FACEP | Toxicology Section |


SUBJECT: Naloxone Access and Education in Public Schools

PURPOSE: ACEP endorse efforts to assure naloxone is in public schools and incorporate education on overdose and substance use disorder into health education.

FISCAL IMPACT: Budgeted resources to endorse the work of other organizations in supporting naloxone-related initiatives in educational settings.

WHEREAS, The number one cause of accidental deaths ages 13-55 in America in 2024 remains overdose deaths; and

WHEREAS, The overdose death rate increased 300% among adolescents aged 13-17 from 2019 to 2022, however, the good news is the number of deaths overall decreased 27% from 2023 to 2024 primarily through restricting fentanyl in our communities and access to naloxone; and

WHEREAS, We can reverse opioid overdoses with rapidly administered naloxone one person at a time, but to change the overdose trajectory into the next generation requires education of that generation and studies show adolescents are receptive to this, and modules already exist; and

WHEREAS, Youth targeted harm reduction strategies already exist for other scenarios and we already have AED's, tourniquets, and fire extinguishers in our schools for public safety and the likelihood of an overdose death far exceeds those events; and

WHEREAS, In 2024, only 13 states have naloxone legislatively mandated on campus, and only 7 states required mandatory training on the topic of opioids, overdose and addiction and as recently as May 2024 template legislation has passed in states such as Colorado to assure this; and

WHEREAS, Other visible organizations have already endorsed these campaigns (i.e., the AMA, the White House Office of National Drug Control Policy, the prior U.S. Secretary of Education, and SAMHSA to name a few), but to engage other policy makers and influential organizations ACEP's endorsement is highly valued; and

WHEREAS, Emergency medicine is often the gurney on which these individuals land, and we now have programs and medications to promote rehabilitation and these are OUR patients along their journeys; therefore be it

RESOLVED, That ACEP endorse efforts to assure naloxone is in public schools and incorporate education on overdose and substance use disorder into health education.

**Background**

This resolution calls for ACEP to endorse efforts to assure naloxone is in public schools and incorporate education on overdose and substance use disorder into health education.

The ongoing surge in synthetic opioid use, particularly fentanyl, which has driven a steep rise in overdose fatalities, has elevated naloxone (and other opiate reversal agents approved by the FDA) to a critical role in emergency response. Provisional data from the CDC reveal that U.S. drug overdose deaths declined nearly 27% from approximately 110,000 in 2023 to around 80,400 in 2024, the lowest figure since 2019. Much of this decline is attributed to the significant drop in synthetic opioid deaths, especially fentanyl, by about one-third in the year ending October 2024, linked to expanded naloxone distribution and broader access to medications for opioid use disorder. With its rapid onset of action and excellent safety profile, naloxone remains indispensable for emergency physicians, EMS providers, and frontline clinicians managing acute opioid toxicity, especially since many overdoses occur outside hospital settings.

Efforts to expand naloxone access have seen substantial progress. Since April 2023, at least two nasal spray formulations, including Narcan®,have been approved for over the counter (OTC) sale. Pharmacy availability has increased accordingly: same-day OTC access rose from 42% to nearly 58% post-OTC approval, and over 2.1 million naloxone prescriptions were dispensed in retail pharmacies in 2023, raising the national dispensing rate from 0.3 to 0.6 per 100 persons since 2019. Additionally, statewide standing orders and community-based distribution programs now operate in every U.S. state, with naloxone dispensing mandates and co-prescribing initiatives embedded in laws in states such as New York and Massachusetts.

For clinicians, integrating naloxone into routine care through targeted risk assessments, patient and caregiver education, and naloxone prescribing or dispensing is essential. Regularly co-prescribing naloxone alongside high-dose opioids or in patients with other overdose risk factors aligns with CDC guidelines and enhances safety nets. Moreover, naloxone distribution in emergency settings, including vending machines and public access points, such as the initiative in Nashville, TN which dispensed over 2,200 doses within five weeks, demonstrates how EDs and health systems can lead community harm-reduction efforts.

Expanding naloxone access and education in schools is a critical public health strategy to combat the growing opioid crisis among youth and adolescents. With the increasing presence of fentanyl and other synthetic opioids in the illicit drug supply, even a single exposure can be fatal and often without the individual knowing they are ingesting an opioid. Equipping school staff, students, and communities with the knowledge to recognize opioid overdose symptoms and administer naloxone can save lives and reduce response time in emergencies. The inclusion of naloxone in school emergency preparedness plans, along with appropriate training, helps destigmatize its use and reinforces its role as a life-saving tool, similar to AEDs or EpiPens. Moreover, integrating substance use education with harm reduction principles fosters early awareness, resilience, and responsible behavior among students, ultimately contributing to safer and more informed school environments.

There are organizations that are working on initiatives and are actively supporting naloxone-related initiatives in educational settings, such as the American Association of School Administrators and the National Association of School Nurses (NASN). For example, NASN has taken a formal leadership role in advocating naloxone access in schools. Its revised position statement asserts that schools should maintain naloxone on-site and that professional school nurses are essential in developing and implementing overdose response protocols and NASN’s toolkit and guidance align with federal recommendations. In 2023, the U.S. Department of Education and the Office of National Drug Control Policy, issued a joint letter encouraging all U.S. schools to maintain naloxone and educate staff and students in its use. This resolution calls for ACEP to potentially work with such organizations and others to endorse these efforts.

**ACEP Strategic Plan Reference**

Practice Innovation: Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.

**Fiscal Impact**

Budgeted resources to endorse the work of other organizations in supporting naloxone-related initiatives in educational settings.

**Prior Council Action**

Substitute Resolution 41(21) Take Home Naloxone Programs in Emergency Departments adopted. Directed ACEP to: 1) amend the policy statement "Naloxone Prescriptions by Emergency Physicians" to include endorsement for Take-Home Naloxone programs in EDs; 2) seek to increase the distribution of naloxone from the ED by researching and advocating for a standardized, lower barrier, and cost-effective take-home model for naloxone for at risk patients; 3) partner with other like-minded organizations to promote Take-Home Naloxone programs as a best practice for patients at risk of opioid overdose, and work to increase the number of Take-Home Naloxone programs in EDs; 4) advocate for regulatory and payment reform to facilitate reimbursement from public and private payers, to hospitals and EDs for naloxone dispensed directly to patients as part of Take-Home Naloxone programs; and 5) educate emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with the Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Resolution 30(18) Naloxone Layperson Training adopted. Directed ACEP to support state chapters in drafting and advocating for legislation to recommend naloxone training in schools and work with national advocacy and capacity-building organizations to advocate for increased naloxone training by laypersons.

Amended Resolution 29(16) The Opioid Epidemic – A Leadership Role for ACEP adopted. Directed ACEP to advocate and support training and equipping all first responders to use injectable and nasal spray Naloxone and advocate and support that appropriately trained pharmacists be able to dispense Naloxone without prescription, and develop a comprehensive policy statement on the prevention and treatment of the opioid use disorder epidemic including innovative treatments.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to review solutions to decrease the death rate from prescription drug overdoses and create a document offering best practice solutions.

Resolution 39(13) Naloxone Prescriptions in the ED not adopted. The resolution sought for ACEP to support and advises emergency physicians to dispense and/or prescribe Naloxone for victims of opioid overdose treated in the ED and promote the ability of emergency physicians to lawfully prescribe Naloxone explicitly for potential future opiate overdose through legislative or regulatory advocacy at the local, state, and national levels.

Resolution 38(13) Naloxone as an Over the Counter Drug not adopted. The resolution called for adoption of a policy in support of Naloxone becoming available as an OTC drug and promote education and safeguards for its use.

**Prior Board Action**

February 2023, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" revised and approved June 2016; originally approved October 2015.

Substitute Resolution 41(21) Take Home Naloxone Programs in Emergency Departments adopted.

February 2021, approved "Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency

Department." The inclusion of harm reduction strategies (including overdose education and naloxone distribution) or prescriptions is also an essential component of the ED visit.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

Resolution 30(18) Naloxone Layperson Training adopted.

Amended Resolution 29(16) The Opioid Epidemic – A Leadership Role for ACEP adopted.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 73(25)

SUBMITTED BY: Stephen Anderson, MD, FACEP
John Bibb, MD, FACEP
Christine Collins, MD, FACEP
Fred Dennis, MD, MBA, FACEP
Anthony Furiato, DO, EJD, FACEP
California Chapter
Pain Management & Addiction Medicine Section

SUBJECT: Promoting Comprehensive Treatment of Substance Use Disorders Across the Nation

PURPOSE: 1) Develop a plan to promote and facilitate the initiation of nation-wide ED programs to improve substance use disorder treatment including, but not limited to, staff training, dispensing harm reduction materials, initiating medication for opioid use disorder, and rapid clinical referrals to outpatient treatment; 2) Potentially work with other organizations such as the AMA, state medical associations, Bridge to Treatment, MATTERS, American Society of Addiction Medicine, American College of Academic Addiction Medicine and potentially others, to obtain funding for substance use disorder programs from federal, state, and/or private sources; and 3) Provide a report to the Council in 2026 on the development of a plan to promote and facilitate the initiation of nation-wide ED programs to improve substance use disorder treatment and any progress made on the goals of the plan.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

WHEREAS, For the first time in over 30 years the overdose death rate in 2024 in United States dropped (from 112,000 to 84,000), but still remained the #1 cause of accidental deaths in America; and

WHEREAS, There are over 170,000 US deaths due to alcohol use disorder according to the CDC; and

WHEREAS, Only 15% of people in the U.S. with substance use disorder (SUD) obtained any treatment for their disease in the last year; and

WHEREAS, These people are our patients, family and friends; and

WHEREAS, There is a wealth of information on treating substance use disorder including E-QUAL, etc.; and

WHEREAS, Initiation of medication for opioid use disorder has been shown to reduce mortality; and

WHEREAS, Only 2% of written prescriptions for naloxone from the emergency department are ever filled; and

WHEREAS, Maryland, California, New York and others have found ways to fund the treatment of substance use disorder from federal, state and private resources; and

WHEREAS, There is evidence for the cost effectiveness of comprehensive substance use disorder treatment programs initiated in the ED benefitting hospitals, health care systems, local communities, and all society; and

WHEREAS, ACEP's own Pain and Addiction Care in the ED (PACED) and other organizations largely composed of ACEP physicians, such as Bridge to Treatment, and MATTERS have worked successfully to improve

SUD treatment in the ED and beyond; therefore be it

RESOLVED, That ACEP develop a plan to promote and facilitate the initiation of nation-wide emergency department programs to improve substance use disorder treatment including, but not limited to, staff training, dispensing harm reduction materials, initiating medication for opioid use disorder, and rapid clinical referrals to outpatient treatment; and be it further

RESOLVED, That ACEP potentially work with other organizations such as the American Medical Association, state medical associations, Bridge to Treatment, MATTERS, American Society of Addiction Medicine, American College of Academic Addiction Medicine and potentially others, to obtain funding for substance use disorder programs from federal, state, and/or private sources; and be it further

RESOLVED, That ACEP report back to the Council in 2026 on the development of a plan to promote and facilitate the initiation of nation-wide emergency department programs to improve substance use disorder treatment and any progress made on the goals of the plan.

**References**


- Bridge to Treatment
- Cost Effectiveness of Emergency Department-Initiated Treatment for Opioid Dependence
- Emergency department screening and interventions for substance use disorders
- Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health [Internet].US Department of Health and Human Services; 2016 Nov.
- E-Qual Opioid Network Initiative
- State Investment in Emergency Department Buprenorphine Pays Off Gail D'Onofrio, MD, MS[1,2]; Jon B. Cole, MD[3,4,5]; Jeanmarie Perrone, MD[6] JAMA.2025;333(14):1209-1211. doi:10.1001/jama.2025.0609
- EDAP, www.acep.org/EDAP
- Maryland Department of Public Health Funding
- MATTERS
- Model Legislation: Legislative Analysis and Public Policy Association
- Washington Post editorial https://www.washingtonpost.com/opinions/2025/05/22/opioids-europe-philadelphia-drugs/


## Background

This resolution calls for ACEP to: 1) Develop a plan to promote and facilitate the initiation of nation-wide ED programs to improve substance use disorder treatment including, but not limited to, staff training, dispensing harm reduction materials, initiating medication for opioid use disorder, and rapid clinical referrals to outpatient treatment; 2) Potentially work with other organizations such as the AMA, state medical associations, Bridge to Treatment, MATTERS, American Society of Addiction Medicine, American College of Academic Addiction Medicine and potentially others, to obtain funding for substance use disorder programs from federal, state, and/or private sources; and 3) Provide a report to the Council in 2026 on the development of a plan to promote and facilitate the initiation of nation-wide ED programs to improve substance use disorder treatment and any progress made on the goals of the plan.

ACEP has helped develop original federal legislation and supports a number of federal legislative advocacy efforts to facilitate access to opioid use disorder (OUD) and substance use disorder (SUD) treatment. For example, in 2018, ACEP was able to secure the inclusion of two ACEP-led and -developed bills, the "Alternatives to Opioids (ALTO) in the Emergency Department Act" and the "Preventing Overdoses While in Emergency Rooms (POWER) Act" as part of the comprehensive opioid crisis response legislation, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271).

- The Alternatives to Opioids (ALTO) in the Emergency Department Act created a demonstration program to implement non-opioid evidence-based pain management protocols, such as nitrous oxide, trigger point injections, nerve blocks, and other pain management options in hospitals across the country, based on the successful and proven ALTO program developed in New Jersey. In 2022, ACEP helped secure a 5-year reauthorization of this program, changing it from a demonstration program to a full permanent program and increasing its appropriation to a total of $8 million (a $2 million increase from FY22 levels).

- The Preventing Overdoses While in Emergency Rooms (POWER) Act established a grant program to implement policies and procedures for initiating Medication-Assisted Treatment (MAT) in the emergency department. It also would provide education and additional resources to help implementation of MAT in the emergency department, as well as develop best practices to provide a "warm handoff" to appropriate community resources and providers to keep patients engaged in treatment. Unlike ALTO, the POWER Act was authorized but never appropriated. The SUPPORT Act reauthorization effort in the current 119th Congress is a streamlined version of the original law and does not extend programs that were authorized but never appropriated, like the POWER Act. As a result, the POWER Act's authorization has expired and ACEP continues looking for potential new legislative champions to reintroduce the bill or related text.

In the 118th Congress, ACEP also supported the "Hospitals as Naloxone Distribution Sites (HANDS) Act" that would provide no-cost coverage under Medicare, Medicaid, and Tricare for preventive distribution of opioid overdose reversal agents, such as naloxone.

Substance use and substance use disorders (SUDs) remain a pervasive public health crisis in the United States, contributing to significant morbidity, mortality, and health care utilization. More than 109,000 people died from drug overdoses in 2023, the vast majority of which involved opioids and particularly synthetic opioids such as fentanyl. Alcohol use also remains a leading preventable cause of death, contributing to approximately 140,000 deaths annually. These figures highlight the ongoing and escalating burden of substance-related harm across communities, exacerbated by the increasing complexity of polysubstance use and co-occurring mental health disorders.

Emergency departments (EDs) serve as critical access points for individuals affected by substance use. Patients may present with acute intoxication, withdrawal symptoms, overdose, or complications from chronic substance use, such as infections, injuries, or psychiatric crises. According to the Centers for Disease Control and Prevention (CDC), ED visits for opioid-related overdoses have increased significantly over the past decade, with notable spikes during and after the COVID-19 pandemic. EDs are also seeing rising numbers of visits associated with methamphetamines, cocaine, xylazine-adulterated opioids, and synthetic cannabinoids, reflecting shifting patterns in drug use and supply.

Emergency physicians are uniquely positioned to intervene in the cycle of addiction. The ED provides a vital opportunity for screening, brief intervention, and referral to treatment (SBIRT), as well as for the initiation of evidence-based medications for opioid use disorder (MOUD), such as buprenorphine. Despite time and resource constraints, emergency medicine is increasingly integrating addiction medicine principles, harm reduction strategies (e.g., naloxone, and other opiate reversal agents, distribution), and linkage to outpatient care into routine practice. These efforts have been supported by evolving legislation and policy changes, including the removal of the federal X-waiver requirement to prescribe buprenorphine.

The impact of substance use on emergency care also extends to provider and system-level challenges. ED crowding, repeat utilization, complex medical and psychiatric needs, and violence associated with intoxicated states can strain resources and staff. Moreover, stigma remains a persistent barrier to effective care and follow-up. As the epidemic evolves, emergency medicine will continue to play a central role, not only in responding to the immediate consequences of substance use, but also in advancing upstream, compassionate, and evidence-based approaches to prevention, treatment, and recovery support.

ACEP has developed a significant number of resources, education, policies and information papers addressing the opioid epidemic and substance use disorders, along with numerous initiatives and partnerships targeted at this issue. In addition to ACEP's clinical policy on "Opioids", there are multiple policy statements on issues related to substance use, including but not limited to:

- Addressing Nicotine Use
- Alcohol Advertising
- Care of Pregnant Individuals with Substance Use Disorder
- Drug Take Back Programs
- Electronic Prescription Drug Monitoring Programs

- Medical Cannabis
- Naloxone Access and Utilization for Suspected Opioid Overdoses
- Physician Reporting of Potentially Impaired Drivers
- Optimizing the Treatment of Acute Pain in the Emergency Department
- Overdose Prevention Centers
- Screening for Disease and Risk Factors in the Emergency Department
- Social Services and Care Coordination in the Emergency Department

ACEP committees have also developed multiple publications on issues related to substance use such as:


- Sandelich S, Hooley G, Hsu G, et al. Acute opioid overdose in pediatric patients. *J Am Coll Emerg Physicians Open*. 2024;5(2):e13134. Published 2024 Mar 7. doi:10.1002/emp2.13134
- Hawk K, Hoppe J, Ketcham E, et al. Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department. Ann Emerg Med. 2021;78(3):434-442. doi:10.1016/j.annemergmed.2021.04.023
- Taylor A, Kinsman J, Hawk K, et al. Development and testing of data infrastructure in the American College of Emergency Physicians' Clinical Emergency Data Registry for opioid-related research. *J Am Coll Emerg Physicians Open*. 2022;3(5):e12816. Published 2022 Oct 25. doi:10.1002/emp2.12816
- Schwarz ES, Dietrich AM, Sandelich S, et al. Emergency department management of opioid use disorder in pediatric patients. *J Am Coll Emerg Physicians Open*. 2024;5(5):e13265. Published 2024 Aug 25. doi:10.1002/emp2.13265
- Chang CD, Saidinejad M, Atanelov Z, et al. Emergency department strategies to combat the opioid crisis in children and adolescents. *J Am Coll Emerg Physicians Open*. 2021;2(4):e12512. Published 2021 Jul 21. doi:10.1002/emp2.12512
- Duber HC, Barata IA, Cioè-Peña E, et al. Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department. *Ann Emerg Med*. 2018;72(4):420-431. doi:10.1016/j.annemergmed.2018.04.007
- Hawk KF, Weiner SG, Rothenberg C, et al. Leveraging a Learning Collaborative Model to Develop and Pilot Quality Measures to Improve Opioid Prescribing in the Emergency Department. *Ann Emerg Med*. 2024;83(3):225-234. doi:10.1016/j.annemergmed.2023.08.490
- Models for Addressing Transitions of Care for Patients with Opioid Use Disorder
- Stoner MJ, Dietrich A, Lam SH, Wall JJ, Sulton C, Rose E. Marijuana use in children: An update focusing on pediatric tetrahydrocannabinol and cannabidiol use. J Am Coll Emerg Physicians Open. 2022;3(4):e12770. Published 2022 Jul 5. doi:10.1002/emp2.12770


ACEP has worked with multiple organizations over many years such as the American Academy of Addiction Psychiatry, American Society of Addiction Medicine, Foundation for Opioid Response Efforts, and others, including federal partners and agencies such as the Center for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration and the Food and Drug Administration, to develop education, tools, resources and initiatives to address the substance use epidemic, including but not limited to in person educational trainings and conferences, publications, policies, clinical point of care tools, webinars, and podcasts.

ACEP launched the EM Opioid Advisory Network in 2022. This initiative was formed by leaders and experts from the Pain Management & Addiction Medicine Section and the Pain & Addiction Care in the Emergency Department (PACED) accreditation program. This program connects emergency physicians combating the opioid crisis with expert advice on managing Opioid Use Disorder patients presenting in the ED, creating a protocol to initiate buprenorphine, and more. This is a free, open access service available to emergency health care professionals.

ACEP convened a summit, Addressing the Opioid Stigma in the Emergency Department, on January 23, 2020. The summit gathered a diverse group of organizations and representatives to discuss and share ideas to gain insight into the prevalence, effect and targeted solutions to limit the impact of stigma on the care of ED patients with OUD.

ACEP has also developed:

- **Buprenorphine in the ED Point of Care tool** that is an algorithm-like tool that walks clinicians through the process of patient evaluation and assessment through to prescription.
- Buprenorphine Initiation in Emergency Departments: Interactive Case Vignettes
- A series **of free webinars on various topics related to Opioid Use Disorder and Treatment and Management of OUD in the ED**
- EM Substance Use Disorder Residency Curriculum
- E-QUAL Network Opioid Initiative

Additionally, ACEP has launched the Pain and Addiction Care in the Emergency Department (PACED) accreditation program. The primary aim of this program is to accelerate the transfer of knowledge about acute pain management and secure appropriate resources to care for patients.

**ACEP Strategic Plan Reference**

Practice Innovation: Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

**Prior Council Action**

Substitute Resolution 46(23) Policy Statement on the Care of Pregnant Individuals with Substance Use Disorder adopted. Directed ACEP to create a policy statement based on the concepts of the "American College of Obstetricians & Gynecologists Committee Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist."

Amended Resolution 43(22) Endorsing ED Resident Competency in Buprenorphine Initiation adopted. Directed ACEP to support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs and coordinate with other organizations in emergency medicine to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency.

Resolution 33(22) Telehealth Bridge Model for the Treatment of Opioid Use Disorder adopted. Directed ACEP to support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder care and advocate for state and federal regulatory and legislative solutions to permit ongoing integration of opioid use disorder treatment including medication therapy through telehealth.

Resolution 29(22) Buprenorphine is an Essential Medicine and Should be Stocked in Every ED adopted. Directed ACEP to advocate for the FDA adding buprenorphine to its list of essential medications and that EDs stock buprenorphine and medications for opioid use disorder. Directed ACEP to work with the AHA, AMA, state agencies, and federal agencies to promote availability of medications for opioid use disorder in EDs and hospital settings and support initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder.

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted. Directed ACEP to support the development of training sessions focused on the implementation of buprenorphine induction and prescribing in the ED to replace the previously required 8-hour X-waiver training; and develop an online peer mentoring platform for emergency physicians, that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices.

Substitute Resolution 41(21) Take Home Naloxone Programs in Emergency Departments adopted. Directed ACEP to: 1) amend the policy statement "Naloxone Prescriptions by Emergency Physicians" to include endorsement for Take-Home Naloxone programs in EDs; 2) seek to increase the distribution of naloxone from the ED by researching and advocating for a standardized, lower barrier, and cost-effective take-home model for naloxone for at risk patients; 3) partner with other like-minded organizations to promote Take-Home Naloxone programs as a best practice for patients at risk of opioid overdose, and work to increase the number of Take-Home Naloxone programs in EDs; 4) advocate for regulatory and payment reform to facilitate reimbursement from public and private payers, to hospitals and EDs for naloxone dispensed directly to patients as part of Take-Home Naloxone programs; and 5) educate emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

Resolution 39(21) Recommit to Lessening Opioid Deaths in America not adopted. The resolution called for ACEP to recommit to the goal of reducing overdose deaths by working with various federal and state agencies, legislatures, and other stakeholders and that ACEP continue to advocate for actions to decrease the supply of fentanyl and other drugs and to highlight the continued increase in overdoses and overdose deaths.

Resolution 31(19) Improving Emergency Physicians Utilization of Medication for Addiction Treatment not adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and advocate for elimination of X-waiver to initiate MAT from the ED.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and continue to advocate for removal of the X-waiver requirement to prescribe buprenorphine for OUD from an ED setting.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with the Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Resolution 30(18) Naloxone Layperson Training adopted. Directed ACEP to support state chapters in drafting and advocating for legislation to recommend naloxone training in schools and work with national advocacy and capacity-building organizations to advocate for increased naloxone training by laypersons.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted. Directed ACEP to advocate for federal/state appropriations and/or grants for use in fully funding substance abuse intervention programs that are accessible 24/7 and will be initiated in EDs, and that ACEP advocate for federal/state funding for substance abuse intervention programs that will be accessible to their full potential by all patients regardless of insurance status or ability to pay.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted. Directed ACEP to pursue legislation for federal/state appropriation funding and/or grants for initiating MAT in emergency departments with provided funding for start-up, training, and robust community resources for appropriate patient follow-up.

Amended Resolution 29(16) The Opioid Epidemic – A Leadership Role for ACEP adopted. Directed ACEP to advocate and support training and equipping all first responders to use injectable and nasal spray Naloxone and advocate and support that appropriately trained pharmacists be able to dispense Naloxone without prescription, and develop a comprehensive policy statement on the prevention and treatment of the opioid use disorder epidemic including innovative treatments.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction

programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to develop guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning Substance Use Disorder patients to sustainable long-term treatment programs from the ED; and provide educational resources to ED providers for improving direct referral of Substance Use Disorder patients to treatment.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 39(14) Naloxone Prescriptions by Emergency Physicians adopted. Directed ACEP to develop a clinical policy on the clinical conditions for which it is appropriate for emergency physicians to prescribe naloxone.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Resolution 39(13) Naloxone Prescriptions in the ED not adopted. The resolution sought for ACEP to support and advises emergency physicians to dispense and/or prescribe Naloxone for victims of opioid overdose treated in the ED and promote the ability of emergency physicians to lawfully prescribe Naloxone explicitly for potential future opiate overdose through legislative or regulatory advocacy at the local, state, and national levels.

Resolution 38(13) Naloxone as an Over the Counter Drug not adopted. The resolution called for adoption of a policy in support of Naloxone becoming available as an OTC drug and promote education and safeguards for its use.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted. Directed ACEP to provide guidance to states and chapters to respond to issues related to psychiatric and substance abuse patients in the ED.

**Prior Board Action**

Substitute Resolution 46(23) Policy Statement on the Care of Pregnant Individuals with Substance Use Disorder adopted.

February 2023, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" revised and approved June 2016; originally approved October 2015.

Amended Resolution 43(22) Endorsing ED Resident Competency in Buprenorphine Initiation adopted.

Resolution 33(22) Telehealth Bridge Model for the Treatment of Opioid Use Disorder adopted.

Resolution 29(22) Buprenorphine is an Essential Medicine and Should be Stocked in Every ED adopted.

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted.

Substitute Resolution 41(21) Take Home Naloxone Programs in Emergency Departments adopted.

February 2021, approved "Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department." The inclusion of harm reduction strategies (including overdose education and naloxone distribution) or

prescriptions is also an essential component of the ED visit.

June 2020, approved the Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted.

Resolution 30(18) Naloxone Layperson Training adopted.

Amended Resolution 29(16) The Opioid Epidemic – A Leadership Role for ACEP adopted.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

October 2014, approved the Public Health & Injury Prevention Committee's recommendation for ACEP to advocate for further research into ED-specific interventions to address prescription drug overdose deaths with the goal of reducing mortality while treating pain for patients seen in the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 39(14) Naloxone Prescriptions by Emergency Physicians adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted.

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 74(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians
Medical Directors Section
Quality Improvement & Patient Safety Section
Rural Emergency Medicine Section

SUBJECT: Necessary Facility-Provided Medications from Emergency Departments

PURPOSE: Identify a list of key medications that should be dispensed at the time of discharge and establish this practice as a standard of care and coordinate legislative resources to assist chapters in addressing legislation aimed at preventing certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

WHEREAS, Patients continue to have care needs during off hours, such as overnights, weekends, and holidays; and

WHEREAS, Emergency departments may be the only source of health care available to patients during off hours, such as overnights, weekends, and holidays; and

WHEREAS, Many emergency departments may be lacking in local pharmacies open during off hours, such as overnights, weekends, and holidays; and

WHEREAS, Not all local pharmacies may stock relevant medications to be filled by patients upon discharge from their local emergency department; and

WHEREAS, It contributes to increased medical waste to utilize a facility-provided medication only used once or a few times during an ED visit which then must be disposed of upon completion of patient care; and

WHEREAS, It contributes to both increased patient costs and health care costs in general to utilize a facility-provided medication in the ED, dispose of that medication, and then prescribe that same medication for a patient to fill upon discharge from the ED; and

WHEREAS, Multi-use medications would otherwise be used in the emergency department and subsequently disposed of if not dispensed with the patient; and

WHEREAS, Some states are now debating the legality of emergency departments from performing the common practice of sending patients home with select medications upon discharge ("facility-provided medication")[1]; and

WHEREAS, Legislation in different states has already been implemented to ensure that practitioners are authorized to provide the remaining unused portion of select facility-provided medications to a patient upon discharge[2,3]; and

WHEREAS, In different states where legislation has been implemented to preserve the dispensing of facility-provided medications, emergency departments are specifically mentioned, where "the prescriber is responsible for counseling the patient on its proper use and administration and the requirement of pharmacist counseling is waived"[3]; therefore be it

RESOLVED, That ACEP acknowledge there is a standard of care for certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available for continued care after discharge from the emergency department, and that deviation from this established standard of care may put a patient's organ function or life at risk; and be it further

RESOLVED, That ACEP develop a list of key classes of medications that patients could receive as facility-provided medications upon discharge from the emergency department; and be it further

RESOLVED, That ACEP coordinate legislative resources to assist state chapters in addressing legislation aimed at preventing certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available.

**Resolution References**

1. Pennsylvania General Assembly, Session of 2025. House Bill 446: An Act Amending the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act. ttps://www.palegis.us/legislation/bills/2025/hb446
2. Delaware 152nd General Assembly. Senate Bill 148: An Act to Amend Title 24 of the Delaware Code Relating to the Topical Medical Waste Reduction Act. https://legis.delaware.gov/BillDetail/140458#:~:text=Original%20Synopsis:,the%20Delaware%20Legislative%20Drafting%20Manual.
3. Illinois 102nd General Assembly. Senate Bill 0579: Facility-Provided Medications. https://www.ilga.gov/legislation/BillStatus.asp?GA=102&DocTypeID=SB&DocNum=579&GAID=16&SessionID=110&LegID=133175

## Background

This resolution requests ACEP to identify a list of key medications that should be dispensed at the time of discharge and establish this practice as a standard of care and coordinate legislative resources to assist chapters in addressing legislation aimed at preventing certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available.

A 2023 report in Pediatrics[1] highlights the benefits of dispensing medications from the ED:

> "Approximately one-third of patients fail to obtain priority medications from a pharmacy after discharge from an ED. The option of judiciously dispensing medications at ED discharge from the outpatient pharmacy within the health care facility is a major convenience that helps to overcome this obstacle, improving the likelihood of medication adherence."

Emergency departments (EDs) are typically not set up to dispense medications like traditional pharmacies due to a combination of factors, including regulatory limitations, logistical challenges, and patient safety concerns.

1. Regulatory limitations
   - State and Federal Regulations: Laws governing the dispensing of medications vary by state and are often quite stringent. These regulations may limit the types and quantities of medications that can be dispensed from an ED, especially controlled substances. For example, in many states, only a pharmacist or an individual under the direct supervision of a pharmacist can dispense medications for use beyond the immediate needs of the patient.
   - Controlled Substances: Rules surrounding controlled substances are particularly strict. Emergency supplies of certain controlled drugs may be restricted or require follow-up prescriptions within a specific timeframe.

2. Logistical challenges
   - Staffing: Hiring pharmacists for dedicated ED roles can be expensive, especially in smaller departments with lower patient volume.
   - Inventory Management: Maintaining a comprehensive medication inventory, similar to a pharmacy, can be challenging in an ED setting, especially with issues like drug shortages and space constraints.
   - Patient Flow: Dispensing medications can add to the time patients spend in the ED, potentially hindering efficient patient flow and creating backlogs.
   - Costs: Operating a pharmacy within an ED, or providing medications free of charge, can incur significant costs for the hospital system.

3. Patient safety
    - Medication Reconciliation: Ensuring accurate and complete medication histories in the fast-paced ED environment can be challenging, increasing the risk of medication errors.
    - Dispensing Accuracy: Without dedicated pharmacy staff and systems, the risk of dispensing errors can increase, particularly when dealing with large volumes of patients and time pressure.
    - Patient Education: Providing comprehensive medication education to patients in a busy ED setting can be difficult, potentially leading to non-adherence and adverse outcomes.

4. Financial Barriers
    - Medication Cost: Many patients, especially those with limited financial resources or without insurance, may struggle to afford medications, even with insurance coverage. Unlike a pharmacy, the ED is not set up for patients to pay for medications at the time they are dispensed. Hospitals may have to absorb the cost when dispensing medications in-house.
    - Insurance Coverage: Insurance companies may deny payment for outpatient medications dispensed by an inpatient pharmacy, particularly if the medication is typically covered under an outpatient benefit. This lack of coverage can create a financial disincentive for hospitals to dispense medications directly to patients. Insurers also have formularies, which can increase the number of drugs needing to be stocked in the ED, and add to the complexity of the prescribing and dispensing process. Prior authorizations represent another challenge.

Despite these challenges, some EDs are exploring or implementing programs to facilitate medication dispensing, especially for patients who might face barriers to accessing medications after discharge, such as transportation or cost. These programs often focus on providing short-term supplies of essential medications and prioritizing patient education and follow-up.

**Background Reference**

1. Suzan S. Mazor, Michelle C. Barrett, Corinne Shubin, Shannon Manzi, COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE; Dispensing Medications at the Hospital Upon Discharge From an Emergency Department. *Pediatrics* June 2023; 151 (6): e2023062144. 10.1542/peds.2023-062144

## ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional

## Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

## Prior Council Action

Resolution 44(14) Support for Clinical Pharmacists as Part of the Emergency Medicine Team adopted. This resolution calls for the College to develop a policy statement in support of clinical pharmacy services in the emergency department (ED), collaborate with emergency medicine providers to promote safe, effective, and evidence-based medication practices, conduct emergency medicine related clinical research, and foster support for pharmacy residency training in emergency medicine.

## Prior Board Action

January 2021, ,approved the revised policy statement "Clinical Pharmacist Services in the Emergency Department;" originally approved June 2015.

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 75(25)

SUBMITTED BY: Louisiana Chapter
Maine Chapter
New Jersey Chapter
Vermont Chapter

SUBJECT: Protecting the Term "Emergency Department" in Critical Access Hospitals

PURPOSE: 1) Develop a policy to ensure the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours. 2) Develop and promote policy and regulation that when Critical Access Hospitals do not have a physician physically present in the ED, the facility should adopt alternative terminology to clearly inform the public that physician-level medical care is not continuously available on-site.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy statement. Unbudgeted additional resources to develop and advocate for regulation for Critical Access Hospitals to adopt alternative terminology to inform the public that physician-level medical care is not continuously available on-site.

WHEREAS, Recent data indicate that 1 in 13 emergency departments operate at times without a physician physically on-site and on duty; and

WHEREAS, The American College of Emergency Physicians (ACEP) affirms that, regardless of geographic location, all patients who present to emergency departments (EDs) deserve access to high-quality, patient-centered care delivered by emergency physician-led teams; and

WHEREAS, The ACEP Emergency Department Accreditation Program promotes transparency to help patients make informed decisions when seeking emergency care; and

WHEREAS, The general public reasonably expects that a visit to an "Emergency Department" will involve being evaluated by a physician; and

WHEREAS, A March 2022 ACEP public opinion survey found that 72% of respondents would be concerned if no physician were available during their medical emergency; and

WHEREAS, Per the Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 485, Subpart F regarding "Conditions of participation: Critical Access Hospitals (CAHs)" do not require an "Emergency Department" as a condition of participation, but must be able to provide emergency care necessary to meet the needs of its inpatients and outpatients; therefore be it

RESOLVED, That ACEP develop a policy to ensure that the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours; and be it further

RESOLVED, That in the interest of public transparency, ACEP develop and promote policy and regulation that when Critical Access Hospitals do not have a physician physically present in the emergency department while it is open, the facility should adopt alternative terminology to clearly inform the public that physician-level medical care is not continuously available on-site.

**Background**

This resolution calls for ACEP to develop a policy to ensure the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours. Additionally, the resolution requests ACEP to develop and promote policy and regulation that when Critical Access Hospitals do not have a physician physically present in the ED, the facility should adopt alternative terminology to clearly inform the public that physician-level medical care is not continuously available on-site.

ACEP believes that every patient deserves to have their care overseen by a board-certified emergency physician and advocates for physician-led care teams in emergency departments, emphasizing that while physician assistants (PAs) and nurse practitioners (NPs) are valuable members of the team, they do not possess the same level of training and expertise as emergency physicians.

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety. Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment."

Federal regulations, like those governing Critical Access Hospitals (CAHs), stipulate that a physician, PA, NP, or clinical nurse specialist with emergency care training must be available, but not necessarily on-site at all times. They must be immediately available by phone or radio for consultation. Most states do not have regulations requiring an onsite physician in the ED. This has been a major state-level advocacy effort for both ACEP and the American Medical Association.[1,2] Some states have moved towards requiring on-site physician presence in emergency departments. In the 2024-25 legislative session, South Carolina joined Indiana (2023) and Virginia (2024) in passing a law requiring all hospitals with emergency departments to have at least one physician physically onsite while the ED is open. Both Virginia and South Carolina chapters were able to use model legislation and receive direct support from ACEP's State Legislative team, including assistance with drafting the legislation, and providing expert-level support during the legislative process.

Ensuring adequate physician coverage, especially in rural areas, presents a challenge for some states. The unique needs of rural emergency departments are often considered when determining the applicability of any exceptions to on-site physician requirements, and some state laws have exceptions for rural settings.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered. ACEP worked with ABEM to pilot a campaign promoting the value of board certification in three markets (urban, suburban, and rural) that included billboards and other environmental ads, a digital campaign, and pre- and post-campaign surveys. Enduring materials for the campaign are available to diplomates and the public on the ABEM website, which includes video content provided by ACEP.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

ACEP developed an information paper that defines the use of the term "Free Standing Emergency Department" and "Urgent Care Center." Additionally, ACEP's policy statement "Urgent Care Centers" states:

> "The American College of Emergency Physicians (ACEP) believes that any facility that does not meet the definition of an ED or freestanding ED as defined by ACEP and that advertises itself as providing unscheduled care should:
>
> - Not use the word "emergency" or "ER" in its name in any way.
> - Not use the word "emergency" or "ER" in any advertisements, claims of service, or to describe the type or level of care provided or as an alternative to an ED. Doing so may be considered a deceptive trade practice, as defined by federal or applicable state law."

However, ACEP does not currently have a specific policy statement defining the term "Emergency Department." While ACEP could develop a policy statement, ensuring the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours would require changes to federal and state regulations.

**Background References**

1. https://www.ama-assn.org/practice-management/scope-practice/having-physician-site-best-way-deliver-emergency-care#:~:text=%E2%80%9CWithout%20the%20availability%20of%20a,emergency%20department%20at%20all%20times.
2. https://emworkforce.substack.com/p/48-states-and-the-feds-dont-require?triedRedirect=true

## ACEP Strategic Plan Reference

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

## Fiscal Impact

Budgeted committee and staff resources to develop a policy statement. Unbudgeted additional resources to develop and advocate for regulation for Critical Access Hospitals to adopt alternative terminology to inform the public that physician-level medical care is not continuously available on-site.

## Prior Council Action

Resolution 69(24) Updating ACEP's Position on PA and NP Supervision in the ED referred to the Board of Directors. The resolution sought to amend the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to remove reference to workforce limitations in specific CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "offsite" by telehealth means for Critical Access Hospitals (CAHs) and Rural Emergency Hospitals (REHs).

Resolution 39(24) Urgent Care Transparency on Available Resources and Credentials adopted. Directed ACEP to advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing resources that are or are not available; and advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments referred to the Board. Requested ACEP to collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician is immediately available for on-site care of emergency department patients at all times.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

Resolution 68(21) Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth) not adopted. Asked ACEP to support legislation to require all facilities who have an ED or designate an area as an ED or emergency room to have a board eligible/certified emergency physician onsite or via telehealth at all times (with a limited exception) to market to the public and bill for emergency services; and to impose requirements on facilities to address shortcomings or to limit their ability to name themselves as emergency departments, etc.

Amended Resolution 33(15) Defining and Transparency in Urgent Care Centers adopted. Directed ACEP to create a policy statement defining an urgent care center to protect patients by ensuring accurate consumer information as to provider qualifications, resources available, and costs to make informed decisions when seeking care; and consider working with state and federal stakeholders to advocate for appropriate regulatory standards for urgent care centers.

**Prior Board Action**

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" and replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department.

Resolution 39(24) Urgent Care Transparency on Available Resources and Credentials adopted.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted.

January 2022, approved the revised policy statement "Urgent Care Centers;" originally approved October 2016.

April 2020, approved the revised policy statement "Freestanding Emergency Departments;" originally approved June 2014.

November 2015, reviewed the information paper "Freestanding Emergency Departments and Urgent Care Centers."

Amended Resolution 33(15) Defining and Transparency in Urgent Care Centers adopted.

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 76(25)

SUBMITTED BY: Puneet Gupta, MD, FACEP
Scott Pasichow, MD, FACEP
California Chapter
New Jersey Chapter
Social Emergency Medicine Section

SUBJECT: Protection and National Standardization of Transgender Care in Emergency Medicine

PURPOSE: Support the development and publication of nationally recognized guidelines for transgender care in emergency medicine and advocate for the protection and of transgender patients and the ability of emergency physicians to provide evidence-based care to patients of all gender identities.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency physicians are on the front lines of providing critical and lifesaving care to all individuals regardless of gender identity; and

WHEREAS, Transgender and gender-diverse individuals face significant barriers in accessing appropriate medical care, including emergency services; and

WHEREAS, Evidence-based transgender health care is an important and growing facet of emergency medicine that requires clear, standardized, and scientifically driven guidelines; and

WHEREAS, The practice of medicine should be governed by scientific evidence and professional standards rather than legislative, judicial, or executive actions that may interfere with the physician-patient relationship; and

WHEREAS, Ensuring the safety and dignity of transgender patients in emergency settings is essential to upholding the ethical principles of medical care, including beneficence, nonmaleficence, and justice; and

WHEREAS, National guidelines for transgender care in emergency medicine will aid physicians in delivering consistent, equitable, and high-quality medical services; therefore be it

RESOLVED, That ACEP support the development and publication of nationally recognized guidelines for transgender care in emergency medicine; and be it further

RESOLVED, That ACEP advocate for the protection of transgender patients and the ability of emergency physicians to provide evidence-based care to patients of all gender identities.

**Background**

This resolution calls for ACEP to support the development and publication of nationally recognized guidelines for transgender care in emergency medicine and advocate for the protection and of transgender patients and the ability of emergency physicians to provide evidence-based care to patients of all gender identities

Emergency physicians frequently treat transgender and gender-diverse (TGD) patients who often encounter significant delays or avoidance of care because of systemic barriers and prior negative experiences. Surveys indicate that approximately 33% of transgender individuals have delayed or avoided medical care because of fear of mistreatment, and nearly 16.8% report experiencing discrimination in emergency department (ED) settings

specifically. TGD patients seen in EDs are disproportionately likely to present with complex chronic medical conditions or mental health comorbidities – 58% and 29% respectively – compared to cisgender counterparts, contributing to higher admission rates (over 52% vs. 17%) following ED visits.

Standardized, evidence-based clinical guidelines tailored to TGD emergency care can and would improve the quality of care and patient outcomes for this patent population. Although the World Professional Association for Transgender Health (WPATH) Standards of Care (Version 8, 2022) offer an international framework, they are not ED-specific and local adaptations remain scarce. Emergency care must be guided by scientific evidence and professional ethics rather than politicized mandates, to ensure equity, dignity, and patient-centered practice. Professional societies including ACEP and the Emergency Medicine Residents' Association (EMRA) have developed policy statements and training materials, however, more rigorous clinical practice guidelines could be beneficial in unifying care standards across emergency settings.

National advocacy organizations, such as the National Center for Transgender Equality (NCTE), continue to call for policies that protect the rights of transgender individuals in health care settings. Establishing and implementing targeted ED guidelines and promoting culturally competent training would help to ensure that transgender and gender-diverse patients receive consistent, affirming, and high-quality care.

ACEP's policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department" states "ACEP believes that:

- Gender-affirming care is supported by evidence and by the medical community. TGD patients should have access to comprehensive gender-affirming health care that is provided in a safe and inclusive clinical setting.
- Emergency physicians need to be knowledgeable and aware of the unique needs and best practices related to care of TGD patients of all ages in the ED. Emergency physicians, patients, and their support structure should engage in shared-decision making based on scientific evidence and best practices regarding appropriate medical care.
- EDs should foster and develop practices, policies, and accessible resources that provide a supportive and inclusive environment for TGD patients, including removing structural barriers to care.
- Hospitals should provide ongoing education, training, and resources to all emergency physicians and ED staff related to best practices and the care of TGD patients.
- Emergency physicians must be able to practice high quality, objective evidence-based emergency medical care without legislative, regulatory, or judicial interference in the physician-patient relationship."

The Public Health Committee developed the Policy Resource & Education Paper (PREP) "A Guide to Caring for Patients Who Identify as Transgender and Gender Diverse in the Emergency Department" as an adjunct to the policy statement.

**ACEP Strategic Plan Reference**

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted.

Directed ACEP to promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED and compile information on the unique needs and best practices related to care of said patients. The resolution also directed ACEP to encourage hospitals to provide adequate and appropriate education, training, and resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients, in addition to encouraging EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

Resolution 21(21) Diversity, Equity, and Inclusion adopted. Directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion within the next year; create a road map to promote diversity, equity, and inclusion; embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and report to the 2022 Council the outcome of the summit and have a roadmap created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and continue to create and advertise free, CME-eligible, online training related to implicit bias.

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. This resolution directed ACEP to oppose all forms of discrimination against patients and employees in emergency medicine on the basis of gender, race, creed, color, national or ethnic origin, religion, disability, or sexual orientation.

**Prior Board Action**

September 2024, approved the policy statement "Diversity, Equity, and Inclusion."

April 2023, reviewed the Policy Resource & Education Paper "A Guide to Caring for Patients Who Identify as Transgender and Gender Diverse in the Emergency Department."

June 2022, approved the policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department."

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; approved April 2008 with the current title' originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018 and April 2012 with the current title; originally approved October 2005 titled "Non-Discrimination."

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

October 2017, reviewed the information paper "Disparities in Emergency Care."

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted.

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 77(25)

SUBMITTED BY: New York Chapter
North Carolina College of Emergency Physicians
Ohio Chapter
Texas College of Emergency Physicians

SUBJECT: Investigating Practice Patterns of NPs and PAs Following Independent Practice Legislation

PURPOSE: Support and, if feasible, conduct or commission a study to investigate the geographic and clinical practice patterns of NPs and PAs in states with independent practice authority and use the findings of the study to inform ACEP policy positions and advocacy efforts regarding team-based care and scope of practice.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. The cost of a study on practice patterns could range between $300,000 and $500,000 to capture a large enough sample to examine geographic and practice patterns.

WHEREAS, There is limited national data regarding the subsequent practice locations, settings (e.g., rural vs urban), or specialties chosen by NPs and PAs following the granting of independent practice rights; and

WHEREAS, Understanding the real-world impact of these laws on healthcare delivery, workforce distribution, and patient access is critical for shaping evidence-based workforce policy; and

WHEREAS, Such data may inform ACEP advocacy, workforce planning, and public health policy in the context of emergency care, therefore be it resolved

RESOLVED That ACEP support and, if feasible, conduct or commission a study to investigate the geographic and clinical practice patterns of nurse practitioners and physician assistants in states with independent practice authority and use the findings of that study to inform ACEP policy positions and advocacy efforts regarding team-based care and scope of practice.

**Background**

This resolution requests ACEP to conduct or commission a study to investigate the geographic distribution and fields of practice of NPs and PAs before and after states grant independent practice authority use the findings of that study to inform ACEP policy positions and advocacy efforts regarding team-based care and scope of practice.

The American Medical Association Advocacy Resource Center is studying each of the states that granted independent practice authority to NPs, although this is not a formal academic study and does not include PAs. The study is tracking metrics for quality and patient safety and watching for information demonstrating why a physician-led team would have potentially had a better outcome.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states that:

> "The American College of Emergency Physicians (ACEP) believes that regardless of where a patient lives, all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric care delivered by emergency physician-led care teams…. the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to

be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in emergency medicine."

Proponents of expanding the scope of practice of non-physicians to allow for unsupervised practice claim that in to improve patient access to care. Currently, there is a shortages of physicians in U.S. and the shortage is worse in rural and underserved areas. Non-physician practitioners (NPPs) have long claimed that expansion of their scope of practice will result in increased access to care in rural and underserved areas and will help fill the gaps in primary care. Despite these promises, however, the evidence demonstrates nurse practitioners tend to practice in the same areas of the state as physicians, even in states where nurse practitioners have had independent practice for decades. The AMA has looked into where NPs practice and found that regardless of scope of practice laws, nurse practitioners tend to practice in the same areas of the state as physicians, and do not expand access in rural settings.[1] Data from several states demonstrate this trend. In Wyoming, for example, which has allowed nurse practitioners to practice independently since 2007, there were 382 nurse practitioners in the state compared with 441 primary care physicians in 2018. Over time, the number of nurse practitioners has increased, but the data shows they are practicing in the same areas that physicians are. In West Virginia, which enacted legislation in 2017, that permits nurse practitioners to diagnose and treat patients without physician involvement, but requires them to have a collaborative relationship with a physician for three years to be able to write prescriptions. While the state saw an increase in the overall number of nurse practitioners in the state, again those new professionals continued to practice in the same area as the state's physicians. In Georgia, nurse practitioners must practice pursuant to a protocol agreement with physician supervision and delegation. As is the case in Wyoming, West Virginia and pretty much across the country, there has been tremendous growth in the number of nurse practitioners. There were 10,291 nurse practitioners in 2020, up from 4,275 in 2013. NPs practice with physicians in urban and rural areas of the state, demonstrating "that changes in nurse practitioner scope of practice laws are not the sole reason for growth of nurse practitioners in a state or where they practice," In Oregon, which allows independent practice by NPs, there has been an overall increase in the number of nurse practitioners, but there has been no measurable shift of nurse practitioners to rural areas.[2]

Another argument often advanced for expanding nurse practitioners' scope of practice is that doing so would help address primary care physician shortages, which are severe and expected to worsen dramatically as more physicians retire and the U.S. population ages and becomes sicker. Research actually shows that, in addition to setting up practice in the same geographic locations as physicians, many nurse practitioners are also opting to pursue non-primary care specialties. For example, the Oregon Center for Nursing found that just 25% of nurse practitioners practiced in primary care. A study by researchers from the State University of New York, Albany, School of Public Health Center of Health Workforce Studies found that newly graduated nurse practitioners in the Empire State were more likely to enter a specialty or subspecialty than they were to pursue primary care.

**Background References**

1. https://www.ama-assn.org/practice-management/scope-practice/are-nurse-practitioners-easing-shortages-underserved-areas
2. https://www.ama-assn.org/practice-management/scope-practice/3-big-reasons-why-letting-nps-practice-independently-bad-idea
3. https://www.chwsny.org/our-work/reports-briefs/a-profile-of-new-york-state-nurse-practitioners-2017/

## ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

## Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. The cost of a study on practice patterns could range between $300,000 and $500,000 to capture a large enough sample to examine geographic and practice patterns.

**Prior Council Action**

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted. Directed ACEP to adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments, and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Amended Resolution 45(22) Offsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department," so that onsite emergency physician presence to supervise nurse practitioners and physicians be stated as the gold standard for staffing all emergency departments.

Resolution 44(22) Competencies of Independent Emergency Medicine Nurse Practitioners and Physician Assistants not adopted. Requested that ACEP: 1) Revise current policy statements regarding the role of NPs and PAs working in the ED; 2) Advocate with CMS and other third-party payers to exclude care provided by NPs and PAs where there is not in-person, real-time physician supervision from an emergency physician (as defined by ACEP) for billing and reimbursement purposes.

Amended Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine adopted. The resolution calls for the College work with the AMA and submit a resolution to their house of delegates to create a universal definition of the practice of medicine to include the ordering of diagnostic tests, diagnosing clinical condition/disease, prescribing of medications, and/or ordering of treatments on human beings.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Substitute Resolution 66(21) ACEP Promotion of Emergency Physician Led Teams (as substituted in lieu of Resolutions 66, 67, and 76) adopted. Directed that ACEP publish and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an ABEM/AOBEM board certified emergency physician and support the standard that board certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative

solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

**Prior Board Action**

April 2025 approved the policy statement "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners"

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" and replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department.

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

April 2023, rescinded the motion approved at the October 28, 2021, meeting to adopt the second resolved and to overrule it. The Board also adopted a motion "that ACEP work with the American Medical Association and other stakeholders to support that anyone, physicians or non-physician practitioners, who engage in the practice of medicine be regulated by the respective state medical board of their respective states."

Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

Amended Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine adopted.

Substitute Resolution 66(21) ACEP Promotion of Emergency Physician Led Teams (as substituted in lieu of Resolutions 66, 67, and 76) adopted.

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

April 2021, approved the revised policy statement, "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, August 1993. Originally approved October 1984 titled, "Contractual Relationships between Emergency Physicians and Hospitals."

April 2020, approved the policy statement "Staffing Models and the Role of the Emergency Department Medical Director."

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

September 2018, accepted the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations to proceed with the NP/PA Utilization Task Force and the Emergency Medicine Workforce Task Force.

July 2018, reviewed the Policy Resource & Education Paper (PREP) "Emergency Physician Contractual Relationships."
June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 78(25)

SUBMITTED BY: Gregory Gafni-Pappas, MD, FACEP
Antony Hsu, MD, FACEP
James Mitchiner, MD, FACEP

SUBJECT: Standardized Emergency Medicine Post-Graduate Training for Advanced Practice Providers

PURPOSE: 1) Reaffirm commitment to physician-led EM teams and oppose the independent practice of PAs and NPs in the ED. 2) Collaborate with other organizations to establish new standards for training and accrediting NPs and PAs as a prerequisite for clinical practice in EDs.

FISCAL IMPACT: Budgeted committee and staff resources to reaffirm commitment to physician-led emergency medicine teams and opposing independent practice of NPs and PAs. Developing standards and accrediting training programs is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort, as well as engage external subject matter experts.

WHEREAS, The scope of practice for Advanced Practice Providers (APPs), including Physician Assistants (PAs) and Nurse Practitioners (NPs), in emergency medicine varies widely across states and hospital systems, leading to inconsistent levels of training and patient care; and

WHEREAS, There is a growing reliance on APPs in emergency departments, yet no standardized, required postgraduate training program exists to ensure competency in emergency medicine; and

WHEREAS, Some institutions and emergency medicine groups have implemented emergency medicine postgraduate training for APPs successfully; and

WHEREAS, APPs with formal postgraduate training in emergency medicine could demonstrate improved clinical competency, reduced medical errors, and increased efficiency in patient care compared to those without such training; and

WHEREAS, Multiple professional organizations, including the Society of Emergency Medicine Physician Assistants (SEMPA) and the American Academy of Emergency Nurse Practitioners (AAENP), support the implementation of structured training programs for APPs in emergency medicine; and

WHEREAS, A standardized emergency medicine training program for APPs would provide critical hands-on experience, procedural training, and supervised clinical education, ensuring that APPs working in emergency departments meet established competency standards; therefore be it

RESOLVED, That ACEP reaffirm its commitment to physician-led emergency medicine teams and opposes independent practice by advanced practice providers (APPs) in emergency departments, while supporting structured training and supervised clinical practice as a means to enhance APP competency within team-based care models; and be it further

RESOLVED, That ACEP work with the Society of Emergency Medicine Physician Assistants (SEMPA) and the American Academy of Emergency Nurse Practitioners (AAENP), and other relevant stakeholders to develop and advocate for the implementation of a standardized, accredited emergency medicine training program for advanced practice providers as a prerequisite for clinical practice in emergency departments, with a legacy process for experienced advanced practice providers based on documented experience and continuing education.

**Background**

This resolution calls for the College to reaffirm its stance opposing independent practice by advanced practice practitioners in emergency departments (EDs) and to develop and advocate for the implementation of a standardized, accredited emergency medicine training program for advanced practice providers as a prerequisite for clinical practice in EDs.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states (excerpted):

> "The American College of Emergency Physicians (ACEP) believes that regardless of where a patient lives, all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric care delivered by emergency physician-led care teams.
>
> ACEP supports the ongoing educational efforts of PAs and NPs in order to improve their clinical and professional knowledge and skills. These ongoing educational efforts may include formal postgraduate emergency medicine training programs. However, these postgraduate training programs for PAs and NPs do not provide training comparable to that provided in an ACGME-accredited emergency medicine residency training program and will never substitute for this comprehensive, specialized, and standardized training.
>
> PAs and NPs should not perform independent, unsupervised care in the ED.
>
> The gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in emergency medicine."

In September 2006, the ACEP Board of Directors reviewed a report from the ACEP NP/PA task force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development. The Emergency Nurses Association (ENA) and Society of Emergency Medicine Physician Assistants (SEMPA) expressed their willingness to work with ACEP on this project. In January 2007, NCCPA sent a letter to ACEP and SEMPA advising of their desire to create a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine. NCCPA advised they would contact the workgroup representatives regarding next steps.

NCCPA launched the Emergency Medicine CAQ, which has structured requirements for certification including an emergency medicine exam. NCCPA offers 11 CAQs, with geriatric medicine coming soon. The Content Blueprint of the EM CAQ was developed using data gathered from the most recent PA Practice Analysis conducted by NCCPA.

The American Academy of Nurse Practitioners (AANP) has a program for certification of Emergency Nurse Practitioners (ENPs).

The Accreditation Commission for Education in Nursing (ACEN) and the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) have partnered to offer nurse practitioner and physician assistant Residency Program Accreditation. This program provides overall accreditation to training programs but is not specialty-specific.

SEMPA has developed the Emergency Medicine Physician Assistant Postgraduate Education Program Standards to be aligned with the Accreditation Council for Graduate Medical Education (ACGME) guidelines and Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) Clinical Postgraduate Standards.

AAENP has also developed a core curriculum, ENP competencies, and Scope and Standards to facilitate ENP program development.

While both AAENP and SEMPA advocate for specialized education and knowledge for NPs and PAs working in emergency departments, neither organization explicitly requires advanced training programs or certification as prerequisites to work in the emergency department.

**ACEP Strategic Plan Reference**

Career Fulfilment: Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

**Fiscal Impact**

Budgeted committee and staff resources to reaffirm commitment to physician-led emergency medicine teams and opposing independent practice of NPs and PAs. Developing standards and accrediting training programs is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort, as well as engage external subject matter experts

**Prior Council Action**

Amended Resolution 47(22) Independent Agency Report for Nurse Practitioner Schools adopted. Directed ACEP to work with the American Medical Association to provide recommendations for nurse practitioner education reform to improve the quality and standards of nurse practitioner training for the purpose of improving physician-led patient care.

Substitute Resolution 66(21) ACEP Promotion of the Role of Emergency Physician Led Teams referred to the Board of Directors. Called for ACEP to 1.) Create and disseminate a policy explicitly stating that all patients presenting to an ED deserve to be assessed by an emergency physician and all patients have the right to have an emergency physician directly oversee their care in-person; and 2.) Reaffirm that ACEP is a professional medical association dedicated to promoting the role of emergency physicians and instruct ACEP staff and officers promote the role of emergency physicians over all other models of care.

Resolution 25(14) CME for Nurse Practitioners and Physician Assistants not adopted. Called for ACEP to develop a policy statement recommending that NPs and PAs working in emergency department or urgent care settings obtain 25 CME credits in emergency care annually.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care and survey states and hospitals on where independent practice by NPs is permitted.

Amended Resolution 25(10) Definition of an Emergency Physician referred to the Board of Directors. The resolution asked ACEP to develop a define an emergency physician as someone who has either completed ACGME or AOA residency training in Emergency Medicine or fellowship in Pediatric Emergency Medicine, or is ABEM or AOBEM certified in Emergency Medicine or Pediatric Emergency Medicine, or began practicing emergency medicine in the 20th century and therefore is eligible to be a member of the American College of Emergency Physicians.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. Directed ACEP to work with NP and PA organizations to establish a curriculum and clinically-based ED educational training program and encourage certifying bodies to develop certifying examinations for competencies in emergency care.

**Prior Board Action**

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved January 2007 titled

"Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" and replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department.

April 2023, approved the revised policy statement "Definition of an Emergency Physician;" revised and approved April 2017; originally approved June 2011.

Amended Resolution 47(22) Independent Agency Report for Nurse Practitioner Schools adopted.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, and June 2001; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

September 2018, accepted the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations to proceed with the NP/PA Utilization Task Force and the Emergency Medicine Workforce Task Force.

April 2017, approved the revised policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" revised and approved October 2014, June 2006, June 2004; reaffirmed October 1999; revised and approved September 1995; originally approved April 1985 titled "Guidelines for Delineation of Clinical Privileges in Emergency Medicine."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. A task force was appointed to review the available information and provide a recommendation to the Board regarding ACEP's potential involvement in the development of specialized training curricula for PAs and NPs that work in the ED.

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
Manager, Clinical Ultrasound Accreditation Program

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 79(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Standards for the Safe and Appropriate Transport of Patients to Psychiatric Facilities

PURPOSE: Work collaboratively with the American Psychiatric Association to develop consensus recommendations and best practices regarding transport requirements for patients being transferred to psychiatric facilities, with specific attention to the transferring facility determining clinical stability, restraint use, and acceptable means of transportation.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency physicians frequently coordinate the transfer of patients experiencing psychiatric emergencies to inpatient psychiatric facilities; and

WHEREAS, The current variability in transport requirements, such as mandated use of medically trained transports, indiscriminate use of restraints, or ALS-level transport, may not be evidence-based and can lead to unnecessary delays, stigmatization, escalation of patient distress, increased cost and resource burden on both hospitals and EMS systems; and

WHEREAS, There is often discordance between emergency medicine and psychiatry regarding criteria for safe interfacility transfer behavioral stability, and level of transport required; and

WHEREAS, The American Psychiatric Association statement Transportation during the commitment process shall be provided by medically trained persons in the least restrictive manner appropriate, avoiding the use of restraints and physically coercive measures whenever possible[3]; and

WHEREAS, It is at the discretion of the transferring physician as to the mode of transport, need for associated equipment during transport, and personnel with the patient[1,2]; therefore be it

RESOLVED, That ACEP work collaboratively with the American Psychiatric Association to develop consensus recommendations and best practices regarding transport requirements for patients being transferred to psychiatric facilities, with specific attention to the transferring facility determining clinical stability, restraint use, and acceptable means of transportation.

**References**


1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf
2. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-15-EMTALA.pdf
3. Council on Psychiatry and Law. Position Statement on Voluntary and Involuntary Hospitalization of Adults with Mental Illness. APA Official Actions. July 2020. Accessed June 3, 2025. https://www.psychiatry.org/getattachment/46011d52-de5d-4738-a132-f5aaa249efb5/Position-Voluntary-Involuntary-Hospitalization-Adults.pdf


## Background

This resolution calls for ACEP to work collaboratively with the American Psychiatric Association (APA) to develop consensus recommendations and best practices regarding transport requirements for patients being transferred to psychiatric facilities, with specific attention to the transferring facility determining clinical stability, restraint use, and acceptable means of transportation.

Emergency physicians frequently coordinate the transfer of patients experiencing psychiatric emergencies to inpatient psychiatric facilities; however, current transport protocols, such as mandatory use of medically trained transport teams, automatic use of restraints, and ALS-level transport, can sometimes be based on custom and common practice rather than evidence. These requirements can sometimes lead to avoidable delays, stigmatization, escalation of patient distress, and increased costs for both hospitals and EMS systems. Additionally, potential discrepancies between emergency medicine and psychiatry in defining behavioral stability and appropriate transport levels further complicate transfers. While the American Psychiatric Association (APA) advocates for medically trained personnel and the least restrictive transport methods, avoiding restraints and coercive measures whenever possible, the decision about transport mode, equipment, and personnel ultimately rests with the transferring physician, underscoring the need for clinical discretion and interdisciplinary collaboration.

Evidence suggests that overly restrictive transport protocols can potentially do more harm than good. A *JACEP Open* study "Interfacility ambulance transport of mental health patients" noted frequent injuries to both patients and EMS personnel during psychiatric transfers and highlighted the lack of standardized guidelines, with institutional policies often conflicting and confusing. Prehospital research further indicates that indiscriminate use of physical restraints can traumatize patients, increase agitation, and elevate the risk of adverse events. These findings reinforce the importance of advocating for the least restrictive, medically supervised transport and highlight the pressing need for harmonized criteria to guide determining transport mode and restraint use.

For emergency physicians, ensuring safe interfacility transfers requires balancing patient safety, patient dignity, and resource stewardship. Incorporating psychiatric consultation in the ED to assess behavioral stability can align transport decisions with clinical rather than administrative criteria. Instituting clear protocols for restraint use and developing pre-transfer checklists can reduce variability and promote transparency. Training ED staff and EMS in de-escalation techniques, mental health first aid, and trauma-informed communication can lower reliance on coercive methods.

At the systems level, institutions should collaborate with psychiatric facilities and EMS medical directors to co-create regional guidelines based on best available evidence and ethical principles. Embedding standardized transport pathways including clear handoff processes, decision tools for transport mode selection, and documentation standards, can decrease delays, improve patient experience, and optimize resource utilization. Future advocacy, education, and research should focus on evaluating outcomes of such guidelines in terms of patient safety, timeliness of psychiatric admission, EMS and ED burden, and staff/patient satisfaction, propelling emergency psychiatry toward more humane, effective, and efficient interfacility transport practices.

The ACEP Board approved the revised policy statement "Adult Psychiatric Emergencies" in April 2023 which states:

> "Emergency departments (EDs) are a critical component of a comprehensive safety net for patients with psychiatric emergencies, and emergency physicians have an obligation to advocate for high-quality psychiatric emergency care. Psychiatric emergencies should be managed like any other medical emergency, with appropriate risk stratification, tailored laboratory work-up, timely treatment, and safe disposition."

The policy statement also recognizes that boarding of patients with psychiatric emergencies in the ED is inhumane, does not provide for a therapeutic alliance, impacts the care of all patients in the ED, and is a rapidly growing symptom of a systemic problem. These speak directly to ACEP's effort and commitment to improving transportation and transfer practices of this patient population,

Additionally, in the June 2024, the ACEP Board approved the revised policy statement "Patient Autonomy and Shared Decision-Making in Emergency Medical Services and Mobile Integrated Healthcare Community Paramedicine Programs." It states:

> "EMS systems programs must utilize a formal process for establishing a patient's medical decision-making capacity for dissent to medical assessment, treatment, and/or transportation."

This further speaks to the incorporation of the patients role in the decision-making process. Additionally, ACEP has multiple other relevant policy statements that advocate for and support evidence based best practices in the care of psychiatric patients and the transportation and transfer of patients, including but not limited to:

- Psychiatric Patient (Clinical Policy – approved December 2024)
- Access to Optimal Emergency Care for Children – (policy statement approved April 2021)
- The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies – (policy statement approved January 2022)
- Transition of Care for Emergency Department Patients – (policy statement approved April 2021)
- Appropriate Interfacility Patient Transfer – (policy statement approved January 2022)
- Emergency Medical Services Interfaces with Health Care Systems – (policy statement approved June 2024)
- Emergency Department Planning and Resource Guidelines – (policy statement approved April 2021)

ACEP President Alison Haddock, MD, FACEP, appointed the Emergency Behavioral Health Workgroup in late 2024 in light of the development of the Focus Practice Designation (FPD) on Behavioral Health Emergencies It was determined to be critical and extremely beneficial for emergency physicians to have access to a clinical resource that guides emergency physicians in the care of behavioral health patients, developed by experts in behavioral health, that is evidence based, and supported by organizations from the entire health care team involved in the care of behavioral health patients. The workgroup is currently developing this resource and it will be shared with other relevant organizations such as the Emergency Nurses Association and the APA for review and feedback prior to publication and release.

ACEP is a member of the Coalition on Psychiatric Emergencies along with the American Association of Emergency Psychiatry, which may be able to provide some further resources.

**ACEP Strategic Plan Reference**

Career Fulfillment: Focus resources, education and networks to assist members in identifying career opportunities and having career fulfillment across different professional interests or life stages.

Practice Innovation: Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care; Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Amended Resolution 53(23) Treating Physician Determines Patient Stability adopted. Directed ACEP to create a policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient.

Amended Resolution 29(23) Addressing Pediatric Mental Health Boarding in Emergency Departments adopted. Directed ACEP to advocate for federal support to decrease ED boarding of pediatric mental health patients and for increased, adequate reimbursement for pediatric mental health admissions and a standard payment for boarding of children for whom there is no other medical necessity for hospital care.

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted. Directed ACEP to create a psychiatric boarding toolkit to help address patient handoff and frequency of evaluation while boarding; activities of

daily living for the boarded patient; initiation of mental health treatment while boarding; and development of ED psychiatric observational medicine.

Amended Resolution 24(16) Mental Health Boarding Solutions adopted. Directed ACEP to work with outside organizations to develop model practices focused on building bed capacity, reducing ED boarding, and improving quality of care for ED patients with acute mental health disorders; develop and disseminate best practices for acute mental health visits to reduce boarding and improve care; and work with AHRQ and other stakeholders to develop community and hospital based benchmark performance metrics for ED flow and link the licensure of inpatient psychiatric facilities to their willingness to accept patients.

Amended Resolution 14(16) Development and Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs adopted. Called for the development and application of throughput quality data measures and dashboard reporting for behavioral health patients boarded in EDs.

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted. Directed ACEP to convene a work group of appropriate stakeholders to explore and identify additional resources, technologies, and best practices that promote quality patient care for timely evaluation and disposition of behavioral health patients and provide a report to the 2013 Council.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted. Directed ACEP to meet with the American Psychiatric Association and other stakeholders to create a standard for the medical stability of psychiatric patients that includes the conclusions from the 2006 ACEP "Clinical Policy: Clinical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department."

Substitute Resolution 28(06) Psychiatric Bed Availability adopted. Directed ACEP to study the impact of psychiatric bed availability on emergency departments.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted. Directed ACEP to provide guidance to states and chapters to respond to issues related to psychiatric and substance abuse patients in the ED.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted. Directed ACEP to support legislative efforts that grant the emergency physician authority to involuntarily hold and/or transfer psychiatric patients to an appropriate facility when medically indicated.

Amended Resolution 24(00) Inpatient Restraint or Seclusion Orders adopted. Directed ACEP to oppose any requirement by hospital representatives that emergency physicians provide inpatient restraint.

**Prior Board Action**

April 2025, approved the policy statement "Treating Physician Determines Patient Stability."

April 2025, approved the policy statement "Protection of Emergency Physicians from Coercion in Patient Transfers."

June 2024, approved the revised policy statement on "Patient Autonomy and Shared Decision-Making in Emergency Medical Services and Mobile Integrated Healthcare Community Paramedicine Programs;" originally approved June 2018 titled "Patient Autonomy and Destination Factors in Emergency Medical Services (EMS) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs, replacing the following rescinded/sunsetted policy statements: Alternate Ambulance Transportation and Destination (2001-2018), Medical Direction of Mobile Integrated Healthcare and Community Paramedicine Programs (2014-2018), Refusal of Medical Aid (2000-2018).

Amended Resolution 53(23) Treating Physician Determines Patient Stability adopted.

Amended Resolution 29(23) Addressing Pediatric Mental Health Boarding in Emergency Departments adopted.

April 2023, approved the revised policy statement on "Adult Psychiatric Emergencies;" originally approved October 2020.

January 2022, approved the revised policy statement "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with the current title; revised and approved February 2009, February 2002, and June 1997; revised and approved September 1992 titled " Appropriate Inter-Hospital Patient Transfer;" originally approved September 1989 titled " Principles of Appropriate Patient Transfer."

February 2020, approved the revised policy statement "Use of Patient Restraints;" revised and approved April 2014; reaffirmed October 2007; revised and approved April 2001, June 2000, January 1996; originally approved with current title January 1991.

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted.

June 2017, the Board approved the Quality & Patient Safety Committee's recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in EDs. The Clinical Emergency Department Registry (CEDR) has dashboard functionality and the ED throughput measures are included in the registry and reportable to CMS for the Quality Payment Program (QPP). CMS currently collects data on CMS OP-18c measure for arrival to ED departure time for psychiatric and mental health patients and CMS ED-2c measure for admit decision to ED departure time for psychiatric and mental health patients.

January 2017, approved the clinical policy "Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department," which replaced the September 2005 clinical policy "Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department." The September 2005 clinical policy replaced the October 1998 "Clinical Policy for the Initial Approach to Patients Presenting with Altered Mental Status."

Amended Resolution 24(16) Mental Health Boarding Solutions adopted.

Amended Resolution 14(16) Development and Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs adopted.

October 2015, reviewed the information paper "Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department."

October 2014, reviewed the information paper "Care of the Psychiatric Patient in the Emergency Department – a Review of the Literature."

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted.

January 2008 approved the survey on Psychiatric Bed Availability for distribution to the Emergency Department Directors Academy e-list.

Substitute Resolution 28(06) Psychiatric Bed Availability adopted.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted. The Board assigned the resolution to the State Legislative/Regulatory Committee to communicate ACEP' s position and assist chapters with legislative efforts in their states.

Amended Resolution 24(00) Inpatient Restraint or Seclusion Orders adopted

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 80(25)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Toolkit for Elective Surgery Scheduling to Mitigate ED Crowding

PURPOSE: Collaborate with stakeholders to develop and disseminate a toolkit that includes evidence-based guidelines, best practices, case studies, and data-driven models that demonstrate successful implementation of elective surgical smoothing, tailored to different hospitals and resource levels. It further asks ACEP to advocate for the adoption of elective surgical smoothing principles as part of a broader hospital-wide patient flow improvement initiative, recognizing its role in reducing ED crowding, improved patient outcomes, and enhanced health care delivery.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort as well as consulting with subject matter experts and collaborating with groups such as the American Hospital Association and the American College of Surgeons. The estimated cost for creation of the toolkit resource is approximately $15,000, with additional costs for dissemination.

WHEREAS, Emergency department (ED) crowding and boarding continue to pose significant risks to patient safety, quality of care, and hospital efficiency, leading to delayed treatment, increased mortality, and patient dissatisfaction; and

WHEREAS, A major contributing factor to ED crowding is inpatient bed availability, which is significantly impacted by scheduled elective surgeries that generate predictable, but often avoidable, surges in admissions; and

WHEREAS, Studies have demonstrated that hospital occupancy fluctuates significantly due to uneven scheduling of elective procedures, with midweek peaks in surgical admissions leading to periods of intense inpatient congestion that exacerbate ED boarding; and

WHEREAS, Research from leading institutions has shown that smoothing elective surgery schedules—by distributing procedures more evenly throughout the week—reduces inpatient census variability, improves hospital throughput, and decreases ED boarding without reducing surgical case volume or revenue; and

WHEREAS, The Institute for Healthcare Optimization (IHO) has demonstrated that elective surgery smoothing can improve hospital-wide flow, lower wait times, and reduce staff burnout by balancing workloads across the week; and

WHEREAS, A 2023 report from the Agency for Healthcare Research and Quality (AHRQ), developed in part from prior ACEP advocacy, identified elective surgery smoothing as an effective and evidence-supported strategy to reduce emergency department boarding and improve hospital flow; and

WHEREAS, Hospitals that have implemented elective surgery smoothing strategies have observed measurable improvements in ED throughput, including lower left-without-being-seen (LWBS) rates, reduced ED length-of-stay, and shorter ambulance diversion times; and

WHEREAS, Elective surgery smoothing has been successfully piloted in health systems such as Cincinnati Children's Hospital, showing that a data-driven approach to scheduling can optimize hospital capacity and improve patient outcomes; and

WHEREAS, Hospitals that fail to address surgical scheduling inefficiencies may inadvertently contribute to healthcare inequities, as ED crowding disproportionately affects vulnerable populations, including those reliant on emergency care due to barriers in primary and specialty care access; and

WHEREAS, The American College of Surgeons (ACS), the Institute for Healthcare Improvement (IHI), and other professional organizations have recognized the importance of system-wide strategies to improve patient flow and reduce crowding; and

WHEREAS, Implementing elective surgery smoothing is a cost-effective intervention that does not require additional hospital resources but instead optimizes existing capacity through improved scheduling strategies; and

WHEREAS, The benefits of elective surgery smoothing extend beyond the ED, improving post-anesthesia care unit (PACU) capacity, reducing ICU bottlenecks, and enhancing staff workflow efficiency across multiple hospital departments; and

WHEREAS, ACEP has previously advocated for policy changes addressing ED crowding, including financial incentives, health equity considerations, and operational improvements, but has not yet developed a comprehensive strategy to mitigate the impact of elective surgical scheduling on ED capacity; and

WHEREAS, A coordinated approach between emergency physicians, hospital administrators, and surgical departments is necessary to ensure that elective surgical scheduling aligns with hospital-wide capacity constraints and patient flow optimization; therefore be it

RESOLVED, That ACEP collaborate with relevant stakeholders, including the American College of Surgeons and the American Hospital Association, to develop and disseminate a comprehensive elective surgery scheduling toolkit aimed at guiding hospitals in implementing effective scheduling practices to mitigate ED crowding; and be it further

RESOLVED, That a comprehensive elective surgery scheduling toolkit developed by ACEP include evidence-based guidelines, best practices, case studies, and data-driven models demonstrating successful implementation of elective surgery smoothing, with specific recommendations tailored to different hospital settings and resource levels; and be it further

RESOLVED, That ACEP advocate for the adoption of elective surgery smoothing principles as part of broader hospital-wide patient flow improvement initiatives, recognizing its role in reducing ED crowding, improving patient outcomes, and enhancing health care efficiency.

**Resolution References**

1. Agency for Healthcare Research and Quality (AHRQ). *Emergency Department Boarding: Consensus Statement and Research Agenda from the Emergency Department Boarding Summit.* March 2023. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/topics/ed-boarding-summit-report.pdf
2. Institute for Healthcare Optimization (IHO). *Smoothing the Flow of Patients Through the Hospital.* Institute for Healthcare Optimization. Accessed May 2025. Available at: http://www.ihoptimize.org/what-we-do/patient-flow.htm

## Background

This resolution asks ACEP to collaborate with stakeholders to develop and disseminate a toolkit that includes evidence-based guidelines, best practices, case studies, and data-driven models that demonstrate successful implementation of elective surgical smoothing, tailored to different hospitals and resource levels. It further asks ACEP to advocate for the adoption of elective surgical smoothing principles as part of a broader hospital-wide patient flow improvement initiative, recognizing its role in reducing ED crowding, improved patient outcomes, and enhanced health care delivery.

It has been well established that boarding in the ED is primarily due to hospital overflow. It is equally well known that boarding in the ED is greatest on Monday, Tuesday, Wednesday, and Thursday. While there is some variation by weekday in admissions through the emergency department and medical elective admissions, nearly all of the variation

seen is because of elective surgical cases. Surgical cases are rarely scheduled over the weekend based on resource limitations and staffing patterns. Studies have shown increased mortality with elective surgeries performed on the weekend.[1,2] This variation can be significant and one report indicated 42% of elective surgeries were performed on Mondays and Tuesdays.[2] Multiple large-scale studies and meta-analyses demonstrate that patients admitted on weekends have a higher risk of in-hospital mortality, even after adjusting for illness severity and demographic factors, though the absolute increase is modest (adjusted odds ratios typically in the range of 1.04–1.19). This effect is partly attributable to a higher acuity of illness among weekend admissions, as well as potential delays in care processes and reduced access to specialized services.[3,4]

Therefore, efforts to smooth the surgical schedule to reduce this variation would be one way to reduce the variation in hospital overload and reduce boarding in the ED. The process involves an analysis of historical surgical volume and case mix and then using data-driven or mathematical models to reallocate OR block time. Such modeling and alteration of the surgical schedule led to greater efficiency and lower peak census.[5]

However, on the horizon there are more effective tools for smoothing the OR schedule. The use of artificial intelligence (AI) has been shown to accurately predict the duration of surgical cases, optimize resource allocation, and reduce surgical cancellations. Multiple companies and algorithms exist today, and given the cost effectiveness of their results, it is likely to revolutionize surgical scheduling in the next year.[6]

Saudi Arabia is one country that is actively embracing the use of AI in health care. Their algorithms analyze factors like surgeon availability, patient data (including complexity and risk factors), and resource requirements (like operating rooms, instruments, and staff) to generate optimal surgical schedules. One anecdotal report suggests that the use of this and related techniques has increased surgical procedures in one hospital by 50%.

AI is moving rapidly into this space and multiple companies have created AI platforms for smoothing the OR schedule with a large return on investment. While a toolkit would be beneficial at this point in time, it is highly likely that technology and economic pressures to improve OR efficiency will happen faster than any toolkit can be compiled, launched, and distributed and could make an ACEP toolkit obsolete before it is completed.

Boarding is top priority for the College and a major focus of advocacy efforts. In November 2022, ACEP sent a letter to the President of the United States on the ED boarding crisis. It was cosigned by 34 other societies including AAEM, AFP, ACOEP, ACR, AMA, ASA, EMRA, ENA. Through ACEPs advocacy efforts, AHRQ held a summit on boarding where causes and solutions were discussed.

ACEP's advocacy efforts also led to the adoption of the Age-Friendly Hospital Measure, which incorporates efforts to address boarding in the geriatric population.

ACEP's toolkit on Emergency Department Crowding: High Impact Solutions discusses smoothing of surgical schedules as a potential solution but does not go into the detail of the toolkit proposed by this resolution.

ACEP has a dedicated area of the website dedicated to boarding resources for members.

**Background References**

1. Aylin P, Alexandrescu R, Jen MH, Mayer EK, Bottle A. Day of Week of Procedure and 30 Day Mortality for Elective Surgery: Retrospective Analysis of Hospital Episode Statistics. *BMJ (Clinical Research Ed.).* 2013;346:f2424. doi:10.1136/bmj.f2424.
2. Ranganathan S, Riveros C, Tsugawa Y, et al. Postoperative Outcomes Following Preweekend Surgery. *JAMA Network Open*. 2025;8(3):e2458794. doi:10.1001/jamanetworkopen.2024.58794..
3. Bressman E, Rowland JC, Nguyen VT, Raucher BG. Severity of Illness and the Weekend Mortality Effect: A Retrospective Cohort Study. *BMC Health Services Research*. 2020;20(1):169. doi:10.1186/s12913-020-5029-6.
4. Ko SQ, Strom JB, Shen C, Yeh RW. Mortality, Length of Stay, and Cost of Weekend Admissions. *J Hosp Med*. 2018;13(7):476-481. doi:10.12788/jhm.2906.
5. Zenteno AC, Carnes T, Levi R, Daily BJ, Dunn PF. Systematic OR Block Allocation in a Large Academic Medical Center: Comprehensive Review on a Data-Driven Surgical Scheduling Strategy. *Ann Surg*. 2016;264(6):973-981. doi:10.1097/SLA.0000000000001560.
6. Bellini V, Russo M, Domenichetti T, et al. Artificial Intelligence in Operating Room Management. *J Med Syst.* 2024;48(1):19. doi:10.1007/s10916-024-02038-2.
7. Caresyntax. https://caresyntax.com. Accessed July 13, 2025

8. Bartek MA, Saxena RC, Solomon S, et al. Improving Operating Room Efficiency: Machine Learning Approach to Predict Case-Time Duration. *J Am Coll Surg*. 2019;229(4):346-354.e3. doi:10.1016/j.jamcollsurg.2019.05.029.
9. The Impact of AI on Surgery Scheduling and Operating Room Efficiency. April 14, 2025. https://www.medigy.com/news/blogs/the-impact-of-ai-on-surgery-scheduling-and-operating-room-efficiency/. Accessed July 13, 2025.

**ACEP Strategic Plan Reference**

Career Fulfillment: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

**Fiscal Impact**

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort as well as consulting with subject matter experts and collaborating with groups such as the American Hospital Association and the American College of Surgeons. The estimated cost for creation of the toolkit resource is approximately $15,000, with additional costs for dissemination.

**Prior Council Action**

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. Called for ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate overcrowding and treatment delays affecting ED and other hospital patients and for it to include 7 specific elements, including smoothing of elective surgery scheduling and diagnostic/therapeutic procedures.

**Prior Board Action**

June 2024, approved the revised policy statement, "Boarding of Pediatric Patients in the Emergency Department." Previously revised September 2018; originally approved January 2012.

February 2023, approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department;" revised and approved February 2023, June 2017, April 2011, April 2008, and January 2007; originally approved October 2000.

November 2022, reviewed ACEP's letter to the President of the United States regarding the "Emergency Department Boarding Crisis."

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

September 2018, approved the revised policy statement "Definition of Boarded Patient;" reaffirmed October 2017; originally approved January 2011.

May 2016, reviewed the report, "Emergency Department Crowding: High Impact Solutions."

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

January 2008, reviewed the information paper, "Optimizing Emergency Department Front-End Operations."

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

**Background Information Prepared by:** Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Sandra Schneider, MD, FACEP
Interim Executive Director

**Reviewed by:** Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

**Late Resolution**

RESOLUTION: 81(25)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: In Memory of Joshua Alinger, MD

WHEREAS, The American College of Emergency Physicians mourns the loss of Joshua Alinger, MD, who passed away on April 6, 2025, at the age of 34; and

WHEREAS, Dr. Alinger was a valued resident physician in the Department of Emergency Medicine at Northwestern University Feinberg School of Medicine; and

WHEREAS, He received his undergraduate degree from Oregon State University, later earning both a doctoral degree and his medical degree from Washington University School of Medicine; and

WHEREAS, Dr. Alinger was known for his curiosity and extensive knowledge base and was admired by colleagues, mentors, and patients alike; and

WHEREAS, During his residency, he contributed meaningfully to research on the topics of hepatic steatosis, vertigo management, as well as HIV, and was selected into the inaugural NIH NINDS Neuro-EM Scholars Pathway; and

WHEREAS, His untimely passing is a profound loss to the field of emergency medicine and to all who had the privilege of knowing him; therefore be it

RESOLVED, That the American College of Emergency Physicians mourns the loss and expresses its deep sorrow at the passing of Joshua Alinger, MD, and extends heartfelt condolences to his family, friends, colleagues, and the Northwestern University Emergency Medicine community.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

**Late Resolution**

RESOLUTION: 82(25)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: In Memory of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired)

WHEREAS, Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), a distinguished scholar, physician, educator, and veteran, departed this life on January 15, 2025, at the age of 82, surrounded by his loving family in San Antonio, TX; and

WHEREAS, Dr. Gordon was born on May 4, 1942, in Washington, DC, to Frank and Frances Gordon, and was raised in Silver Spring, MD, alongside his brothers Edward, Michael, and Carl; and

WHEREAS, Dr. Gordon demonstrated an unwavering commitment to education, earning a B.S. in Physical Chemistry from Howard University where he graduated Summa Cum Laude, followed by a PhD in the same field from Oregon State University as a NASA fellow; and

WHEREAS, Dr. Gordon answered the call to serve his country, serving with distinction in the Vietnam War as a member of the First Cavalry and receiving numerous commendations, including the Bronze Star and the Air Medal with Oak Leaf Clusters; and

WHEREAS, Following his military service, Dr. Gordon pursued a career in medicine, earning his MD from the University of Maryland School of Medicine, completing his residency at Brooke Army Medical Center, and retiring as a Lieutenant Colonel after 20 years of dedicated service in the United States Army; and

WHEREAS, Dr. Gordon's passion for education and leadership was evident in his tenure as a professor at the U.S. Military Academy at West Point and later at the UT Health Science Center, where he retired as a full professor, shaping the next generation of medical professionals; and

WHEREAS, His commitment to public health extended beyond the classroom, as he served for 22 years as the Medical Director for San Antonio and Bexar County's EMS, ensuring the highest standards of emergency medical care; and

WHEREAS, He was active for many years with the Texas College of Emergency Physicians, particularly with the EMS Committee meetings and activities; and

WHEREAS, Dr. Gordon devoted his time and leadership to numerous organizations, serving as president of the American Red Cross in San Antonio, the Bexar County Medical Society, the Northwest Rotary Club, and the West San Antonio Chamber of Commerce; and

WHEREAS, In addition to his professional accomplishments, Dr. Gordon was a talented musician, skilled craftsman, and dedicated community volunteer, sharing his artistry through performances with the National Symphony and crafting intricate stained-glass lamps, exotic pens, and chess sets; and

WHEREAS, His legacy of service extended to the American Heart Association, the Multiple Sclerosis Society, and countless other charitable causes, reflecting his lifelong dedication to improving lives and advancing medical care; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the memory of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), and his extraordinary contributions to emergency medicine, education, and community service; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), acknowledging that though he may be gone, his remarkable achievements and enduring impact will be remembered with gratitude and admiration.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

**Late Resolution**

RESOLUTION: 83(25)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: In Memory of Elizabeth B. Jones, MD, FACEP

WHEREAS, Elizabeth B. Jones, MD, FACEP, a devoted physician, researcher, and mentor, passed away on December 7, 2024, at the age of 64, following a courageous battle with gastric cancer; and

WHEREAS, Dr. Jones earned her medical degree from Louisiana State University School of Medicine, and completed residencies in internal medicine at the Medical College of Virginia, and in emergency medicine at Carolinas Medical Center in Charlotte, NC; and

WHEREAS, She served for a decade in the Department of Emergency Medicine in the Medical College of Virginia before joining the faculty of McGovern Medical School in Houston in 1999, where she would become a respected senior faculty member in the Department of Emergency Medicine; and

WHEREAS, Dr. Jones made pioneering contributions to emergency medicine research, serving as principal investigator for the UTHealth Houston hub of the Neurological Emergency Treatment Trials Network since 2006 and as a site PI for the CORE-EM hub, leading investigations in time-critical conditions such as sepsis, status epilepticus, and stroke; and

WHEREAS, Dr. Jones was known by colleagues and students as a fierce patient advocate, a leader of high standards, and a professional whose integrity and dedication inspired all who worked with her; and

WHEREAS, She was active for many years with the Texas College of Emergency Physicians; and

WHEREAS, She was not only a brilliant physician and researcher, but also a beloved mentor, colleague, and friend – remembered for her intelligence, kindness, unwavering support, and example of excellence; and

WHEREAS, Outside of medicine, Dr. Jones lived life with joy and adventure, as an avid white-water kayaker, a dedicated marathon runner in cities across the world, and a passionate and talented cook who trained at both the Culinary Institute of America in New York and Le Cordon Bleu in Paris; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the memory of Elizabeth B. Jones, MD, FACEP, and her extraordinary contributions to emergency medicine, patient advocacy, academic excellence, and integrity in research and clinical care; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Elizabeth B. Jones, MD, FACEP, acknowledging that though she may be gone, her remarkable achievements and enduring impact will be remembered with gratitude and admiration.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

**Late Resolution**

RESOLUTION: 84(25)

SUBMITTED BY: California Chapter

SUBJECT: In Memory of Brian Wai Lin, MD

WHEREAS, With the passing of Brian Wai Lin, MD, on June 15, 2025, emergency medicine lost a brilliant clinician, an innovative educator, a beloved colleague, and an extraordinary mentor to countless students and residents in California and beyond; and

WHEREAS, Dr. Lin earned his medical degree from the Icahn School of Medicine at Mount Sinai in 2005, and completed his residency in emergency medicine at Stanford Health Care, where he began a lifelong commitment to excellence in emergency care and medical education; and

WHEREAS, Dr. Lin was board certified in emergency medicine by the American Board of Emergency Medicine and practiced with distinction in Northern California, including at Stanford Health Care and Kaiser Permanente San Francisco Medical Center since 2009; and

WHEREAS, Dr. Lin served as Assistant Clinical Professor of Emergency Medicine at the University of California, San Francisco (UCSF) School of Medicine, where he developed a longitudinal clerkship for medical students and earned the 2024 TPMG Teaching Award for Excellence in Undergraduate and Graduate Medical Education in recognition of his outstanding contributions to medical education; and

WHEREAS, Dr. Lin was nationally recognized for his expertise in wound management and suturing, frequently teaching at leading conferences such as ACEP's Scientific Assembly and SEMPA 360, and sharing his knowledge widely through his educational platform, www.lacerationrepair.com; and

WHEREAS, Dr. Lin authored multiple peer-reviewed publications that advanced clinical practice and education, including work on telehealth integration, ECG interpretation, and dermal wound care; and

WHEREAS, Dr. Lin's unique combination of clinical excellence, humility, generosity, and warmth left an indelible mark on those who worked with him and he was described by colleagues as brilliant, compassionate, and profoundly kind; and

WHEREAS, Dr. Lin's passing has deeply saddened the emergency medicine community, where his legacy continues to inspire those who had the privilege to know and learn from him; and

WHEREAS, Beyond his professional accomplishments, Dr. Lin was a man of vibrant spirit and diverse talents; he was a talented capoeirista, ukelele player, and rock climber, bringing grace and energy to his pursuits; and

WHEREAS, His infectious laugh lit up every room, and he was cherished for the joy and authenticity he shared so freely; and

WHEREAS, He had a deep and unwavering love for his patients, for the art of medicine, and most profoundly, for his family and all those around him and his compassion and presence enriched the lives of many and will be remembered with gratitude and admiration; therefore be it

RESOLVED, That the American College of Emergency Physicians and the California Chapter recognizes the extraordinary contributions of Brian Wai Lin, MD, to the specialty of emergency medicine as a physician, educator, innovator, and mentor; and be it further

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to the family of Brian Wai Lin, MD, especially his beloved children Isaiah, Elliot, and Daphne, along with his loved ones, friends, students, residents, and colleagues our heartfelt condolences and deepest appreciation for his lasting impact on the specialty of emergency medicine and the lives of those he touched with generosity and grace.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 85(25)

SUBMITTED BY: Virginia College of Emergency Physicians

SUBJECT: In Memory of Forrest Daniel McCoig, MD

WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Forrest Daniel McCoig, MD, passed away surrounded by his family on June 1, 2025, at the age of 87; and

WHEREAS, Dr. McCoig completed his undergraduate studies at Asbury College in Kentucky before proceeding to the Medical College of Virginia and earning his medical degree in 1963; and

WHEREAS, He completed his internship at Riverside Hospital in Newport News and began his emergency medicine career at Hampton General Hospital; and

WHEREAS, Dr. McCoig joined the U.S. Navy as a medical officer aboard the nuclear submarine, the Ethan Allen, stationed out of New London, CT and Norfolk, VA, he finished those tours in 1969 as a Lt. Commander; and

WHEREAS, He then returned to the Hampton General Hospital Emergency Department as a staff physician, where he treated more than 175,000 patients over 28 years; and

WHEREAS, Dr. McCoig was also on staff at Mary Immaculate Hospital and the HOPE Center during that tenure; and

WHEREAS, Dr. McCoig was at the helm of numerous professional organizations and training programs over his career; and

WHEREAS, He became a charter member and first president of the Virginia College of Emergency Physicians, serving from 1971-1974; and

WHEREAS, He received a lifetime achievement award from Virginia College of Emergency Physicians and was honored with it becoming an award named in his honor; and

WHEREAS, Dr. McCoig served as Chairman of the Hampton General Hospital Emergency Department several times and chaired the Advanced Life Support subcommittee under five governors, becoming the first appointee to the Governor's Advisory Committee on Emergency Medicine Services; and

WHEREAS, In 1972, and again in 1982, he was cited by the Mayor of Hampton for his part in starting, and teaching, the first EMT and Cardiac Tech courses in Virginia; and

WHEREAS, Dr. McCoig retired in 1992 and received a White Coat award from the Virginia College of Emergency Physicians, recognizing his many years of service in the specialty of emergency medicine; and

WHEREAS, Forrest, or "Frosty" to many friends and colleagues, owing to his sun-bleached hair, was a big personality, who worked, played, and lived vivaciously; and

WHEREAS, He excelled, and delighted, in a variety of hobbies, activities, interests and adventures, began a life-long love of magic as a young teen and performed a legion of shows for family, friends, parties, and charity events throughout his lifetime; and

WHEREAS, He achieved the top rank of Excelsior in the Order of Merlin, from the International Brotherhood of Magicians, for over 50 years of membership and entertained others with his expert ventriloquy skills, where his witty banter with his dummy, Shaggy, always kept folks laughing; and

WHEREAS, As a Civil War historian, Forrest collected a vast array of prints and books and spoke fluently on the subject; and

WHEREAS, Behind the scenes, he was an exceptional artist, drew true-to-life portraits for every senior in his high school graduating class, which were displayed in the yearbook alongside their photos, and he illustrated numerous newsletters, cards, and even grandchildren's school projects over the years; and

WHEREAS, As a college student, Forrest went on a mission trip as a trumpeter with a music quartet to Central America, preaching the gospel and playing music in more than 300 services, in both English and Spanish; and

WHEREAS, Though he was an enthusiast of skiing, boating, and even flying, he was probably best known for his passion for cars and motorcycles and owned a vast array of both over his lifetime, but retirement found him mostly riding Harleys with his fellow "Rumbling Farts" motorcycle group; and

WHEREAS, "Doc" as his cycling brethren called him, led them all over Virginia, as well as road trips to South Dakota and Florida for Bike Weeks, always abiding by their motto, "Live to Ride, Ride to Eat"; and therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Forrest Daniel McCoig, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Virginia College of Emergency Physicians extends to his devoted wife Katharine (married in 1958) of 23 years, and mother to their children James, Amy, and Laura, and his wife Janet (married in 1991) of 34 years, and mother to Kelly, gratitude for his service as an emergency physician, as well as for his dedication and commitment to the specialty of emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Memorandum

**To:** 2025 Council

**From:** Sonja Montgomery, CAE
Governance Operations Director

**Date:** August 4, 2025

**Subj:** ACEP Composition Annual Report

The 2019 Council adopted Amended Resolution 12 ACEP Composition Annual Report:

> RESOLVED, That ACEP provide the Council with an annual report on the demographics of its councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment.

The attached report contains the demographic information that was requested in the resolution.

Although ACEP's membership system has the ability to capture the information, the data is limited to the extent that members provide the information in their membership profile and how often the information is updated.

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
Alison J. Haddock, MD, FACEP
*President*
L. Anthony Cirillo, MD, FACEP
*President-Elect*
Gabor D. Kelen, MD, FACEP
*Chair of the Board*
Jeffrey M. Goodloe, MD, FACEP
*Vice President – Communications*
Kristin B. McCabe-Kline, MD, FACEP
*Vice President – Membership*
Heidi C. Knowles, MS, MD, FACEP
*Secretary-Treasurer*
Aisha T. Terry, MD, MPH, FACEP
*Immediate Past President*
Jennifer J. Casaletto, MD, FACEP
C. Ryan Keay, MD, FACEP
Chadd K. Kraus, DO, DrPH, CPE, FACEP
Ahbi Mehrotra, MD, MBA, FACEP
Diana B. Nordlund, DO, JD, FACEP
Henry Z. Pitzele, MD, FACEP
James L. Shoemaker, Jr., MD, FACEP
Ryan A. Stanton, MD, FACEP

COUNCIL OFFICERS
Melissa W. Costello, MD, FACEP
*Speaker*
Michael J. McCrea, MD, FACEP
*Vice Speaker*

INTERIM EXECUTIVE DIRECTOR
Sandra M. Schneider, MD, FACEP

## Gender

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Female | 12,403 | *31.43%* | 250 | *36.71%* | 264 | *36.07%* | 10 | *40.00%* | 105 | *41.83%* | 4 | *11.11%* | 8 | *47.06%* |
| Gender Nonconforming | 10 | *0.03%* | | | | | | | | | | | | |
| I Prefer Not to Answer | 67 | *0.17%* | 11 | *1.62%* | 2 | *0.27%* | | | 1 | *0.40%* | 1 | *2.78%* | | |
| Male | 21,176 | *53.66%* | 398 | *58.44%* | 452 | *61.75%* | 15 | *60.00%* | 137 | *54.58%* | 31 | *86.11%* | 9 | *52.94%* |
| Non-binary | 18 | *0.05%* | | | | | | | | | | | | |
| Other/Not Listed | 21 | *0.05%* | | | | | | | | | | | | |
| Trans Man | 6 | *0.02%* | | | | | | | | | | | | |
| Trans Woman | 8 | *0.02%* | 2 | *0.29%* | | | | | | | | | | |
| Unanswered | 5,752 | *14.58%* | 20 | *2.94%* | 14 | *1.91%* | | | 8 | *3.19%* | | | | |

## Sexual Orientation

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Asexual | 11 | *0.03%* | 1 | *0.15%* | | | | | | | | | | |
| Bisexual | 162 | *0.41%* | 2 | *0.29%* | 1 | *0.14%* | | | 2 | *0.80%* | | | | |
| Gay/Lesbian | 287 | *0.73%* | 13 | *1.91%* | 4 | *0.55%* | | | 8 | *3.19%* | | | | |
| I Don't Know | 11 | *0.03%* | 1 | *0.15%* | | | | | | | | | | |
| I Prefer Not to Answer | 449 | *1.14%* | 47 | *6.90%* | 9 | *1.23%* | | | 8 | *3.19%* | 1 | *2.78%* | | |
| Pansexual | 26 | *0.07%* | | | | | | | | | | | | |
| Something Else | 14 | *0.04%* | | | 1 | *0.14%* | | | | | | | | |
| Straight | 4,255 | *10.78%* | 193 | *28.34%* | 86 | *11.75%* | 2 | *8.00%* | 50 | *19.92%* | 9 | *25.00%* | 10 | *58.82%* |
| Unanswered | 34,246 | *86.78%* | 424 | *62.26%* | 631 | *86.20%* | 23 | *92.00%* | 183 | *72.91%* | 26 | *72.22%* | 7 | *41.18%* |

## Race / Ethnicity

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Asian | 2,269 | *5.75%* | 40 | *5.87%* | 47 | *6.42%* | | | 14 | *5.58%* | 1 | *2.78%* | 1 | *5.88%* |
| Black or African American | 1,057 | *2.68%* | 24 | *3.52%* | 29 | *3.96%* | | | 8 | *3.19%* | 1 | *2.78%* | 1 | *5.88%* |
| Hispanic or Latino | 1,489 | *3.77%* | 21 | *3.08%* | 22 | *3.01%* | 1 | *4.00%* | 9 | *3.59%* | | | | |
| I Prefer Not to Answer | 289 | *0.73%* | 21 | *3.08%* | 5 | *0.68%* | | | 3 | *1.20%* | 2 | *5.56%* | 1 | *5.88%* |
| Middle Eastern/North African | 229 | *0.58%* | 2 | *0.29%* | 2 | *0.27%* | | | 1 | *0.40%* | | | | |
| More Than One/Multiracial | 583 | *1.48%* | 9 | *1.32%* | 20 | *2.73%* | | | 8 | *3.19%* | | | 1 | *5.88%* |
| Native American or Alaska Native | 71 | *0.18%* | 3 | *0.44%* | | | | | | | | | | |
| Native Hawaiian or Other Pacific Islander | 29 | *0.07%* | 1 | *0.15%* | | | | | | | | | | |
| Other/Not Listed | 5,557 | *14.08%* | 91 | *13.36%* | 145 | *19.81%* | 10 | *40.00%* | 38 | *15.14%* | 1 | *2.78%* | | |
| Unanswered | 13,971 | *35.40%* | 105 | *15.42%* | 150 | *20.49%* | 2 | *8.00%* | 54 | *21.51%* | | | | |
| White | 13,917 | *35.27%* | 364 | *53.45%* | 312 | *42.62%* | 12 | *48.00%* | 116 | *46.22%* | 31 | *86.11%* | 13 | *76.47%* |

## Disability

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ambulatory | 75 | *0.19%* | 7 | *1.03%* | 2 | *0.27%* | | | | | | | | |
| Cognitive | 8 | *0.02%* | | | | | | | | | | | | |
| Hearing | 31 | *0.08%* | 2 | *0.29%* | 3 | *0.41%* | | | 1 | *0.40%* | 1 | *2.78%* | 2 | *11.76%* |
| I Prefer Not to Answer | 204 | *0.52%* | 18 | *2.64%* | 6 | *0.82%* | | | 2 | *0.80%* | 1 | *2.78%* | 1 | *5.88%* |
| Independent Living | 8 | *0.02%* | 1 | *0.15%* | | | | | | | | | | |
| Mental Health | 19 | *0.05%* | | | 1 | *0.14%* | | | 2 | *0.80%* | | | | |
| Not Applicable | 2,755 | *6.98%* | 174 | *25.55%* | 70 | *9.56%* | 1 | *4.00%* | 42 | *16.73%* | 7 | *19.44%* | 5 | *29.41%* |
| Other/Not Listed | 57 | *0.14%* | 6 | *0.88%* | 1 | *0.14%* | | | 2 | *0.80%* | | | | |
| Self-care | 2 | *0.01%* | 2 | *0.29%* | | | | | | | | | | |
| Unanswered | 36,284 | *91.95%* | 469 | *68.87%* | 648 | *88.52%* | 24 | *96.00%* | 200 | *79.68%* | 27 | *75.00%* | 8 | *47.06%* |
| Vision | 18 | *0.05%* | 2 | *0.29%* | 1 | *0.14%* | | | 2 | *0.80%* | | | 1 | *5.88%* |

## Practice Geography

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| I Prefer Not to Answer | 183 | *0.46%* | 10 | *1.47%* | 3 | *0.41%* | | | 1 | *0.40%* | | | | |
| Not Applicable | 1,101 | *2.79%* | 11 | *1.62%* | 11 | *1.50%* | | | 3 | *1.20%* | 1 | *2.78%* | | |
| Other/Not Listed | 210 | *0.53%* | 8 | *1.17%* | 7 | *0.96%* | | | 3 | *1.20%* | 2 | *5.56%* | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rural | 1,644 | *4.17%* | 49 | *7.20%* | 24 | *3.28%* | | | 10 | *3.98%* | 2 | *5.56%* | 1 | *5.88%* | | |
| Suburban | 4,356 | *11.04%* | 139 | *20.41%* | 81 | *11.07%* | 3 | *12.00%* | 39 | *15.54%* | 5 | *13.89%* | 5 | *29.41%* | | |
| Unanswered | 24,351 | *61.71%* | 200 | *29.37%* | 288 | *39.34%* | 12 | *48.00%* | 79 | *31.47%* | 13 | *36.11%* | 2 | *11.76%* | | |
| Urban | 7,616 | *19.30%* | 264 | *38.77%* | 318 | *43.44%* | 10 | *40.00%* | 116 | *46.22%* | 13 | *36.11%* | 9 | *52.94%* | | |

## Practice Setting

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Academic Medical Center | 3,497 | *8.86%* | 172 | *25.26%* | 168 | *22.95%* | 4 | *16.00%* | 63 | *25.10%* | 4 | *11.11%* | 4 | *23.53%* |
| Community Hospital | 4,086 | *10.35%* | 155 | *22.76%* | 52 | *7.10%* | 1 | *4.00%* | 40 | *15.94%* | 5 | *13.89%* | 6 | *35.29%* |
| Critical Care | 100 | *0.25%* | 1 | *0.15%* | 2 | *0.27%* | | | | | | | | |
| EMS | 142 | *0.36%* | 3 | *0.44%* | 6 | *0.82%* | | | 1 | *0.40%* | | | | |
| Freestanding Emergency Department (ED) | 183 | *0.46%* | 8 | *1.17%* | 2 | *0.27%* | | | 2 | *0.80%* | | | | |
| Government | 150 | *0.38%* | 6 | *0.88%* | 6 | *0.82%* | | | 1 | *0.40%* | | | 1 | *5.88%* |
| I Prefer Not to Answer | 123 | *0.31%* | 7 | *1.03%* | 3 | *0.41%* | | | 1 | *0.40%* | | | | |
| Military | 269 | *0.68%* | 4 | *0.59%* | 3 | *0.41%* | | | | | | | | |
| Not Applicable | 1,040 | *2.64%* | 9 | *1.32%* | 11 | *1.50%* | | | 3 | *1.20%* | 1 | *2.78%* | | |
| Other/Not Listed | 225 | *0.57%* | 6 | *0.88%* | 6 | *0.82%* | | | 4 | *1.59%* | 2 | *5.56%* | | |
| Unanswered | 29,496 | *74.75%* | 306 | *44.93%* | 469 | *64.07%* | 20 | *80.00%* | 135 | *53.78%* | 24 | *66.67%* | 6 | *35.29%* |
| Urgent Care | 150 | *0.38%* | 4 | *0.59%* | 4 | *0.55%* | | | 1 | *0.40%* | | | | |

## Age

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 20s | 5,574 | *14.13%* | 15 | *2.20%* | 17 | *2.32%* | | | 2 | *0.80%* | | | | |
| 30s | 12,778 | *32.38%* | 185 | *27.17%* | 186 | *25.41%* | 4 | *16.00%* | 75 | *29.88%* | | | | |
| 40s | 7,488 | *18.98%* | 228 | *33.48%* | 240 | *32.79%* | 12 | *48.00%* | 90 | *35.86%* | 2 | *5.56%* | 7 | *41.18%* |
| 50s | 4,810 | *12.19%* | 129 | *18.94%* | 165 | *22.54%* | 8 | *32.00%* | 47 | *18.73%* | 3 | *8.33%* | 8 | *47.06%* |
| 60s | 2,644 | *6.70%* | 67 | *9.84%* | 66 | *9.02%* | | | 22 | *8.76%* | 6 | *16.67%* | 1 | *5.88%* |
| 70+ | 1,605 | *4.07%* | 50 | *7.34%* | 55 | *7.51%* | 1 | *4.00%* | 14 | *5.58%* | 25 | *69.44%* | 1 | *5.88%* |
| Unanswered | 4,562 | *11.56%* | 7 | *1.03%* | 3 | *0.41%* | | | 1 | *0.40%* | | | | |

## Career Stage

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fellow | 573 | *1.45%* | 6 | *0.88%* | 7 | *0.96%* | | | 2 | *0.80%* | | | | |
| Intern | 3,031 | *7.68%* | 1 | *0.15%* | 2 | *0.27%* | | | | | | | | |
| Medical Student | 2,297 | *5.82%* | | | 8 | *1.09%* | | | | | | | | |
| New To Practice | 5,591 | *14.17%* | 61 | *8.96%* | 69 | *9.43%* | 1 | *4.00%* | 30 | *11.95%* | | | | |
| Practicing Physician | 18,987 | *48.12%* | 556 | *81.64%* | 586 | *80.05%* | 24 | *96.00%* | 213 | *84.86%* | 33 | *91.67%* | 17 | *100.00%* |
| Resident | 6,763 | *17.14%* | 36 | *5.29%* | 23 | *3.14%* | | | 3 | *1.20%* | | | | |
| Retired | 49 | *0.12%* | | | 1 | *0.14%* | | | | | | | | |
| Semi-retired | 1,068 | *2.71%* | 21 | *3.08%* | 27 | *3.69%* | | | 3 | *1.20%* | 3 | *8.33%* | | |
| Unknown | 1,102 | *2.79%* | | | 9 | *1.23%* | | | | | | | | |

## Medical School Specialty

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Allopathic | 25,780 | *65.33%* | 542 | *79.59%* | 626 | *85.52%* | 24 | *96.00%* | 206 | *82.07%* | 32 | *86.49%* | 14 | *82.35%* |
| Osteopathic | 7,957 | *20.16%* | 107 | *15.71%* | 67 | *9.15%* | 1 | *4.00%* | 30 | *11.95%* | 2 | *5.41%* | 2 | *11.76%* |
| Unanswered | 5,724 | *14.51%* | 32 | *4.70%* | 39 | *5.33%* | | | 15 | *5.98%* | 3 | *8.11%* | 1 | *5.88%* |

## Board Certifications

| | All Members | % | Council | % | Committee Members | % | Committee Chairs | % | Section Leadership | % | Past Leadership | % | ACEP Board of Directors | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ABEM | 16,050 | *39.67%* | 501 | *69.58%* | 508 | *64.30%* | 21 | *77.78%* | 183 | *66.79%* | 16 | *42.11%* | 16 | *80.00%* |
| AOBEM | 276 | *0.68%* | 9 | *1.25%* | 8 | *1.01%* | | | 2 | *0.73%* | | | | |
| None | 22,924 | *56.65%* | 163 | *22.64%* | 205 | *25.95%* | 4 | *14.81%* | 63 | *22.99%* | 20 | *52.63%* | 1 | *5.00%* |
| Other | 1,213 | *3.00%* | 47 | *6.53%* | 69 | *8.73%* | 2 | *7.41%* | 26 | *9.49%* | 2 | *5.26%* | 3 | *15.00%* |

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Memorandum

**To:** 2025 Council

**From:** Sonja Montgomery
Governance Operations Director

**Date:** August 4, 2025

**Subj:** Compensation Committee Report

The Compensation Committee has not yet developed their recommendations for stipends for FY 2025-26 Board member and officer terms, October 2025-October 2026. The committee's recommendations will be presented to the Board at their meeting on September 4. 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, as approved September 26, 2024:

| | |
|---|---|
| President | $148,143 |
| President-Elect | $107,791 |
| Chair | $ 35,930 |
| Vice President (2 positions) | $ 30,403 |
| Secretary-Treasurer | $ 30,021 |
| Immediate Past President | $ 28,639 |
| Speaker | $ 35,272 |
| Vice Speaker | $ 20,729 |
| Non-Officer Board Members (8) | $ 11,055 |

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
Alison J. Haddock, MD, FACEP
*President*
L. Anthony Cirillo, MD, FACEP
*President-Elect*
Gabor D. Kelen, MD, FACEP
*Chair of the Board*
Jeffrey M. Goodloe, MD, FACEP
*Vice President – Communications*
Kristin B. McCabe-Kline, MD, FACEP
*Vice President – Membership*
Heidi C. Knowles, MS, MD, FACEP
*Secretary-Treasurer*
Aisha T. Terry, MD, MPH, FACEP
*Immediate Past President*
Jennifer J. Casaletto, MD, FACEP
C. Ryan Keay, MD, FACEP
Chadd K. Kraus, DO, DrPH, CPE, FACEP
Ahbi Mehrotra, MD, MBA, FACEP
Diana B. Nordlund, DO, JD, FACEP
Henry Z. Pitzele, MD, FACEP
James L. Shoemaker, Jr., MD, FACEP
Ryan A. Stanton, MD, FACEP

COUNCIL OFFICERS
Melissa W. Costello, MD, FACEP
*Speaker*
Michael J. McCrea, MD, FACEP
*Vice Speaker*

INTERIM EXECUTIVE DIRECTOR
Sandra M. Schneider, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 Town Hall Meeting

Friday, September 5, 2025
Hyatt Regency Salt Lake
Regency Ballroom (Level 4)
1:15 pm – 2:00 pm

**Emergency Department ACcreditation (EDAC):**
**Why ED Accreditation is Right for Your ED!**

**Moderator:** Michael J McCrea, MD, FACEP
Council Vice Speaker

**Panelists:** Marianne Gausche-Hill, MD, FACEP
Chair, ED Accreditation Board of Governors

Paul Kivela, MD, FACEP
ED Accreditation Board of Governors

Gillian Schmitz, MD, FACEP
ED Accreditation Board of Governors

Jonathan Fisher, MD, FACEP,
ACEP Interim Associate Executive Director, Clinical Affairs

**Session Format:** The Town Hall Meeting is open to everyone attending the Council meeting. Seating is open without restriction to the Council floor.

**Description:** ACEP launched its much-anticipated ED ACcreditation (EDAC) earlier this year, accrediting its first ED in February 2025 at the University of Alabama at Birmingham as a Level 1 ED. During this panel discussion, attendees will learn the differences in the levels of accreditation offered by EDAP and learn how to apply for accreditation.

**Objectives:**
1. Review the five differentiating criteria between level 1, 2, and 3 accreditations.
2. Learn how to apply for ED accreditation.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Memorandum

**To:** 2025 Council

**From:** Sandra M. Schneider, MD, FACEP
Interim Executive Director

**Date:** August 7, 2025

**Subj:** Action on 2024 Resolutions

The 2024 Council considered 70 resolutions: 55 adopted, 6 were not adopted, 1 was withdrawn, and 9 were referred to the Board of Directors. Non-Bylaws resolutions, except for Council Standing Rules amendments, require a majority vote of the Board for acceptance.

*Note: The first resolved of Resolution 22 was adopted and the second resolved was not adopted. Amended Resolution 41 was adopted in lieu of Resolution 41 and Resolution 42. Resolveds 2,3, and 4 of Resolution 43 were adopted and resolveds 1, 5, 6, and 7 were referred to the Board of Directors.*

The Council adopted one Council Standing Rules resolutions that does not require action by the Board of Directors. Four Bylaws amendments were submitted to the 2024 Council and were adopted. Bylaws resolutions adopted by the Council require a 2/3 affirmative vote of the Board of Directors for ratification.

The attached report summarizes the actions taken on the 2024 resolutions adopted by the Council and those that were referred to the Board of Directors. The updated actions are also available on the ACEP website. Scroll to the end of each resolution to see amended or substituted language and to see the implementation action.

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
Alison J. Haddock, MD, FACEP
*President*
L. Anthony Cirillo, MD, FACEP
*President-Elect*
Gabor D. Kelen, MD, FACEP
*Chair of the Board*
Jeffrey M. Goodloe, MD, FACEP
*Vice President – Communications*
Kristin B. McCabe-Kline, MD, FACEP
*Vice President – Membership*
Heidi C. Knowles, MS, MD, FACEP
*Secretary-Treasurer*
Aisha T. Terry, MD, MPH, FACEP
*Immediate Past President*
Jennifer J. Casaletto, MD, FACEP
C. Ryan Keay, MD, FACEP
Chadd K. Kraus, DO, DrPH, CPE, FACEP
Abhi Mehrotra, MD, MBA, FACEP
Diana B. Nordlund, DO, JD, FACEP
Henry Z. Pitzele, MD, FACEP
James L. Shoemaker, Jr., MD, FACEP
Ryan A. Stanton, MD, FACEP

COUNCIL OFFICERS
Melissa W. Costello, MD, FACEP
*Speaker*
Michael J. McCrea, MD, FACEP
*Vice Speaker*

INTERIM EXECUTIVE DIRECTOR
Sandra M. Schneider, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Action on 2024 Council Resolutions

**Resolution 1 Commendation for Stephen V. Cantrill, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians commends Stephen V. Cantrill, MD, FACEP, for his outstanding dedication and contributions on behalf of the College and the specialty of emergency medicine.

*Action:* A framed resolution was sent to Dr. Cantrill.

**Resolution 2 Commendation for J.T. Finnell, II, MD, MSc, FACMI, FACEP**

RESOLVED, That the American College of Emergency Physicians commends and thanks J.T. Finnell, II, MD, MSc, FACMI, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of emergency medicine.

*Action:* A framed resolution was presented to Dr. Finnell.

**Resolution 3 Commendation for Mary Ellen Fletcher, CPC, CEDC, CAE**

RESOLVED, That the American College of Emergency Physicians commends Mary Ellen Fletcher, CPC, CEDC, CAE, for her outstanding service and dedication to the College and the specialty of emergency medicine and extends heartfelt gratitude and appreciation for her extraordinary contributions.

*Action:* A framed resolution was presented to Ms. Fletcher.

**Resolution 4 Commendation for Christopher S. Kang, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians commends Christopher S. Kang, MD, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

*Action:* A framed resolution was presented to Dr. Kang.

**Resolution 5 Commendation for Rami R. Khoury, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians commends Rami R. Khoury, MD, FACEP, for his outstanding service, leadership, and commitment to the College, the specialty of emergency medicine, and the patients we serve.

*Action:* A framed resolution was presented to Dr. Khoury.

**Resolution 6 Commendation for Shari Purpura**

RESOLVED, That the American College of Emergency Physicians commends Shari Purpura for her outstanding service and commitment to the College, its chapters, and the specialty of emergency medicine.

*Action:* A framed resolution was sent to Ms. Purpura.

**Resolution 7 In Memory of Neal F. Aulick, II, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Neal Aulick, II, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians, the Ohio Chapter, the Pennsylvania College of Emergency Physicians, and the West Virginia College of Emergency Physicians extends to his wife Ginger of 33 years, and his daughters Afton and Harper Aulick, gratitude for his service as an emergency physician at multiple hospitals in Ohio, Pennsylvania, and West Virginia, as well as for his dedication and commitment to the specialty of emergency medicine.

*Action:* A framed resolution was sent to Dr. Aulick's family.

**Resolution 8 In Memory of Marilyn J. Gifford, MD**

RESOLVED, That the American College of Emergency Physicians and the Colorado Chapter extend to Marilyn J. Gifford, MD's son, Eric Caplan, MD, and his wife Melissa Ewer, MD, son Brian Caplan, JD, and his wife Christina, brother Steve Gifford, and his wife Mimi, her five grandchildren Connor, Carson, Alaina, Piper, and Relic, other family members, friends and colleagues, condolences and profound gratitude for her advocacy to Emergency Medical Services and her commitment to the specialty of emergency medicine

*Action:* A framed resolution was presented to Dr. Gifford's family.

**Resolution 9 In Memory of Veronica Greer, MD**

RESOLVED, That the American College of Emergency Physicians hereby honors the memory of Veronica Greer, MD, for her exceptional contributions to the field of emergency medicine, her inspiring leadership, and her unwavering dedication to education and patient care; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Veronica Greer, MD, acknowledging that though she may be gone, her legacy as a friend, mentor, and role model will live on in perpetuity.

*Action:* A framed resolution was sent to Dr. Greer's family.

**Resolution 10 In Memory of Christopher H. Linden, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians honors the life and legacy of Christopher H. Linden, MD, FACEP, expressing our deepest condolences to his family and all who loved him and acknowledging his remarkable achievements and the profound impact he had on the fields of emergency medicine and medical toxicology and the lives of those fortunate enough to have known him

*Action:* A framed resolution was sent to Dr. Linden's family.

**Resolution 11 In Memory of Gregory L. Walker, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognize the outstanding dedication and contribution of Gregory L. Walker, MD, FACEP, to the specialty of emergency medicine as a clinician, partner, educator, leader, and advocator; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extend to the family of Gregory L. Walker, MD, FACEP, especially his sons Andy and Sam, his colleagues, partners, former residents, and all friends, our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Michigan, where his impact will be felt for generations to come.

*Action:* A framed resolution was sent to Dr. Walker's family.

**Resolution 12 In Memory Jesse A. Weigel, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Jesse A. Weigel, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his children Karen Weigel, Kevin Weigel, and Jennifer Hudson gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

*Action:* A framed resolution was sent to Dr. Wiegel's family.

**Resolution 13 Allocation of Councillors – Bylaws Amendment (as amended)**

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 1 – Composition of the Council, paragraph one, be amended to read:

Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such chartered chapter. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the **average** membership roll~~s~~ of the College ~~on December 31~~ **of the preceding** ~~**during the**~~ **calendar year**. **The average will be calculated by using the count of primary members in each chapter** ~~**at midnight**~~ **on the first day of the month then adding together each month's total and dividing by 12.** However, a member holding memberships simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one chapter. Councillors shall be elected or appointed from regular and candidate physician members in accordance with the governance documents or policies of their respective sponsoring bodies.

*Action:* The Bylaws were updated and are available on the ACEP website. Membership staff were informed of the new procedure to use when calculating councillor allocations beginning in 2025. Chapters were notified that the new procedure will be implemented beginning in January 2025. The councillor allocations for 2025 were determined using the proscribed calculation procedure. The total councillor allocation for the 2025 Council meeting is 436 based on the average total membership as of December 31, 2024. This is 14 additional councillors than were allocated for the 2024 meeting. The following chapters gained one councillor for 2025: Arkansas, California, Colorado, Florida, Government Services, Kansas, Missouri, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Virginia, and West Virginia. No chapter lost any councillors based on the average membership calculation. Under the prior allocation method, based on the total membership of the chapter as of December 31, the total councillor allocation would have been 430. The following chapters would have gained one councillor: Alaska, Arkansas, California, Florida, Kansas, New Jersey, North Carolina, Ohio, Oklahoma, and West Virginia. The Government Services Chapter would have gained 2 councillors. The following chapters would have lost one councillor: Connecticut, Idaho, Illinois, and Maryland.

**Resolution 14 College Parliamentary Authority - Bylaws Amendment (as amended)**

RESOLVED, That the ACEP Bylaws, Article XIV –Miscellaneous, Section 3 – Parliamentary Authority, be amended to read:

The parliamentary authority for meetings of the College shall be **the ~~most recent~~ current edition** of ~~***The Standard Code of Parliamentary Procedure (Sturgis)***~~ ***The American Institute of Parliamentarians Standard Code of Parliamentary Procedure***, except when in conflict with the Bylaws of the College or the Council Standing Rules.

*Action:* The Bylaws were updated and are available on the ACEP website.

**Resolution 16 International Members Serving as Section Officers - Bylaws Amendment**

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 2.4 – International Members, be amended to read:

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.~~

**International members may not seek election to or serve on the national Board of Directors, may not seek election to or serve as Council Speaker or Council Vice Speaker, may not serve as a councillor or alternate councillor, and may not serve on a Council committee. With the exception of those in inactive status, international members may serve as voting members of College committees to which they are appointed but may not serve as committee chairs, may participate as voting members in sections of membership, and may serve as a section officer except for the positions of councillor and alternate councillor**.

*Action:* The Bylaws were updated and are available on the ACEP website. Committee and section staff liaisons were informed of the Bylaws change.

**Resolution 17 Removing Gendered Pronouns from ACEP's Bylaws – Bylaws Amendment**

RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 3 – Qualifications be amended to read:

The membership of a chapter shall consist of members of the College who meet the qualifications for membership in that chapter. To qualify for membership in a chapter, a person must be a member of the College and have residential or professional ties to that chapter's jurisdiction. Likewise, with the exception of members who are retired from medical practice regardless of membership class, each member of the College must hold membership in a chapter in which the member resides or practices if one exists. If membership is transferred to a new chapter, dues for the new chapter shall not be required until the member's next anniversary date.

A member with professional and/or residential ties in multiple chapters may hold membership in these chapters, providing the member pays full chapter dues in each chapter. Such members with multiple chapter memberships shall designate which single chapter membership shall count for purposes of councillor allotment. A member of a chapter who

retires from medical practice regardless of membership class and changes ~~his/her~~ state of residence may retain membership in a chapter of prior professional practice/residence.; and be it further

RESOLVED, That the ACEP Bylaws Article IX – Board of Directors, Section 2 – Composition and Election be amended to read:

Election of Directors shall be by majority vote of the Councillors present and voting at the annual meeting of the Council.

The Board shall consist of 12 elected directors, plus the president, president-elect, immediate past president, and chair if any of these officers is serving following the conclusion of ~~his or her~~ **an** elected term as director. The outgoing past president shall also remain a member of the Board of Directors until the conclusion of the Board meeting immediately following the annual meeting of the Council. In no instance may a member of the Board of Directors sit as a member of the Council.; and be it further

RESOLVED, That the ACEP Bylaws Article X– Officers/Executive Director, Section 7 – Vice President be amended to read:

"The vice president shall be a member of the Board of Directors. A director shall be eligible for election to the position of vice president if ~~he or she has~~ at least one year ~~remaining~~ **remains** as an elected director on the Board and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The vice president's term of office shall begin at the conclusion of the meeting at which the election as vice president occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected"; and be it further

RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 9 – Secretary-Treasurer be amended to read:

A director shall be eligible for election to the position of secretary-treasurer if ~~he or she has~~ at least one year ~~remaining~~ **remains** on the Board as an elected director and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The secretary-treasurer's term of office shall begin at the conclusion of the meeting at which the election as secretary-treasurer occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. No secretary-treasurer may serve more than two consecutive terms.; and be it further

RESOLVED That the ACEP Bylaws Article XI – Committees, Section 5 – Finance Committee be amended to read:

The Finance Committee shall be appointed by the president. The committee shall be composed of the president-elect, secretary-treasurer, speaker of the Council or ~~his/her~~ **the speaker's** designee, and at least eight members at large. The chair shall be one of the members at large. The Finance Committee is charged with an audit oversight function and a policy advisory function and may be assigned additional objectives by the president. As audit overseers, the committee performs detailed analysis of the College budget and other financial reports ensuring due diligence and proper accounting principles are followed. In addition, expenses incurred in attending official meetings of the Board, shall be reimbursed consistent with amounts fixed by the Finance Committee and with the policies approved by the Board.; and be it further

RESOLVED, That the ACEP Bylaws Article XV – Mandatory Indemnification, Section 3 – Non-Exclusive; Continuation) be amended to read:

The indemnification provided by this Article XV shall not be deemed exclusive of any other rights to which the person claiming indemnification may be entitled under any agreement or otherwise both as to any action in ~~his or her~~ **the individual's** official capacity and as to any action in another capacity while holding such office, and shall continue as to a person who shall have ceased to be a Director, Officer, or Employee of the College engaged in any other enterprise at the request of the College and shall inure to the benefit of the heirs, executors and administrators of such person.

*Action:* The Bylaws were updated and are available on the ACEP website.

**Resolution 22 Support for the "Well Workplace" Policy Statement – *first resolved***

RESOLVED, That ACEP promote, advertise, and support the best practices as defined in the "Well Workplace" policy statement.

*Action:* Assigned to communications staff to promote the policy statement. The policy statement was featured on the front page of the ACEP website and highlighted in multiple issues of the *EM Today* email newsletter distributed to members.

The Well-Being Committee has an objective to create a process for recognizing organizations that adhere to the ACEP "Well Workplace" policy statement. The nomination form for the Emergency Medicine Center of Wellness award was updated to include a link to the "Well Workplace policy statement" and for nominators to indicate the components of the policy statement the institution utilizes.

Many components of the policy statement are incorporated in the ED Accreditation criteria. Assigned the ED Accreditation Board of Governors to review the policy statement to ensure the components are included as the accreditation criteria continue to be developed.

**Resolution 24Address ED Boarding and the Medicare Three-Midnight Rule for Post-Acute Rehabilitation**

RESOLVED, That the American College of Emergency Physicians prioritize advocacy to have the Medicare three-midnight rule for skilled nursing placement removed.

*Action:* Assigned to Advocacy & Practice Affairs staff to continue federal advocacy initiatives. Elimination of the three-midnight rule has been a priority on ACEP's legislative and regulatory agenda for the past 20 years and continues to be a priority for ACEP's advocacy initiatives. ACEP has supported every Congressional proposal and related regulatory action or proposal to rescind or ameliorate the rule's effects by at least counting time in observation toward the three-day requirement. ACEP currently supports the Improving Access to Medicare Coverage Act (H.R. 5138/S. 4137) to count time spent under observation status towards the three-day hospital stay for coverage of skilled nursing care, and establish a 90-day appeal period following passage for those that have a qualifying hospital stay and have been denied skilled nursing care after January 1, 2024. This bipartisan, bicameral legislation was introduced in the current 118th Congress by U.S. Representatives Joe Courtney (D-CT), Glenn Thompson (R-PA), and others, and Senators Sherrod Brown (D-OH), Susan Collins (R-ME), and Sheldon Whitehouse (D-RI). The legislation remains a priority for ACEP's federal advocacy. ACEP is also a member of a larger coalition solely focused on addressing this issue. While there is significant industry and stakeholder support for changing this policy, Congress has not yet acted on this legislation. However, as there is now a greater body of evidence from the pandemic experience that revising the three-day stay rule leads to better outcomes for patients without increasing costs, ACEP and coalition advocates have renewed the push for Congress to take up and pass this legislation. ACEP also identified removal of the three-midnight rule as a key policy solution for addressing ED boarding in the Policy Solutions to ED Boarding document, a document that guides ACEP advocacy strategies.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress continue to include "Encourage the use of waivers to restrictive payment policies such as telehealth and the 3-day SNF rule, as appropriate, based on experience from waivers granted during the COVID-19 public health emergency."

**Resolution 25 Boarding – Follow the Money**

RESOLVED, That ACEP collaborate with relevant stakeholders including the AMA, hospital associations, nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the emergency department to hospital discharge and chronic care facility placement if necessary for all patients admitted to observation and inpatient status from the emergency department.

*Action:* Assigned to Advocacy & Practice Affairs staff to initiative discussions with relevant stakeholders, as directed in the resolution, to pursue proposing federal legislation.

The Emergency Medicine Policy Institute (EMPI) Board of Directors commissioned RAND to conduct a new study of emergency medicine to focus on the value of emergency care, evaluate impediments to ED resources and capacity, trends in emergency medicine reimbursement, and propose new innovative funding strategies for emergency care. The report is expected to be released in March 2025.

**Resolution 26 Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events (as amended)**

RESOLVED, That ACEP advocate for and support the development of policies that will ensure appropriate consideration of context of contemporaneous boarding and overcrowding during Root Cause Analysis and related patient safety processes in hospitals; and be it further

RESOLVED, That ACEP commit resources for establishing best practices and assisting hospitals with considering relevant corrective actions for medical errors committed as a result of ED overcrowding; and be it further

RESOLVED, That ACEP provide a written proposal to The Joint Commission and other relevant accrediting organizations suggesting a revision to the framework for Root Cause Analysis and corrective actions that includes emergency department and hospital capacity constraints and overcrowding as a "Root Cause Type" and "Causal Factor" as part of the root cause analysis.

*Action:* Assigned to the Quality & Patient Safety Committee to develop a policy statement and other resources to address the first and second resolveds. Assigned third resolved to Advocacy & Practice Affairs staff to work with the Quality & Patient Safety Committee to develop the proposal to submit to The Joint Commission and other relevant accrediting organizations.

**Resolution 29 Minimum Standards for Freestanding Emergency Departments (as substituted)**

RESOLVED, That ACEP promote the maintenance of more specific minimum standards for freestanding emergency departments (FSEDs) pertaining to appropriate staffing, lab, security, service availability, and imaging capabilities, and update the FSED policy statement accordingly.

*Action:* ACEP's "Freestanding Emergency Departments" policy statement addresses some of the standards requested, including staffing by appropriately qualified emergency physicians, adequate medical and nursing personnel, and provision of stabilizing treatment by any FSED that presents itself as an ED. ACEP has resources available on FECs on the web site, including an information paper and the Freestanding Emergency Centers Section newsroom.

Assigned to the Emergency Medicine Practice Committee to collaborate with the Freestanding Emergency Centers Section to review the policy statement and provide recommendations to the Board of Directors regarding potential revisions.

Assigned to the State Legislative/Regulatory Committee to review state laws and regulations related to FSEDs.

**Resolution 30 Hospital Network Requirements for Emergency Physicians**

RESOLVED, That ACEP formally request that appropriate federal government agencies investigate whether health insurers and hospitals violate antitrust or other laws by requiring emergency physicians to be in-network as a condition for an emergency professional service contract.

*Action:* Assigned to Advocacy & Practice Affairs staff.

**Resolution 32 Preventing Harmful Health Care Deals (as amended)**

RESOLVED, That ACEP advocate for legislation that would require health systems to file notice with regulatory agencies before completing critical transactions – including but not limited to sale-leaseback agreements, purchases or sales of health system facilities or real estate, dividend recapitalization, private practice rollups, and changes in majority owner equity stakes – to protect the integrity of health systems and maintain competitive markets.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives. Assigned to the Federal Government Affairs Committee to develop a policy statement addressing competitive markets and health systems.

**Resolution 33 Promotion of Nursing in Emergency Medicine (as amended)**

RESOLVED, That ACEP collaborate with relevant organizations and stakeholders to look at models including, but not limited to incentivized pay structures, to recruit and maintain nursing staff in emergency medicine, in alignment with our organization's beliefs and policies, to maintain a safe standard of care for our patients.

*Action:* Assigned to Advocacy & Practice Affairs staff to discuss strategies and collaboration with the Emergency Nurses Association.

**Resolution 34 Reimbursement for Emergency Physician Services Provided Out-of-Hospital**

RESOLVED, That ACEP collaborate with other stakeholders to investigate ways to establish EMS physician reimbursement pathways.

*Action:* Assigned to the Reimbursement Committee to collaborate with the EMS Committee and develop strategies to address the resolution.

**Resolution 35 Sharing of Protected Health Information**

RESOLVED, That ACEP provide guidance to members on legally and operationally sound practices for sharing of protected health information; and be it further

RESOLVED, That ACEP encourage hospital systems to improve the education of relevant employees regarding the legality and appropriateness of accessing and/or sharing protected health information with emergency physicians actively engaged in patient care.

*Action:* Assigned to the Medical-Legal Committee to develop a policy statement.

**Resolution 36 Reform to Improve Patient Access to Necessary Care (as substituted)**

RESOLVED, That ACEP collaborate with the Arizona and Connecticut Chapters and others to develop model state policy, regulation, and legislation, that requires reporting of ED/hospital crowding and interhospital transfer data to a relevant state entity (e.g. State Department of Health) and develop a state-wide system to facilitate interfacility transfers.

*Action:* Assigned to the State Legislative/Regulatory Committee.

**Resolution 37 Reinforcing EMTALA in Pregnancy Related Emergency Medical Care**

RESOLVED, That ACEP develop a policy statement that delineates:

- EMTALA applies to all emergency medical conditions and there should be no exceptions to EMTALA for any specific emergency medical condition or the evidence-based treatment that would be used to stabilize a patient.
- ACEP supports that the decision to provide any procedure in the course of patient care to satisfy EMTALA requirements, including, but not limited to, abortion care and/or pregnancy termination, be made between the patient and the emergency clinician, and that laws and regulations should not inhibit or obstruct the patient-physician relationship.
- ACEP reinforces the need for emergency physicians to be able to provide care at the standard required by medical best practices and that no procedure or treatment be removed from those treatment options in the care of emergency patients served under federal EMTALA protections.

*Action:* Assigned to the Medical-Legal Committee.

**Resolution 38 Termination of Pregnancy (as substituted)**

RESOLVED, That ACEP will work with the federal government and support chapters in working with their state government entities, along with other relevant stakeholders, to ensure all patients have access to the full spectrum of evidence-based prenatal, peripartum, and postpartum physical and mental health care, including but not limited to termination of pregnancy of a non-living fetus, a fetus with no hope of survival, or to protect the health or life of a pregnant person.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. ACEP's legislative and regulatory priorities for the first session of the 119th Congress include: "Enact liability immunity for physicians providing EMTALA-mandated services, with considerations for reproductive health and patient safety related emergencies." (legislative strategy) and "Monitor new guidance and proposed regulations released by the Administration on reproductive health and patient safety related emergencies." (regulatory strategy)

Assigned to the State Legislative/Regulatory Committee to compile resources for chapters to use in advocating for access to reproductive health care in alignment with existing ACEP policy.

**Resolution 39 Urgent Care Transparency on Available Resources and Credentials**

RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing what resources are or are not available at a given time; and be it further

RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. Assigned the Urgent Care Task Force to review ACEP's "Urgent Care Centers" policy statement and determine if any revisions are needed.

**Resolution 41 Workplace Violence (in lieu of Resolutions 41 and 42) (as amended)**

RESOLVED, That ACEP advocate for all emergency departments to preserve and protect the accurate reporting of each workplace violence incident while preserving employee confidentiality without repercussion or recrimination for employment purposes; and be it further

RESOLVED, That ACEP officially work with the Occupational Safety and Health Administration, the Department of Justice, and other relevant stakeholders to advocate for national legislation that standardizes the prevention and the response to harmful acts of violence on health care workers in emergency departments.

*Action:* This tenets of this resolution are addressed in the proposed "Safety from Violence for Healthcare Employees (SAVE) Act" legislation. Assigned to Advocacy & Practice Affairs staff to continue advocacy initiatives in support of the SAVE Act and/or other legislation and continue working with OSHA. ACEP's legislative and regulatory priorities

for the first session of the 119th Congress include: "Advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED and secure new congressional champions." (legislative strategy) and "Continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department." (regulatory strategy)

**Resolution 43 Addressing Challenges Related to the New ABEM Oral Board Exam Format (as substituted) – *resolveds 2,3, and 4***

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to explore additional testing sites to reduce travel costs and minimize time zone impacts for candidates; and be it further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to implement a fee structure for the new oral board examination to improve affordability and accessibility for all candidates, including differentiating between early career attendings and fellows; and be it further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to ensure oral board candidates will not bear undue financial burdens related to the newly proposed ABEM Oral Boards Update for 2026;

*Action:* Continue dialogue with ABEM for potential solutions to address the resolution. ABEM submitted a response to the resolution and it will be discussed by the ACEP Board of Directors during the March 19, 2025, meeting.

**Resolution 44 Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations (as amended)**

RESOLVED, That ACEP continue to advocate for additional critical access hospital funding to cover the salary, housing, and travel costs of emergency medicine resident rotations at rural Critical Access Hospitals; and be it further

RESOLVED, That ACEP support the Rural Emergency Medicine Section in maintaining a central "Rural Rotation List" to be managed by the ACEP Rural Emergency Medicine Section and shared with the Council of Residency Directors in Emergency Medicine; and be it further

RESOLVED, That ACEP request that the Accreditation Council for Graduate Medical Education encourage all emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

*Action:* Assigned first resolved to Advocacy & Practice Affairs staff for federal advocacy initiatives. ACEP's legislative and regulatory priorities for the first session of the 119th Congress include: "Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs." (legislative strategy)

Assigned second and third resolveds to the Academic Affairs Committee to work with the Rural Emergency Medicine Section and integrate into ACEP's response to the ACGME requirements.

**Resolution 45 Climate Change Research and Education in Emergency Medicine (as amended)**

RESOLVED, That ACEP encourage and support comprehensive research efforts on the health effects of climate change and the pivotal role of emergency medicine in mitigating and responding to these effects; and be it further

RESOLVED, That ACEP call for and promote initiatives to facilitate data collection on climate-related health emergencies, such as heat-related illnesses, vector-borne diseases, and extreme weather events, to inform evidence-based interventions, strengthen disaster preparedness, and enhance the capacity to respond effectively to climate change-induced health challenges; and be it further

RESOLVED, That ACEP support the introduction of curricula that address climate change in medical schools and residency programs.

*Action:* ACEP's policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine" partially addresses the resolution. Assigned to the Public Health Committee to determine if changes to the policy statement are needed and if any information needs to be included in the PREP that is being developed as an adjunct to the policy statement. Assigned third resolved to the Academic Affairs Committee.

ABEM plans to review "The Model of the Clinical Practice of Emergency Medicine" in 2025. Assigned third resolved to the Academic Affairs Committee to recommend that ABEM include climate change in the updated Model.

**Resolution 46 Human Trafficking Training for All Emergency Medicine Residents (as amended)**

RESOLVED, That ACEP develop training presentations and resources for identification of human trafficking that can be used at all institutions and included at Scientific Assembly.

*Action:* Assigned to the Public Health Committee to develop the training materials and work with ACEP's Education staff on courses and materials to include at Scientific Assembly. Utilize ACEP Anytime to disseminate courses and training materials.

**Resolution 47 Human Trafficking is a Public Health Crisis (as amended)**

RESOLVED, That ACEP declare human trafficking a public health crisis in the United States and revise ACEP's policy statement on human trafficking.

*Action:* Assigned to the Public Health Committee to revise the "Human Trafficking" policy statement.

**Resolution 48 Alarm Fatigue (as amended)**

RESOLVED, That ACEP collaborate with stakeholders to identify evidence-based solutions to address alarm fatigue in the emergency department setting, with topics including indications for clinical monitoring devices in the emergency department and appropriate silencing of clinical alarms including when latching (silencing the alarm after the initial alert) is appropriate.

*Action:* Assigned to the Quality & Patient Safety Committee develop a strategy to address the resolution, such as an information paper or best practice reference document or guideline.

**Resolution 49 Centralized Repository of Credentialing Data (as amended)**

RESOLVED, That ACEP advocate for the establishment of a centralized repository of verified primary source documents, work history, case logs, certificates of insurance, and other materials; and be it further

RESOLVED, That ACEP work with the American Medical Association, the American Osteopathic Association, the Federation of State Medical Boards, The Joint Commission, American Hospital Association, state agencies, and other interested parties to establish a recognized centralized repository of verified credentialing documents that can be used by all hospitals in the process of credentialing and privileging physicians at their facility that requires a minimum amount of additional submissions by physicians applying for privileges.

*Action:* Assigned first resolved to Advocacy & Practice Affairs staff for advocacy initiatives. Assigned to the AMA Section Council on Emergency Medicine to review and consider submitting a resolution to the AMA.

**Resolution 50 Communication to Established Patients Being Referred to the Emergency Department (as amended)**

RESOLVED, That ACEP work with other stakeholders to develop a strategy to address the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression of which they and their families were not educated by the physicians responsible for doing so.

*Action:* Assigned to the Emergency Medicine Practice Committee to work with the Palliative Care Section to develop a strategy to address the resolution.

**Resolution 54 Mandated Public Health Screening (as amended)**

RESOLVED, That ACEP work with relevant stakeholders, including but not limited to departments of health, accreditation bodies, and hospital systems, to prioritize the acute care and evaluation of emergent patients and not require routine unrelated screenings in the emergency department without adequate resources, funding and supports; and be it further

RESOLVED, That ACEP develop a policy statement noting that mandating the emergency department to offer public health disease screening and behavioral health screening outside of the reason for the acute visit in the emergency department, without adequate resources, funding and supports, has unintended consequences on workflow and care of emergency department patients.

*Action:* Assigned first resolved to Advocacy & Practice Affairs staff for advocacy initiatives. Assigned second resolved to the Public Health Committee to review the "Screening for Disease Factors in the ED" policy statement and determine if revisions are needed or if a new policy statement should be developed.

**Resolution 56 Patient and Visitor Code of Conduct (as substituted)**

RESOLVED, That ACEP create and implement a concise, universal code of patient and visitor conduct for emergency departments, featuring prominently displayed signage that clearly defines acceptable behavior and states that non-medical aggression may result in immediate removal.

*Action:* Assigned to the Public Health Committee (lead) to work with the Emergency Medicine Practice Committee and the Medical-Legal Committee.

**Resolution 57 Rationalizing Communication of Imaging Hazards to Improve Care (as amended)**

RESOLVED, That ACEP work with the American College of Radiology and other stakeholders, to develop a policy statement or other resource information on the rational communication of imaging hazards to emergency patients.

*Action:* Assigned to the Quality & Patient Safety Committee to develop a policy statement or other resource information as directed in the resolution.

**Resolution 58 Reducing Waste in Our Emergency Departments (as amended)**

RESOLVED, That ACEP encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and be it further

RESOLVED, That ACEP work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste.

*Action:* Assigned to the Public Health Committee to review existing resources and develop a policy statement with input from other stakeholders as identified in second resolved.

**Resolution 59 Tap Water is Sufficient Treatment**

RESOLVED, That ACEP advocate to transition to hospital tap water in the United States for wound irrigation to decrease the carbon footprint of emergency departments contributing to global efforts to combat climate change; and be further

RESOLVED, That ACEP emphasize the importance of research and education within the emergency medicine community, and to raise awareness of the financial and environmental benefits of tap water for wound irrigation in the United States highlighting its safety, efficacy, and potential for cost savings; and it further

RESOLVED, That ACEP urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

*Action*: Assigned first and second resolveds to the Public Health Committee to review existing resources and consider developing a policy statement. Assign third resolved to Advocacy & Practice Affairs staff for advocacy initiatives. A saline shortage occurred in late September 2024 because of Hurricane Helene.

**Resolution 60 Lethal Means Firearm Counseling (as amended)**

RESOLVED, That ACEP develop resources for ACEP members to provide evidence-based lethal means safety counseling to at risk youth; and be it further

RESOLVED, That ACEP work with other organizations to develop training for health care providers in lethal means safety training.

*Action:* Assigned to the Public Health Committee to investigate available resources and enhance their availability to ACEP members. Seek input from other committees and sections as needed.

**Resolution 61 Safe Storage of Firearms (as amended)**

RESOLVED, That ACEP create education to raise awareness that secure gun storage, (storing guns locked, unloaded and separate from ammunition) can save lives, can prevent theft, and can prevent access by unauthorized users who may pose a danger to themselves or others; and be it further

RESOLVED, That ACEP encourage emergency physicians and/or departments to function as messengers to patients about safe gun storage.

*Action:* Assigned to the Public Health Committee to develop strategies to address the resolution. Seek input from other committees and sections as needed.

**Resolution 62 Stop the Bleed Education (as substituted)**

RESOLVED, That ACEP promote activities that foster education and awareness of bleeding control techniques within high-risk communities including at risk youth.

*Action:* Assigned to the EMS Committee to develop strategies to address the resolution. The EMS Committee was assigned an objective for the 2024-25 committee year to "collaborate with other organizations to support the accessibility and visibility of community education programs, such as Stop the Bleed, Chest Compression-Only CPR, Narcan, etc., to enhance the chain of survival in patient care."

**Resolution 63 Commendation for Todd B. Taylor, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the contributions of Todd B. Taylor, MD, FACEP, to the advancement of emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians commends Todd B. Taylor, MD, FACEP, for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

*Action:* A framed resolution was presented to Dr. Taylor.

**Resolution 64 In Memory of Amy H. Kaji, MD, PhD, MPH**

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Amy H. Kaji MD, PhD, MPH, 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 Amy H. Kaji, MD, PhD, MPH, her friends, and her colleagues our condolences and gratitude for her tremendous service to the specialty of emergency medicine, and to the patients and physicians of California and the United States.

*Action:* A framed resolution was sent to Dr. Kaji's family.

**Resolution 65 In Memory of Joseph Sabato, Jr., MD, FACEP**

RESOLVED, That the American College of Emergency Physicians honors the memory of Joseph Sabato, Jr., MD, FACEP, and extends its deepest sympathies to his family, friends, and colleagues and acknowledges that his legacy will continue to inspire and guide the emergency medicine community.

*Action:* A framed resolution was sent to Sabato's family.

**Resolution 66 In Memory of Christopher J. Karns, DO**

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Christopher J. Karns, DO;

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Dawn E. Beemer Karns, their three children Nathan Christopher, Carter Alexander, and Alaina Grace, his parents John and Cynthia Karns, and the rest of his family gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.

*Action:* A framed resolution was sent to Karns' family.

**Resolution 67 In Memory of Madeline Giegold, MD**

RESOLVED, That the American College of Emergency Physicians and the California Chapter extend their heartfelt gratitude to the family of Madeline "Maddie" Giegold, MD, for sharing her extraordinary life with us; and be it further

RESOLVED, That the memory of Madeline "Maddie" Giegold, MD, will be cherished and her impact on emergency medicine will be felt for years to come

*Action:* A framed resolution was sent to Giegold's family.

**Resolution 68 In Memory of Jeffery Scott Shafer, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians honors the memory of Jeffery Scott Shafer, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Illinois College of Emergency Medicine extends to his wife of 19 years Jamie, their two children Seth and Allison, his mother, Bonnie (John) Howard, his father Clyde (Trish) Shafer, his father-in-law and mother-in-law, Gary and Vicki Elis, his brother Jeremy (Staci) Shafer, step-brothers, Patrick (Tana) Howard and Steve (Angela) Benard, brother-in-law Jeremy Ellis, maternal grandmother Dorothy Farris and cherished family members gratitude for his service to the pre-hospital community and his dedication to the specialty of emergency medicine.

*Action*: A framed resolution was sent to Dr. Shafer's family.

**70(24) Reaffirming EMRA's Vital Relationship with ACEP**

RESOLVED, That our American College of Emergency Physicians formally recognize the Emergency Medicine Residents' Association as our official partner representing the voice of emergency medicine physicians-in-training.

*Action:* ACEP has recognized EMRA and is committed to remaining in partnership with EMRA. Negotiations with EMRA are ongoing regarding various partnership initiatives. A strategic partnership agreement was signed in February 2025.

---

## Council Standing Rules Resolution

(Does not require action by the Board of Directors.)

**Resolution 15 College Parliamentary Authority - Council Standing Rules Amendment (as amended)**

RESOLVED, That the ACEP Council Standing Rules, Parliamentary Procedure (paragraph one) be amended to read as follows with the proviso that the changes will become effective after the 2024 Council meeting and only upon adoption of the companion resolution College Parliamentary Authority – Bylaws Amendment:

**Parliamentary Procedure**

The ~~**most recent**~~ **current** edition of ~~*Sturgis, Standard Code of Parliamentary Procedure*~~ ***The American Institute of Parliamentarians Standard Code of Parliamentary Procedure*** will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. ***See also Limiting Debate and Voting Immediately***.

*Action:* The Council Standing Rules were updated and are available on the ACEP Website.

---

## Resolutions Referred to the Board of Directors

**Resolution 18 ACEP Council and Scientific Assembly Meeting Location**

RESOLVED, That ACEP survey the membership to obtain robust, direct member feedback on Scientific Assembly locations, including whether they would prefer a rotating or semi-permanent site, preferred and non-preferred cities, and provide input on the other factors that the College should consider when designating a conference location.

*Action:* Assigned to Education and Membership staff to develop a strategy for the best approach to obtain input from members regarding the location of Scientific Assembly.

**Resolution 21 Printable Volunteer Recognition Certificate**

RESOLVED, That ACEP develop a volunteer recognition certificate for ACEP physician volunteers and leaders that can be printed and proudly displayed for interested parties.

*Action:* Assigned to Member Engagement and Governance Operations staff to continue to develop strategies to recognize member volunteers in their leadership roles. Prioritize implementation in the new AMS and utilize the AMS to create a volunteer profile that tracks volunteer activities for each member.

**Resolution 27 Continuous Physician Staffing for Rural Emergency Departments (as amended)**

RESOLVED, That ACEP collaborate with the American Medical Association to advocate that the Centers for Medicare and Medicaid Services (CMS) modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician be ~~required to be~~ **immediately available for** on-site ~~and available for~~ care of emergency department patients at all times.

*Action:* Assigned to the AMA Section Council on Emergency Medicine to review and provide a recommendation to the Board of Directors on the advisability of submitting a resolution to the AMA.

**Resolution 28 Data Gathering on Freestanding EDs: Examining Regulations, Services Offered, and Staffing Policies**

RESOLVED, That ACEP collect data on free standing emergency department-type facilities (FSEDs) nationally, and any state regulations specifically pertaining to them, and this may include a survey of current services and equipment offered at FSEDs in each state as well as staffing and other pertinent policies that might be helpful to ACEP chapters who may be addressing issues with these facilities.

*Action:* Assigned to Advocacy & Practice Affairs staff to review and provide a recommendation to the Board with a cost analysis and the advisability of implementing the referred resolution. Share the analysis with the State Legislative/Regulatory Committee for their work in analyzing state laws and regulations related to FSEDs in response to Substitute Resolution 29(24) Minimum Standards for Freestanding Emergency Departments.

**Resolution 40 Telehealth Emergency Physician Standards (as amended)**

RESOLVED, That ACEP affirm that physicians providing telehealth emergency medicine be board certified or board eligible in emergency medicine, in congruence with existing ACEP policy on telehealth.

*Action:* Assigned to the Emergency Medicine Practice Committee to work with the Emergency Telehealth Section to review the "Emergency Medicine Telehealth" policy statement and provide a recommendation to the Board on the advisability of revising the policy statement to address the referred amended resolution.

**Resolution 43 Addressing Challenges Related to the New ABEM Oral Board Exam Format (as substituted) – *resolveds 1,5,6, and 7***

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to explore delaying implementation of the new oral board examination format to allow for adequate preparation by emergency medicine residency programs and graduating residents; and be it further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to provide a 5-year period after implementation during which the cost of retaking the new oral boards will be waived for those who do not pass; and be further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to develop and implement a comprehensive, candidate facing, evaluation process for the new oral board examination format to ensure that it equitably assesses communication, procedural skills, patient management, high-stakes communication, difficult conversations, patient communications beyond diagnosis, procedural skills, clinical decision making/shared decision making, team management, leadership, troubleshooting, task switching, prioritization, and continues to bring value to the public and diplomates; and be it further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to establish accommodations and alternative arrangements for candidates with health, safety, or legal concerns, who may face risks or challenges in traveling to the examination site.

*Action:* Continue dialogue with ABEM for potential solutions to address the resolution. ABEM submitted a response to the resolution and it will be discussed by the ACEP Board of Directors during the March 19, 2025, meeting.

**Resolution 52 Delegation of Critical Care to Non-Physician Practitioners**

RESOLVED, That ACEP revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department"[6] policy statement to include that:

1. Emergency physicians should retain primary responsibility for performing critical care activities within emergency departments to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care scenarios effectively; and
2. Credentialing processes must prioritize patient safety and quality of care, ensuring that physicians and non-physician practitioners are granted privileges to manage patients commensurate with their training; and
3. The scope of practice for nurse practitioners and physician assistants in emergency departments should be clearly defined, focusing on roles where their training and expertise can complement but not substitute for the specialized skills of emergency physicians in critical care.

*Action:* Assigned to the Emergency Medicine Practice Committee to review the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement and provide a recommendation to the Board on the advisability of revising the policy statement to address the referred resolution.

**Resolution 53 Emergency Nursing and Emergency Department Accreditation**

RESOLVED, That ACEP collaborate with relevant organizations to amend and include requirements for emergency nursing within the tiered levels of the ACEP ED accreditation pathway.

*Action:* Assigned to the Emergency Department Accreditation Program Board of Governors to review and provide a recommendation on the advisability of implementing the referred resolution.

**Resolution 69 Updating ACEP's Position on PA and NP Supervision in the ED**

RESOLVED, That ACEP amend by deletion its "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to read:

~~"ACEP Acknowledges that there are currently workforce limitations in specific CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "Offsite" by telehealth means as follows:~~

- ~~Critical Access Hospitals (CAHs)~~
- ~~Rural Emergency Hospitals (REHs)~~

*Action:* The Board of Directors discussed the referred resolution on October 28, 2024, and approved removing the language from the policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department."

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Memorandum

**To:** 2025 Council

**From:** Sandra M. Schneider, MD, FACEP
Interim Executive Director

**Date:** August 7, 2025

**Subj:** Action on 2023 Resolutions

The 2023 Council considered 62 resolutions: 46 adopted, 10 were not adopted, and 7 were referred to the Board of Directors. There are 7 commendation resolutions, 12 memorial resolutions, and two Bylaws resolutions.

*Note: The first resolved of Amended Resolution 39 was adopted and the second resolved was referred to the Board of Directors.*

The attached report summarizes the actions taken on the 2023 resolutions adopted by the Council and those that were referred to the Board of Directors. The updated actions are also available on the ACEP website. Scroll to the end of each resolution to see amended or substituted language and to see the implementation action.

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
Alison J. Haddock, MD, FACEP
*President*
L. Anthony Cirillo, MD, FACEP
*President-Elect*
Gabor D. Kelen, MD, FACEP
*Chair of the Board*
Jeffrey M. Goodloe, MD, FACEP
*Vice President – Communications*
Kristin B. McCabe-Kline, MD, FACEP
*Vice President – Membership*
Heidi C. Knowles, MS, MD, FACEP
*Secretary-Treasurer*
Aisha T. Terry, MD, MPH, FACEP
*Immediate Past President*
Jennifer J. Casaletto, MD, FACEP
C. Ryan Keay, MD, FACEP
Chadd K. Kraus, DO, DrPH, CPE, FACEP
Abhi Mehrotra, MD, MBA, FACEP
Diana B. Nordlund, DO, JD, FACEP
Henry Z. Pitzele, MD, FACEP
James L. Shoemaker, Jr., MD, FACEP
Ryan A. Stanton, MD, FACEP

COUNCIL OFFICERS
Melissa W. Costello, MD, FACEP
*Speaker*
Michael J. McCrea, MD, FACEP
*Vice Speaker*

INTERIM EXECUTIVE DIRECTOR
Sandra M. Schneider, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Action on 2023 Council Resolutions

**Resolution 1 Commendation for Patrick Elmes, EMT-P**

RESOLVED, That the American College of Emergency Physicians commends Patrick Elmes, EMT-P, for his outstanding service and commitment to the College and the specialty of emergency medicine.

*Action:* A framed resolution was presented to Mr. Elmes.

**Resolution 2 Commendation for Kelly Gray-Eurom, MD, MMM, FACEP**

RESOLVED, That the American College of Emergency Physicians commends Kelly Gray-Eurom, MD, MMM, FACEP, for her service as Council Speaker, Council Vice Speaker, and for her enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

*Action:* A framed resolution was presented to Dr. Gray-Eurom.

**Resolution 3 Commendation for Russell H. Harris, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the contributions of Russell H. Harris, MD, FACEP, to the advancement of emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians commends Russell H. Harris, MD, FACEP for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

*Action:* A framed resolution was presented to Dr. Harris.

**Resolution 4 Commendation for Rick Murray, EMT-P, FAEMS**

RESOLVED, That the American College of Emergency Physicians commends Rick Murray, EMT-P, FAEMS, for his outstanding service and commitment to the College, the specialty of emergency medicine, and the subspecialty of emergency medical services.

*Action:* A framed resolution was presented to Mr. Murray.

**Resolution 5 Commendation for Gillian R. Schmitz, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians commends Gillian R. Schmitz, MD, FACEP, for her outstanding service, leadership, and commitment to the specialty of emergency medicine and to the patients and communities we serve.

*Action:* A framed resolution was presented to Dr. Schmitz.

**Resolution 6 Commendation for JoAnne Tarantelli**

RESOLVED, That the American College of Emergency Physicians commends and thanks JoAnne Tarantelli for her outstanding career and decades of dedicated service, leadership, commitment to the College, the emergency physicians of New York, the specialty of emergency medicine, and the patients that we serve.

*Action:* A framed resolution was sent to Ms. Tarantelli.

**Resolution 7 In Memory of Clifford Findeiss, MD**

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the contributions of a trailblazing pioneer, visionary leader, invaluable mentor, and outstanding emergency physician, J. Clifford “Cliff” Findeiss, MD, and his selfless contributions to emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians extends condolences and appreciation to his wife Jean; his four sisters Marcia, Joan, Pat, and Michele; as well as his four children and his granddaughter in whom his legacy lives on: Dr. Laura Findeiss, Craig Findeiss, Amanda (Findeiss) Rosillo, Allison Findeiss, granddaughter Elizabeth

(Lily) Rosillo; and to his family, friends, and colleagues for his remarkable service to the specialty of emergency medicine, patient care, and the communities he served.

*Action:* A framed resolution was sent to Dr. Findeiss's family.

**Resolution 8 In Memory of Scott A. Hall, MD**

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments of Scott A. Hall, MD, and offer our heartfelt condolence to his wife, daughter, and the entire Hall family.

*Action:* A framed resolution was sent to Dr. Hall's family.

**Resolution 9 In Memory of Gene W. Kallsen, MD**

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to the family of Gene W. Kallsen, MD, gratitude for his tremendous service to emergency medicine.

*Action:* A framed resolution was sent to Dr. Kallsen's family.

**Resolution 10 In Memory of Michael Kleinman, DO**

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Michael Kleinman, DO, who dedicated himself to his patients, his trainees, his profession, and his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Jacklyn, his sons Dr. Steve Kleinman and David Kleinman, gratitude for his tremendous service as an emergency physician at the WellSpan York Hospital, as well as for his dedication and commitment to the specialty of emergency medicine.

*Action:* A framed resolution was sent to Dr. Kleinman's family.

**Resolution 11 In Memory of Gloria J. Kuhn, DO, PhD**

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians hereby expresses their enduring appreciation to Gloria J. Kuhn, DO, PhD, as a champion for emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extends to the family of Gloria J. Kuhn, DO, PhD, her colleagues, and former residents, our condolences along with our profound gratitude for her lifetime of service to the specialty of emergency medicine, Michigan emergency physicians, and patients, who will never fully know her impact, across the United States of America and likely beyond.

*Action:* A framed resolution was sent to Dr. Kuhn's family.

**Resolution 12 In Memory of Richard M. Nowak, MD, MBA, FACEP**

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Richard M. Nowak, MD, MBA, FACEP, to the specialty of emergency medicine as a clinician, educator, researcher, scholar, and leader; and be it further

RESOLVED, That the College extends condolences to his wife, Deborah, and children, Michael and Kathryn, and he will forever endure in the minds of all who had the great opportunity to interact with him.

*Action:* A framed resolution was sent to Dr. Nowak's family.

**Resolution 13 In Memory of Barbara W. Trainor**

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to her daughter Karyn Trainor and son William Trainor and his partner Patrice Pineda, her brothers David Wallace and Doug Wallace, and sisters Carolyn Wallace Dee and Melanie Wallace, and the many others she impacted, gratitude for her tremendous service to emergency medicine.

*Action:* A framed resolution was sent to Ms. Trainor's family.

**Resolution 14 In Memory of Lori Weichenthal, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians, the California Chapter, and the Wellness and Wilderness Medicine Sections hereby acknowledge the many contributions made by Lori Weichenthal, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to her family gratitude for her tremendous service to emergency medicine.

*Action:* A framed resolution was sent to Dr. Weichenthal's family.

**Resolution 15 Additional Vice President Position on the ACEP Board of Directors (as amended)**

RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 1 – Officers, Section 2 – Election of Officers, and Section 7 – Vice President, and Article XI – Committees, Section 2 – Executive Committee, be revised to read:

ARTICLE X – OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

The officers of the Board of Directors shall be president, president-elect, chair, immediate past president, vice president**s**, and secretary-treasurer. The officers of the Council shall be the speaker and vice speaker. The Board of Directors may appoint other officers as described in these Bylaws.

Section 2- Election of Officers

The chair, vice-president**s**, and secretary-treasurer shall be elected by a majority vote at the Board meeting immediately following the annual meeting. The president-elect shall be elected each year and the speaker and vice speaker elected every other year by a majority vote of the councillors present and voting at the annual meeting.

Section 7 – Vice President**s**

**There shall be two vice president positions.** The vice president**s** shall be ~~a~~ member**s** of the Board of Directors. A director shall be eligible for election to ~~the~~ **a** position of vice president if he or she has at least one year remaining as an elected director on the Board and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. ~~The~~ **A** vice president's term of office shall begin at the conclusion of the meeting at which the election as **a** vice president occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected.

ARTICLE XI – COMMITTEES

Section 2 – Executive Committee

The Board of Directors shall have an Executive Committee, consisting of the president, president-elect, vice president**s**, secretary-treasurer, immediate past president, and chair. The speaker shall attend meetings of the Executive Committee. The Executive Committee shall have the authority to act on behalf of the Board**,** subject to ratification by the Board at its next meeting.

Meetings of the Executive Committee shall be held at the call of the chair or president. A report of its actions shall be given by the Executive Committee to the Board of Directors in writing within two weeks of the adjournment of the meeting.**; and be it further**

**RESOLVED, That the additional vice president position on the ACEP Board of Directors be implemented in a budget neutral manner.**

*Action:* The Bylaws were updated. The Board elected both vice president positions on October 12, 2023. The Compensation Committee presented their recommendation to the Board on October 12, 2023, to retain the Global Stipend Pool at the current budgeted amount. The stipends for all officer and non-officer positions were adjusted to accommodate the second vice president officer position.

**Resolution 16 Council Quorum – Defining "Present" – Housekeeping Bylaws Amendment**

RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 4 – Quorum, of the ACEP Bylaws be amended to read:

Article VIII - COUNCIL

Section 4 — Quorum

A majority of the number of councillors credentialed by the Tellers, Credentials, and Elections Committee during each session of the Council meeting shall constitute a quorum for that session. The vote of a majority of councillors voting in person or represented by proxy (if applicable) shall decide any question brought before such meeting, unless the question is one upon which a different vote is required by law, the Articles of Incorporation, or these Bylaws.

**Whenever the term "present" is used in these Bylaws to determine a quorum present, with respect to councillor voting, "present" is defined as either in person or participating by approved remote communication technology**.

*Action:* The Bylaws were updated.

**Resolution 19 Scientific Assembly Vendor Transparency (as amended)**

RESOLVED, For transparency as part of the vendor contract, vendors recruiting emergency physicians for employment be encouraged to bring a current contract for physicians to review during Scientific Assembly exhibits and the sample contracts must include stipulations relating to non-compete clauses, due process, and policies on transparency in billing/collections.

*Action:* Assigned to Corporate Development staff to update the exhibitor contract and communicate to vendors.

**Resolution 20 Emergency Medicine Research Mentorship Network (as substituted)**

RESOLVED, That ACEP foster collaborations with Society for Academic Emergency Medicine, Council of Residency Directors in Emergency Medicine, and Emergency Medicine Foundation, and other stakeholders to support robust research mentorship opportunities.

*Action:* Assigned to the Research Committee to work with CORD, SAEM, EMF, EMRA, and other stakeholders stakeholders to enhance the research scholar pipeline within emergency medicine and support robust research mentorship opportunities. The committee is continuing to work on the resolution in the 2024-25 committee year.

**Resolution 21 Mitigation of Competition for Procedures Between Emergency Medicine Resident Physicians and Other Learners**

RESOLVED, That ACEP support emergency medicine resident physicians' right of first refusal over non-physicians, such as physician assistants and nurse practitioners, in performing ACGME-required procedures that are deemed medically necessary in emergency medicine.

*Action:* Assigned to the Academic Affairs Committee to develop a policy statement. The committee developed the policy statement "Prioritization of Resident Education in Procedures" and it was approved by the Board of Directors on March 2024. The Board also directed the AMA Section Council on Emergency Medicine to advocate for and promote the prioritization of residents for procedures needed for education over non physician practitioners at the AMA including submitting a resolution as appropriate. The Physician Extenders H-310.913 AMA policy was reaffirmed at AMA Interim Meeting 2023. The policy reads: In academic environments, our American Medical Association will only support payment models for non-physician practitioners that do not interfere with graduate medical training. Our AMA supports the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures."

**Resolution 22 Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation**

RESOLVED, That ACEP recognizes the value of choice in emergency medicine residency training formats and supports the continued accreditation of both three-year and four-year emergency medicine residency programs.

*Action:* Assigned to the Academic Affairs Committee to develop a policy statement. The committee developed the policy statement "Length of Residency Training in Emergency Medicine" and it was approved by the Board of Directors in April 2023.

**Resolution 24 Addressing the Growing Epidemic of Pediatric Cannabis Exposure**

RESOLVED That ACEP advocate for changes in product packaging so as not to resemble non-cannabis containing products, i.e., candy commonly marketed towards children; and be it further

RESOLVED, That ACEP appeal to regulatory bodies and public health agencies for labeling regulations to reduce the likelihood of accidental ingestion by young children and clearly communicate dosing information as well as the potential risks to children associated with cannabis products.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives.

**Resolution 28 Facilitating EMTALA Interhospital Transfers**

RESOLVED, That ACEP work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA; and be it further

RESOLVED, That ACEP support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

In November 2024, the Centers for Medicare and Medicaid Services (CMS) finalized changes to the Emergency Services Condition of Participation (CoP), which includes new requirements for transfer protocols: Facilities must have written policies and procedures for transferring patients under their care; and Facilities must provide training to the relevant staff regarding the hospital policies and procedures for transferring patients under its care. Though (as of July 2025) CMS interpretive guidance has not been released, ACEP worked with the American College of Obstetricians and Gynecologists (ACOG) to create a guidance document for members to ensure that their hospitals meet the protocols described in the CoP.

**Resolution 29 Addressing Pediatric Mental Health Boarding in Emergency Departments (as amended)**

RESOLVED, That ACEP advocate for federal support to decrease ED boarding of pediatric mental health patients; and be it further

RESOLVED, That ACEP advocate for increased, adequate reimbursement for pediatric mental health admissions and a standard payment for boarding of children for whom there is no other medical necessity for hospital care.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress include:

1) Develop and promote legislative efforts to address ED boarding and crowding crisis, including increased, adequate reimbursement for pediatric mental health admissions and payment for boarding of children for whom there is no other medical necessity for hospital care.
2) Seek opportunities to address increase in pediatric ED visits and improve coordination of acute mental health care services for children and young adults.

ACEP has helped develop several federal bills, including the "Improving Mental Health Access from the Emergency Department Act," that will help address various aspects of the ED boarding crisis. ACEP also endorsed the "Helping Kids Cope Act" (H.R. 2412), bipartisan legislation to fund necessary staffing, capacity increases, and infrastructure adjustments needed to alleviate pediatric boarding, maintaining initiatives to allow more children to access care outside EDs, and addressing gaps in the continuum of care for children. ACEP continues working to get this legislation reintroduced in the 119th Congress.

ACEP also secured introduction of new ACEP-developed bipartisan legislation based upon the output of the boarding summit and AHRQ roundtable, introduced by Reps. John Joyce (R-PA) and Debbie Dingell (D-MI) and Senators Chris Coons (D-DE), Dave McCormick (R-PA), and Angus King (I-ME). The bill, the "Addressing Boarding and Crowding in the Emergency Department (ABC-ED) Act," utilizes existing an existing federal health data modernization grant to support development and implementation of real-time hospital bed tracking and hospital capacity management systems with a focus on ED boarding, supports innovative care models through Medicare pilot programs focused on improving geriatric emergency care and psychiatric emergency care and transfers, and commissions a GAO study to identify best practices for hospital capacity tracking and its effect on boarding, wait times, and EMS offload delays.

**Resolution 31 Combating Mental Health Stigma in Insurance Policies (as amended)**

RESOLVED, That ACEP advocate and commit resources for the elimination of discrimination against emergency physicians with treated mental health conditions in life, health, disability, and/or professional liability (malpractice) insurance policies; and be it further

RESOLVED, That ACEP work with other organizations to promote equitable access to life, health, disability, and/or professional liability (malpractice) insurance for all emergency physicians.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

**Resolution 35 Declaring Firearm Violence a Public Health Crisis**

RESOLVED, That ACEP declare firearm violence to be a public health crisis in the United States.

*Action:* Assigned to the Public Health Committee to include in the revision of the "Firearm Safety and Injury Prevention" policy statement (as directed in the 3rd resolved of Resolution 36). The revised policy statement was approved by the Board in June 2024. The U.S. Surgeon General issued an advisory on June 25, 2024, declaring firearms violence a public health crisis. ACEP provided a brief quote from ACEP's President Aisha Terry, MD, FACEP, to be included in the press release on this issue: "By raising awareness of this public health crisis, the Surgeon General's Advisory on Firearm Violence Prevention speaks to the gun violence that emergency physicians observe all too often, as well as the repercussions on the communities they serve."

**Resolution 36 Mandatory Waiting Period for Firearm Purchases**

RESOLVED, That ACEP advocate for a mandatory federal waiting period prior to firearm purchases; and be it further

RESOLVED, That ACEP assist state chapters in promoting legislation on mandatory waiting periods at the state level; and be it further

RESOLVED, That ACEP add language to its "Firearm Safety and Injury Prevention" policy statement supporting mandatory waiting periods prior to firearm purchases.

*Action:* Assigned first and second resolveds to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. Assigned third resolved to the Public Health Committee. The revised policy statement "Firearm Safety and Injury Prevention" was approved by the Board in June 2024.

ACEP's legislative and regulatory priorities continue to include working with Members of Congress to promote efforts that may prevent firearm- related injuries/deaths and support continued and increased funding for firearms injury research.

**Resolution 37 Support for Child-Protective Safety Firearm Safety and Storage Systems (as amended)**

RESOLVED, That ACEP support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership; and be it further

RESOLVED, That ACEP promote child-protective firearm safety and storage systems.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. ACEP's legislative and regulatory priorities continue to include working with Members of Congress to promote efforts that may prevent firearm-related injuries/deaths and support continued and increased funding for firearms injury research.

Assigned to Communications staff to develop messaging.

**Resolution 38 Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals (as amended)**

RESOLVED, That ACEP advocate for sufficient reimbursement for emergency physician services in Critical Access Hospitals and Rural Emergency Hospitals, and other rural hospitals, to ensure the availability of board certified emergency physicians who possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient safety, and supporting the sustainability of health care services in rural communities.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. ACEP's legislative and regulatory priorities include:

1) Monitor the willingness of critical access hospitals and rural hospitals to convert to Rural Emergency Hospitals and develop policy suggestions that would make this a more attractive option.
2) Identify innovative staffing, payment, and reimbursement models, such as potential global budgeting for emergency physician professional services to maintain viability of ED coverage in rural and underserved areas.

3) Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs.
4) Support innovative models of care that enable or promote access to emergency care, such as Rural Emergency Hospitals, digital health, Free Standing Emergency Departments, telehealth, etc.

**Resolution 39 Medicaid Reimbursement for Emergency Services (as amended) – *first resolved***

RESOLVED, That ACEP advocate at the federal level and support chapters in advocating at the state level for Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates; and be it further

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

**Resolution 40 Support for Reimbursement of Geriatric ED Care Processes (as amended)**

RESOLVED, That ACEP advocate for and support the development of policies that will allow for appropriate reimbursement, outside of the CPT and RUC processes, for high-value Geriatric Emergency Department Accreditation program-defined care processes that have been shown to improve both health system focused and patient centered outcomes.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

In the FY 2025 Inpatient Prospective Payment System (IPPS) final rule, CMS incorporated the mandatory Age-Friendly Hospital Measure, which incorporates concepts and standards included in the Geriatric Emergency Department Accreditation program, into the Inpatient Quality Reporting (IQR) Program. Hospitals that participate in Medicare's IQR Program will be required to report on whether hospitals have protocols in place to: 1) elicit patient health care goals, 2) responsibly manage medications, 3) implement frailty screening and intervention (including for cognition and mobility), 4) assess social vulnerability (e.g. social isolation, caregiver stress, elder abuse) and 5) designate age-friendly leadership. Hospitals that choose not to participate in the IQR program face a significant reduction in their annual Medicare payment update.

**Resolution 42 On-site Physician Staffing in Emergency Departments (as amended)**

RESOLVED, That ACEP work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments; and be it further

RESOLVED, That ACEP continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician certified by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, or certified by the American Board of Pediatrics in pediatric emergency medicine.

*Action:* Assigned first resolved to State Legislative/Regulatory Committee. The committee developed a toolkit after the successful passage of the Indiana legislation and used the language from that legislation (HOUSE BILL No. 1199) along with other model provisions, drafting notes and definitions, as well as current regulatory language to consider. The toolkit was distributed to chapters in time for the 2023-24 state legislative season.

Assigned second resolved to Communications staff to include in ongoing communications. ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

**Resolution 43 Adopt Terminology "Unsupervised Practice of Medicine"**

RESOLVED, That ACEP adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on-site supervision of non-physician practitioners.

*Action:* Assigned to Emergency Medicine Practice Committee to develop a policy statement. The committee developed two policy statements to address the resolution, one for residents and one for attendings. The policy statements "Resident Moonlighting in the Emergency Department" and "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners" were approved by the Board of Directors in April 2025.

**Resolution 45 Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss (as amended)**

RESOLVED, That ACEP work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; and be it further

RESOLVED, That ACEP recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and be it further

RESOLVED, That ACEP develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

*Action:* Assigned first resolved to the Academic Affairs Committee. The committee continues to work on the resolution in the 2024-25 committee year.

Assigned second and third resolveds to the Public Health Committee to develop a policy statement. The Public Health Committee developed the policy statement "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss" and it was approved by the Board of Directors on September 26, 2024.

**Resolution 46 Policy Statement on the Care of Pregnant Individuals with Substance Use Disorder (as substituted)**

RESOLVED, That ACEP create a policy statement on the care of pregnant individuals with substance use disorder, based upon the concepts of the "American College of Obstetricians & Gynecologists Committee Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist."

*Action:* Assigned to the Public Health Committee to develop a policy statement. The policy statement "Care of Pregnant Individuals with Substance Use Disorder" was approved by the Board of Directors in June 2024.

**Resolution 47 Clarification of and Taking a Position Against Use of Excited Delirium Syndrome (as amended)**

RESOLVED, That ACEP develop a statement to clarify that the 2009 White Paper Report on Excited Delirium is no longer current with the College's position based on new science and understanding of the entity; and be it further

RESOLVED, That ACEP clarify its position in writing, that the 2009 white paper is inaccurate and outdated, and that while the ACEP Board of Directors had previously approved the 2009 White Paper Report on Excited Delirium, it has withdrawn such approval; and be it further

RESOLVED, That ACEP disseminate their position that they no longer endorse or approve the 2009 White Paper on Excited Delirium among the wider medical and public health community, law enforcement organizations, and ACEP members acting as expert witnesses testifying in relevant civil or criminal litigation.

*Action:* Assigned to ACEP's communications staff. A statement was issued on October 12, 2023, reaffirming several ACEP positions regarding the use of the terms "excited delirium" and "hyperactive delirium with severe agitation." The statement emphasized "ACEP's 2009 White Paper Report on Excited Delirium Syndrome is outdated and does not align with the College's position based on the most recent science and better understanding of the issues surrounding hyperactive delirium. ACEP has withdrawn its approval of this paper." The results of ACEP's communications efforts were:

- 1,047 articles mentioned ACEP
- Coverage included: Associated Press, Becker's Hospital Review, CNN, CNN International, Daily Mail, HealthLeaders, Kaiser Family Foundation, MSN, MedPage Today, Medscape, NBC News, NBC News – Boston, NBC News – Bay Area, NBC News – New York, Newsday, Politico, Los Angeles Times, New York Post, Washington Post, US News & World Report.
  - 68 articles quoted designated subject matter expert, Dr. Jeff Goodloe.
  - 406 articles resulted from the Associated Press article: A doctors group calls its 'excited delirium' paper outdated and withdraws its approval (October 13, 2023)
  - 78 articles resulted from two Kaiser Family Foundation articles Police Blame Some Deaths on 'Excited Delirium.' ER Docs Consider Pulling the Plug on the Term (October 2, 2023) Doctors Abandon a Diagnosis Used to Justify Police Custody Deaths. It Might Live On, Anyway. (October 16, 2023)
  - 72 articles resulted from the HealthDay article: Doctor's Group Pulls Paper on 'Excited Delirium,' Often Cited in Cases Involving Excessive Force by Police (October 13, 2023)
  - 56 broadcast mentions in local media markets, including Buffalo, Chicago, Denver, Los Angeles, Minneapolis, Reno, Sacramento, San Diego, and San Francisco.

The Clinical Policies Committee developed the "Clinical Policy: Critical Issues in the Evaluation and Management of Adult Prehospital or Emergency Department Patients Presenting with Severe Agitation" and it was approved by the Board in October 2023. This clinical policy is intended for the initial treatment of undifferentiated agitation in which the underlying etiology is unknown, and attempts to summarize the current body of literature surrounding the safety and efficacy of agents used for treatment of severe agitation in the emergency department by addressing the following critical question: "Is there a superior parenteral medication or combination of medications for the acute management of adult prehospital or emergency department patients with severe agitation?"

In June 2021, the Board of Directors approved the document titled *ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings*. In August 2021, the task force report was submitted to *Annals of Emergency Medicine* for publication consideration and it was not accepted based on the length of the paper. *Annals* recommended that the report be edited down to comply with the maximum word limit for acceptance, but the suggestion was rejected by the authors since all content presented in the report was considered necessary to inform the paper's intended audience of EMS professionals, emergency physicians, and ED medical staff (e.g., nurses, technicians, etc.). The report was also submitted to *JACEP Open*, which resulted in the same outcome. Shortly after the discussions with *Annals* and *JACEP Open*, work began to draft an executive summary of the 2021 task force report that would be submitted to *Annals*. Work on the paper was suspended following the submission of Resolution 47(23) Clarification of and Taking a Position Against the Use of Excited Delirium Syndrome" to the ACEP Council. Work on the paper resumed after the amended resolution was adopted by the Council and the Board of Directors. The paper includes information about the action taken by the Council and the Board. The Board of Directors reviewed the final paper "Hyperactive Delirium with Severe Agitation – Evolving Recognition and Evidence-Based Recommendations" in April 2024 and it was submitted to *JACEP Open* for publication consideration.

**Resolution 48 Medical Malpractice Certificate of Merit (as amended)**

RESOLVED, That ACEP recommends an affidavit of merit must be from an emergency physician who is board certified per ACEP policy in the same specialty of emergency medicine, as well as licensed and currently practicing in the same state.

*Action:* Assigned to the Medical-Legal Committee to review ACEP's policy statement "Anonymous Affidavits of Merit" and determine if revisions should be made or whether a new policy statement should be developed. The committee developed a revised policy statement and it was approved by the Board of Directors in January 2025.

**Resolution 51 Quality Measures and Patient Experience Scores (as amended)**

RESOLVED, That ACEP advocate for alignment with current ACEP policy and previous recommendations that patient experience surveys be extended to all appropriate categories of emergency department patients to attempt to improve validity; and be it further

RESOLVED, That ACEP oppose reimbursement metrics and employment decisions correlated with or dependent on patient experience surveys; and be it further

RESOLVED, That ACEP work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal, state, and professional advocacy initiatives.

Assigned to the Emergency Medicine Practice Committee to revise ACEP's policy statement "Patient Experience of Care Surveys" to address the intent of the resolution. The committee plans to submit a revised policy statement to the Board of Directors for discussion at their April 30, 2025, meeting.

Patient experience metrics like the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) continue to be optional for reporting and reimbursement programs. In various Medicare and Medicaid responses to regulations and requests for information, ACEP repeatedly states our opposition to using patient experience scores in reimbursement mechanisms and requests that these remain optional or removed in future rulemaking.

**Resolution 53 Treating Physician Determines Patient Stability (as amended)**

RESOLVED, That ACEP enact policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient; and be it further

RESOLVED, That ACEP develop an additional policy statement that speaks to the implications of coercion or threats of financial penalties to the emergency physician who has not personally evaluated the patient to coerce or threaten financial penalties to force the treating emergency physician to transfer a patient when the treating physician believes that the patient is unstable and such a transfer may compromise patient safety.

*Action:* Assigned to the Emergency Medicine Practice Committee to develop policy statements as directed in the resolution. The policy statements "Treating Physician Determines Patient Stability" (addresses first resolve) and "Protection of Emergency Physicians from Coercion in Patient Transfers" (addresses second resolved) were approved by the Board of Directors in April 2025.

**Resolution 54 Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions**

RESOLVED, That ACEP engage with The Joint Commission to oppose credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

*Action:* Assigned to Advocacy & Practice Affairs staff and Clinical Affairs staff to continue dialoguing with The Joint Commission and working with the Coalition of Board Certified Emergency Physicians (formerly known as the Coalition Opposing Medical Merit Badges) to oppose credentialing requirements for individual emergency conditions by engaging in efforts to educate hospitals and medical staff credentialing entities on the training, core competencies and scope of care that is encompassed in accredited emergency medicine residency training and validated by board certification through ABEM, AOBEM, or ABP and ABEM partner boards for dual/subspecialties.

In April 2025, ACEP leadership and staff met with The Joint Commission to raise concerns regarding current credentialing requirements for individual emergency conditions given the training, core competencies and scope of care that is encompassed in accredited emergency medicine residency training and validated by board certification and asked for simplification and clarifying guidance on credentialing.

Assigned to the Emergency Medicine Practice Committee to create talking points to assist physicians in lobbying hospital administrators to use board certifications such as ABEM to validate training, core competencies, and scope of care. The committee continues to work on the resolution in the 2024-25 committee year.

**Resolution 55 Uncompensated Required Training (as amended)**

RESOLVED, That ACEP convene a working group to evaluate fair market compensation for required training, accurate estimates of the time to completion, and appropriate protected time allowances for training without requiring completion during off hours; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations to reduce unnecessary or redundant annual or onboarding training for physician employment.

*Action:* Assigned to the Emergency Medicine Practice Committee to develop an information paper or other resources. The committee continues to work on the resolution in the 2024-25 committee year.

Requested AMA Section Council on Emergency Medicine review the second resolved and consider whether a resolution should be submitted to the AMA.

**Resolution 56 In Memory of William A. Nice, MD**

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of William A. Nice, MD, to emergency medicine and extends the College's condolences to his family and his life-long medical group partners.

*Action:* A framed resolution was sent to Dr. Nice's family.

**Resolution 57 Commendation for Raymond L. Fowler MD, FACEP, FAEMS**

RESOLVED, That the American College of Emergency Physicians commends Raymond Logan Fowler, MD, FACEP, FAEMS, for his outstanding service and commitment to the College, the specialty of emergency medicine, the subspecialty of EMS medicine, and his patients

*Action:* A framed resolution was sent to Dr. Fowler.

**Resolution 58 In Memory of Bradley Middleton, MD**

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Bradley Middleton, MD, whose short career touched many lives; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife Liz, their daughters Penelope (3) and Mae (2), and son Vander (2 months), as well as the extended Middleton and West families, gratitude for his tremendous service to emergency medicine.

*Action:* A framed resolution was sent to Dr. Middleton's family.

**Resolution 59 In Memory of Ann L. Harwood-Nuss, MD**

RESOLVED, That the American College of Emergency Physicians remembers with honor and appreciation the accomplishments and contributions of a gifted emergency physician, Ann Harwood-Nuss, MD, and extends condolences and gratitude to her husband, Robert C. Nuss, MD; her step-daughters Jennifer Nuss, and Robin Gefin; her brothers George, John, David, and Donald Harwood; family; friends; and colleagues for her remarkable service to the specialty of emergency medicine, patient care, and the communities she served so well.

*Action:* A framed resolution was sent to Dr. Harwood-Nuss's family.

**Resolution 60 In Memory of Frank S. Pettyjohn, MD**

RESOLVED, That the American College of Emergency Physicians honors and commends Frank S. Pettyjohn, MD, who dedicated his life to emergency medicine and was critical in its inception, and offers our sincerest condolences to his beloved family, both at home and in the emergency department.

*Action:* A framed resolution was sent to Dr. Pettyjohn's family.

**Resolution 61 ACEP Financial Decision Transparency (as amended)**

RESOLVED, That ACEP suspend passing on credit processing fees pending an open comment period from member chapters; and be it further

RESOLVED, That ACEP provide a substantial notice period to chapters and/or sections before passing on costs to allow for budgeting; and be it further

RESOLVED, That ACEP evaluate mechanisms for improved communication between ACEP and chapter leaders and representatives to increase transparency to the membership regarding dues related fees.

*Action:* The Executive Committee met on October 8, 2023, and adopted a motion to suspend the decision to require chapters to pay the credit card processing fees for their chapter membership dues. This decision was ratified by the Board of Directors on October 12, 2023. The following message was distributed to chapters on October 18, 2023: "The ACEP Board respects the Council resolution and has suspended the implementation of asking chapters to cover their own credit card fees beginning January 1, 2024. Discussions on this will continue and additional chapter leader and executive feedback will be included prior to any new decisions being made. In addition, the Board and staff will continue to investigate the feasibility of providing alternative payment options with lower fees to help reduce this burden on ACEP and its chapters."

A new payment option for membership dues was implemented effective February 5, 2024, to allow ACH transfers, also known as electronic bank drafts. ACH transfers are electronic, bank-to-bank money transfers processed through the Automated Clearing House (ACH) Network. This new payment option is now available on the membership application for new and renewing members. Staff are working on adding this option to My Account so that members using installments and auto-renew can easily update their payment information. Work is also underway to incentivize members to choose ACH payments instead of credit card payments.

The Board discussed chapter credit card fees on April 17, 2024, and approved giving chapters notice of the plan to withhold their portion of the credit card fees related to membership and state PAC transactions starting July 1, 2025. Chapters were notified of this intent and provided a comment period through May 31, 2024, to submit feedback, ask questions, and offer ideas on how national ACEP and chapters can work together to incentivize use of ACH payments, increase membership, or reduce costs.

The Board discussed chapter relations and next steps that could be taken to improve relations based on feedback received from several large chapters and the need for effective, bidirectional, consistent, and active communications to help achieve trust between chapters and national ACEP during the June 26-27, 2024, Board meeting. The Board also discussed the possibility of deferring or eliminating the pass through of credit card fees and the possibility of reinvesting the recovered fees into support for the chapters such as through staff time, new services, scalable technologies, better reporting, or accelerating the AMS project. It was acknowledged that recent budget constraints, staff turnover, and technology challenges have impacted ACEP's ability to consistently meet chapter expectations. Staff continued working to prioritize chapter needs, finding the best ways to communicate, promoting the use of ACH to reduce the credit card fees, and continuing to investigate the possibility of charging a processing fee or the ability for members to pay the credit card processing fee at the time of any transactions. Discussions with individual chapters continued and additional feedback sought to assess possible improvements for two-way communication throughout the year.

During the fall of 2024, staff implemented verbiage on the checkout for membership, meeting registration, and group billing that actively explains to members why choosing payment by bank account (ACH) helps more of their dollars

go towards ACEP's mission. Promotion of ACH is also included in ACEP's series of emails sent to members during their membership renewal cycle. Chapter Leaders were notified and provided with suggested similar language to include in their member communications to encourage use of ACH. Legal and technical research into the feasibility of three different ways to pass through the credit card fees directly to members was conducted, as well as the approximate percentage of members that would need to move to ACH to reduce fees significantly enough to cover the chapters' portion. Current system limitations and the difficulty of keeping up with 50 different state laws would require a significant amount of overhead effort. ACEP will continue to investigate options for members to voluntarily pay the fees.

Despite efforts by ACEP to offer and publicize the ACH option, uptake has been limited. Members have expressed security concerns and many prefer to use their credit card to receive points or miles. Staff modeled out the possible impact of implementing a cash discount (legally preferable over service charge/convenience fee), which showed a high threshold of over 50% uptake to save the $150,000 that would otherwise be passed through to chapters.

In January and February 2025, chapter executives and chapter leaders were separately presented with the results of staff research regarding the legal and technical options. No additional feedback or concerns were raised during or after those calls. Chapters were encouraged to help incentivize or communicate ACH as a payment method.

Chapters were notified on May 7, 2025, of the Board's April 30, 2025, decision that beginning July 1, 2026, chapters will be responsible for paying the credit card processing fees (3%) for transactions associated with their own portion of membership dues (chapter dues) and chapter PAC contributions (if ACEP collects the dues on behalf of the chapter). ACEP will continue to pay for the credit card processing fees (3%) associated with its own portion of membership dues (National dues) and NEMPAC contributions. ACEP will continue encouraging members to opt in for ACH/bank payment as they renew their membership, through timely automated messaging and on-screen reminders during checkout. As of April 1, 2025, ACH/bank payment is the default payment option instead of credit card. Chapters received in June 2025 their actual dues and PAC contribution amounts collected by credit card during the 18-month period between July 1, 2023, and December 30, 2024, to assist chapters with budgeting. The fees will be deducted from chapter monthly direct deposits starting in August 2026 for July transactions and itemized on their monthly statements.

Chapters were also notified on May 7, 2025, of the Board's decision to implement a 3% national dues increase for regular members effective July 1, 2025. No changes were made to candidate or international member dues.

---

## Resolutions Referred to the Board of Directors

### Resolution 23 Opposing Sale-Leaseback Transactions by Health Systems

RESOLVED, That ACEP advocate for regulatory agencies and other entities, as appropriate, to closely monitor, discourage, and oppose sale-leaseback transactions involving health systems, ensuring transparency, accountability, and consideration of the long-term impact on patient care and health care infrastructure.

*Action:* Assigned to Advocacy & Practice Affairs staff to review the referred resolution and provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution.

### Resolution 27 Addressing Interhospital Transfer Challenges for Rural EDs (as amended)

RESOLVED, That ACEP work with state and federal agencies to ~~create~~ **advocate for** state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems and to report their activities publicly; and be it further

RESOLVED, That ACEP advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not available at the referring hospital, ~~even when capacity is limited at the tertiary center~~; and be it further

RESOLVED, That ACEP advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined as patient catchment areas rather than jurisdictional boundaries; and be it further

RESOLVED, That ACEP support research to strengthen the evidence base regarding rural hospital transfer processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes and experience and include investigation of common challenges experienced by all small, non-networked hospitals~~; and be it further~~

~~RESOLVED, That ACEP create a task force to examine current models and existing research yielding detailed recommendations for ACEP advocacy efforts regarding interhospital transfer challenges for rural EDs and the task force should:~~

- ~~Examine existing and theoretical transfer models to identify best practices, including coordination of transfers across state borders.~~
- ~~Enumerate and endorse effective mechanisms to facilitate tertiary care hospitals' acceptance of patients in transfer with time-sensitive conditions who are initially treated at EDs without needed services.~~
- ~~Identify key capacity measures for public reporting of hospital capacity limitations, and propose mechanisms to create and sustain appropriate state/regional dashboards.~~

*Action:* Assigned to the Federal Government Affairs Committee and the State Legislative/Regulatory Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution. A recommendation to implement the referred resolution with additional edits was submitted to the Board of Directors for consideration at their September 26, 2024, meeting. The Board approved the committee's recommendation to amend the referred resolution to read:

RESOLVED, That ACEP work with state and federal agencies to advocate for state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems; and be it further

RESOLVED, That ACEP advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from hospitals when the patient needs an emergency intervention not available at the referring hospital; and be it further

RESOLVED, That ACEP advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease); and be it further

RESOLVED, That ACEP support research to strengthen the evidence base regarding hospital transfer processes including delays, administrative burden on sending hospitals, and association with patient outcomes and experience.

Implementation of the resolution was assigned to Advocacy & Practice Affairs staff for federal and state advocacy work and creating a workgroup consisting of subject matter experts from the Federal Government Affairs Committee, State Legislative/Regulatory Committee, and the Medical-Legal Committee to develop the guidance or best practices to establish appropriate procedures to avoid EMTALA violations. An objective was assigned to the committees. The committees are continuing to work on the resolution in the 2024-25 committee year.

**Resolution 39 Medicaid Reimbursement for Emergency Services (as amended) – *second resolved***

RESOLVED, That ACEP work with the AMA to assist states with model legislation and regulatory language to require that all publicly funded insurance plans be reimbursed at a minimum of 100% of the prevailing Medicare rate.

*Action:* Assigned to the AMA Section Council on Emergency Medicine to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution.

**Resolution 44 Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss (as amended)**

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is medication management initiated in the emergency department by an emergency physician safe and effective compared to expectant management?; and be it further

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is procedural management in the emergency department by an emergency physician safe and effective compared to expectant management?

*Action:* Assigned to the Clinical Policies Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution. ACEP's current "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" is based on two critical questions:

1. Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the ED with abdominal pain and/or vaginal bleeding and a β-hCG level below a discriminatory threshold?
2. In patients who have an indeterminate transvaginal ultrasound result, what is the diagnostic utility of β-hCG for predicting possible ectopic pregnancy?

This clinical policy was approved in 2016 and is currently in the process of being updated. The writing group has decided to proceed with updating the clinical policy to include a single critical question regarding the safety of imaging

modalities in suspected pulmonary embolism. In accordance with the Clinical Policies Committee procedures, the critical questions called for in this resolution would require development of two new single-question clinical policies.

The Clinical Policies Committee and the Writing Committee on Early Pregnancy reviewed the resolution, conducted a review of the current literature on the topic in emergency medicine, and discussed the possibility of creating a robust clinical policy regarding the management of early pregnancy loss in the emergency department. In the literature review process, we identified the most current reaffirmed policy statement on early pregnancy loss management from the American College of Obstetricians and Gynecologists (ACOG) from 2018. ACOG does not have guidelines or policies regarding this topic. A Cochrane review on the topic was identified, but the included studies were not specific to emergency medicine and were critically appraised (graded) as low quality by their reviewers, and was last updated in 2012. It was also noted there is little literature (and no quality literature) on early pregnancy loss management in the emergency department. The remaining literature is written from the perspective of obstetrics and, even then, is poor quality. Based on the lack of sufficient quality literature to inform a clinical policy recommendation, the Clinical Policies Committee recommended that development of a clinical policy not be pursued and that a policy statement be developed regarding the role of emergency physicians in treating and evaluating patients presenting with early pregnancy loss as directed in Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss. The Board of Directors affirmed the findings of the Clinical Policies Committee in April 2024.

**Resolution 49 Patients Leaving the ED Prior to Completion of Care Against Medical Advice (as amended)**

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department prior to completion of care may not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, and all indicated consults; and be it further

RESOLVED, That ACEP ~~create a document acknowledging that physicians and hospitals/systems share a joint responsibility to notify patients who have left prior to the completion of care regarding testing requiring intervention that results after their departure and develop reasonable systems to help communicate these results~~ **work with relevant stakeholders such as the American Hospital Association to create a document or tool outlining responsibilities and systems of communication for the conveyance of information about testing and follow up of patients who leave the emergency department prior to the completion of care**; and be it further

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department prior to completion of ~~care~~ **evaluation and treatment bear ~~some~~ responsibility for ongoing care and** may not have all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.

*Action:* Assigned to the Emergency Medicine Practice Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution. The committee continues to work on the resolution in the 2024-25 committee year.

**Resolution 50 Metric Shaming (as amended)**

RESOLVED, That ACEP develop practices and policies to prevent the ~~publishing~~ **public or external publication**, ~~transmitting~~ **transmission**, and/or ~~releasing~~ **release** of unblinded metric-related **productivity** information about individual emergency physician performance to safeguard the welfare of our membership.

*Action:* Assigned to the Emergency Medicine Practice Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution. The committee plans to submit a revised policy statement to the Board of Directors for discussion at their April 30, 2025, meeting.

*Note: ABEM provided the following information to ACEP:*

> ABEM publicly reports physician certification status, which is a physician-specific metric. This practice is a service to hospital systems, crendentialers, and the certified physicians themselves. ABEM does not publicly report the names of any physicians who are not certified, nor does ABEM publicly provide any information about the specific level of performance on any ABEM assessment. We believe that most physicians take personal and professional pride in the accomplishment of ABEM certification. Moreover, ABEM posts the names of all physicians who have been ABEM-certified for at least 30 years.

**Resolution 62 Cooperation Between National ACEP and State Chapters**

RESOLVED, That ACEP staff revise the membership payment process to allow members to voluntarily pay for any credit card fees that are permitted to be passed on to the member and then require each state chapter to pay for any fees not paid.

*Action:* Assigned to membership, legal, technology, and accounting staff to provide an update and recommendation to the Board of Directors regarding the implementation of initiatives to address the resolution. Staff have researched the feasibility of such an option and various state laws make implementation of this resolution of questionable legality, and if legal, complicated to implement. The flexibility of ACEP's current membership system is significantly limited. Any changes to the checkout process and/or dynamic logic regarding pricing require several sprints of IT development. Chapter executives have been involved in the requirements gathering process for the new membership system, which will be implemented in the next few years.

A new payment option for membership dues was implemented effective February 5, 2024, to allow ACH transfers, also known as electronic bank drafts. ACH transfers are electronic, bank-to-bank money transfers processed through the Automated Clearing House (ACH) Network. This new payment option is now available on the membership application for new and renewing members. Staff are working on adding this option to My Account so that members using installments and auto-renew can easily update their payment information. Work is also underway to incentivize members to choose ACH payments instead of credit card payments.

The Board discussed chapter credit card fees on April 17, 2024, and approved giving chapters notice of the plan to withhold their portion of the credit card fees related to membership and state PAC transactions starting July 1, 2025. Chapters were notified of this intent and provided a comment period through May 31, 2024, to submit feedback, ask questions, and offer ideas on how national ACEP and chapters can work together to incentivize use of ACH payments, increase membership, or reduce costs.

The Board discussed the possibility of deferring or eliminating the pass through of credit card fees and the possibility of reinvesting the recovered fees into support for the chapters such as through staff time, new services, scalable technologies, better reporting, or accelerating the AMS project during the June 26-27, 2024, Board meeting. It was acknowledged that recent budget constraints, staff turnover, and technology challenges have impacted ACEP's ability to consistently meet chapter expectations. Staff continued working to prioritize chapter needs, finding the best ways to communicate, promoting the use of ACH to reduce the credit card fees, and continuing to investigate the possibility of charging a processing fee or the ability for members to pay the credit card processing fee at the time of any transactions.

During the fall of 2024, staff implemented verbiage on the checkout for membership, meeting registration, and group billing that actively explains to members why choosing payment by bank account (ACH) helps more of their dollars go towards ACEP's mission. Promotion of ACH is also included in ACEP's series of emails sent to members during their membership renewal cycle. Chapter Leaders were notified and provided with suggested similar language to include in their member communications to encourage use of ACH. Legal and technical research into the feasibility of three different ways to pass through the credit card fees directly to members was conducted, as well as the approximate percentage of members that would need to move to ACH to reduce fees significantly enough to cover the chapters' portion. Current system limitations and the difficulty of keeping up with 50 different state laws would require a significant amount of overhead effort. ACEP will continue to investigate options for members to voluntarily pay the fees.

Despite efforts by ACEP to offer and publicize the ACH option, uptake has been limited. Members have expressed security concerns and many prefer to use their credit card to receive points or miles. Staff modeled out the possible impact of implementing a cash discount (legally preferable over service charge/convenience fee), which showed a high threshold of over 50% uptake to save the $150,000 that would otherwise be passed through to chapters.

In January and February 2025, chapter executives and chapter leaders were separately presented with the results of staff research regarding the legal and technical options. No additional feedback or concerns were raised during or after those calls. Chapters were encouraged to help incentivize or communicate ACH as a payment method.

Chapters were notified on May 7, 2025, of the Board's April 30, 2025, decision that beginning July 1, 2026, chapters will be responsible for paying the credit card processing fees (3%) for transactions associated with their own portion of membership dues (chapter dues) and chapter PAC contributions (if ACEP collects the dues on behalf of the chapter). ACEP will continue to pay for the credit card processing fees (3%) associated with its own portion of membership dues (National dues) and NEMPAC contributions. ACEP will continue encouraging members to opt in for ACH/bank payment as they renew their membership, through timely automated messaging and on-screen reminders during checkout. As of April 1, 2025, ACH/bank payment is the default payment option instead of credit card. Chapters received in June 2025 their actual dues and PAC contribution amounts collected by credit card during the 18-month period between July 1, 2023, and December 30, 2024, to assist chapters with budgeting. The fees will be deducted from chapter monthly direct deposits starting in August 2026 for July transactions and itemized on their monthly statements.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Memorandum

**To:** 2025 Council

**From:** Sandra M. Schneider, MD, FACEP
Interim Executive Director

**Date:** August 7, 2025

**Subj:** Action on 2022 Resolutions

The 2022 Council considered 65 resolutions: 45 were adopted, 17 were not adopted, and four were referred to the Board of Directors. There are five commendation resolutions, 10 memorial resolutions, one Bylaws resolution, and two Council Standing Rules resolutions.

*Note: The first resolved of Resolution 19 was not adopted and the second resolved was adopted as amended.*

The attached report summarizes the actions taken on the 2022 resolutions adopted by the Council and those that were referred to the Board of Directors. The updated actions are also available on the ACEP website. Scroll to the end of each resolution to see amended or substituted language and to see the implementation action.

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
Alison J. Haddock, MD, FACEP
*President*
L. Anthony Cirillo, MD, FACEP
*President-Elect*
Gabor D. Kelen, MD, FACEP
*Chair of the Board*
Jeffrey M. Goodloe, MD, FACEP
*Vice President – Communications*
Kristin B. McCabe-Kline, MD, FACEP
*Vice President – Membership*
Heidi C. Knowles, MS, MD, FACEP
*Secretary-Treasurer*
Aisha T. Terry, MD, MPH, FACEP
*Immediate Past President*
Jennifer J. Casaletto, MD, FACEP
C. Ryan Keay, MD, FACEP
Chadd K. Kraus, DO, DrPH, CPE, FACEP
Abhi Mehrotra, MD, MBA, FACEP
Diana B. Nordlund, DO, JD, FACEP
Henry Z. Pitzele, MD, FACEP
James L. Shoemaker, Jr., MD, FACEP
Ryan A. Stanton, MD, FACEP

COUNCIL OFFICERS
Melissa W. Costello, MD, FACEP
*Speaker*
Michael J. McCrea, MD, FACEP
*Vice Speaker*

INTERIM EXECUTIVE DIRECTOR
Sandra M. Schneider, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Action on 2022 Council Resolutions

**Resolution 1 Commendation for Michael L. Callaham, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the contributions of Michael L. Callaham, MD, FACEP, to the advancement of science and success of *Annals of Emergency Medicine*; and be it further

RESOLVED, That the American College of Emergency Physicians commends Michael L. Callaham, MD, FACEP, for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

*Action:* A framed resolution was sent to Dr. Callaham.

**Resolution 2 Commendation for Virginia Kennedy Palys, JD**

RESOLVED, That the American College of Emergency Physicians commends Virginia (Ginny) Kennedy Palys, JD, for her career of dedicated service, outstanding leadership, commitment to the College, the emergency physicians of Illinois, the specialty of emergency medicine, and the patients that we serve.

*Action:* A framed resolution was sent to Ms. Kennedy-Palys.

**Resolution 3 Commendation for Commendation Paul Pomeroy, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians commends Paul R Pomeroy, Jr., MD, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

*Action:* A framed resolution was sent to Dr. Pomeroy.

**Resolution 4 Commendation for Loren Rives, MNA**

RESOLVED, That the American College of Emergency Physicians commends Loren Rives, MNA, for her outstanding service and commitment to the College and the specialty of emergency medicine.

*Action:* A framed resolution was sent to Ms. Rives.

**Resolution 5 Commendation for Mark S. Rosenberg, MD, MBA, FACEP**

RESOLVED, That the American College of Emergency Physicians commends Mark S. Rosenberg, DO, MBA, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

*Action:* A framed resolution was presented to Dr. Rosenberg.

**Resolution 6 In Memory of Carey D. Chisholm, MD**

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Carey D. Chisholm, MD, to the specialty of emergency medicine, especially as an educator, and extends the College's condolences to his wife of almost 40 years, Robin Chisholm, as well as to their daughters, Kelsey and Tyler.

*Action:* A framed resolution was sent to Dr. Chisholm's family.

**Resolution 7 In Memory of Loren A. Crown, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Loren A. Crown, MD, FACEP, and extends condolences and gratitude to his wife, Elaine Kathleen Ellis, family, and friends for his service to the specialty of emergency medicine and to patient care.

*Action:* A framed resolution was sent to Dr. Crown's family.

**Resolution 8 In Memory of Sherill Mullenix**

RESOLVED, That the American College of Emergency Physicians, the Delaware Chapter, and the friends and colleagues of Sherrill Mullenix recognizes her longstanding dedication and incredible contributions to the current state and the future of emergency medicine and acknowledges that she is irreplaceable and is missed.

*Action:* A framed resolution was sent to Ms. Mullenix's family.

**Resolution 9 In Memory of Adetolu "Tolu" Odufuye, MD**

RESOLVED, That the American College of Emergency Physicians extends to the family of Adetolu "Tolu" Odufuye MD, FACEP, her friends, and her colleagues our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the patients and physicians of Florida and the United States.

*Action:* A framed resolution was sent to Dr. Odufuye's family.

**Resolution 11 Establishing a Young Physician Position on the ACEP Nominating Committee**

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 7 – Nominating Committee be amended to read:

A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members**, at least one of which shall be a young physician, defined as a member under the age of 40 or within the first ten years of practice,** and the president shall appoint the president-elect plus two additional Board members. A member of the College cannot concurrently accept nomination to the Board of Directors and Council Office. Nominations will also be accepted from the floor.

*Action:* The Bylaws were updated.

**Resolution 15 Electronic Voting During the Council Meeting – Council Standing Rules Amendment (as amended)**

RESOLVED, That the ACEP Council Standing Rules, "Election Procedures" section, paragraph one, and the "Voting on Resolutions and Motions" first paragraph be amended to read:

**Election Procedures**

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot**, which may include remote communication and voting technology**. There shall be no write-in voting. **Individual connectivity issues or individual disruption of remote communication technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the Speaker.**

**Voting on Resolutions and Motions**

Voting may be accomplished by an electronic voting system, **including remote communication technology,** voting cards, standing, or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue. **Individual connectivity issues or individual disruption of remote communication and voting technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the Speaker.**

*Action:* The Council Standing Rules were updated.

**Resolution 16 Required Candidate Campaign Materials from Floor Candidates**

RESOLVED, That the ACEP Council Standing Rules, "Nominations" section, be amended to read:

**Nominations**

A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, past speaker, or past chair of the Board, after which nominations will be closed and shall not be reopened.

Members not nominated by the Nominating Committee may **self-nominate by** declar~~e~~**ing** themselves "floor candidates" at any time after the release of the Nominating Committee report and before the speaker closes nominations during the Council meeting. All floor candidates must notify the Council speaker in writing. Upon receipt of this notification, the candidate becomes a "declared floor candidate," has all the rights and responsibilities of candidates otherwise nominated by the Nominating Committee, and must comply with all rules and requirements of the candidates. **All required candidate materials (including but not limited to professional photo, CV, Candidate Campaign Rules Attestation, responses to written questions, candidate data sheet, conflict of interest disclosure statement) must be available immediately at the time of floor nomination – either completed by the due date for all nominees or at the time of notification to the Speaker of intent to seek nomination, whichever date is later.**

*Action:* The Council Standing Rules were updated.

**Resolution 17 Criteria for the Location of Future National ACEP Events (as substituted)**

RESOLVED, That in considering where to schedule future national level ACEP events, ACEP shall take into consideration whether that location restricts access to reproductive health care.

*Action:* Assigned to educational meetings staff to consider when developing recommendations for future national ACEP meetings.

**Resolution 19 Due Process and Interaction with ACEP (as amended) – *second resolved***

RESOLVED, That ACEP create a method for members to report incidents of denial of due process, review member-submitted contractual clauses, or other methods of denying such that are of concern.

*Action:* Assigned to legal staff to guide the appropriate development and implementation of this reporting mechanism for members.

There are a growing number of resources available on the ACEP website dedicated to the topics of employment contracts and other practice and legal issues, including a checklist to negotiate the best contract and an on-demand course on standard contract provisions. The site also includes a list of local attorneys available to review contracts and assist with other legal matters. In addition, ACEP partnered with Resolve, a well-established physician contract review service, in March 2023, to provide all ACEP members a 20% discount on contract review services, ranging in price from $499 to $1,999 based on the complexity of review required. Resolve also provides insight into compensation data and the competitiveness of other terms in the contract. The service was tested by two ACEP members needing contract review for their real-life employment agreements prior to finalizing the partnership and both members had positive feedback about their experiences.

**Resolution 24 Access to Reproductive Rights (as amended)**

RESOLVED, That ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

*Action:* Assigned to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP's policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care. Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

In October 2022, ACEP responded to a Department of Veterans Affairs (VA) interim final rule in which VA proposed to amend its medical regulations to establish exceptions to the exclusion on abortions and remove the exclusion on abortion counseling in the medical benefits package for veterans who receive care set forth in that package, and to expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries and remove the exclusion on abortion counseling.

In December 2022, ACEP provided input for the American Medical Association (AMA) Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted noting the passage of this resolution and iterating ACEP's commitment to support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

The Emergency Medicine Reproductive Health & Patient Safety Task Force developed a new and comprehensive policy statement "Access to Reproductive Healthcare in the Emergency Department" that includes and expands on the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy." The new policy statement is intended to focus on protecting the patient-physician relationship, which will allow it to be used to

serve patients throughout the United States. The policy statement was approved by the Board in June 2023. Elements of the new policy statement were used in ACEP's response to HIPAA Privacy Rule to Support Reproductive Health Care Privacy.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress include "enact liability immunity for physicians providing EMTALA-mandated services, with considerations for reproductive health and patient safety related emergencies" and "monitor new guidance and proposed regulations released by the Administration on reproductive health and patient safety related emergencies."

**Resolution 25 Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care (as amended)**

RESOLVED, That ACEP affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure; and be it further

RESOLVED, That ACEP support the position that the early termination of pregnancy (publicly referred to as "abortion") is a medical procedure, and as such, involves shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients; and be it further

RESOLVED, That ACEP oppose statutory provision of criminal penalties for any medically appropriate care provided in the emergency department and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, which includes, but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss; and be it further

RESOLVED, That ACEP specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals; and be it further

RESOLVED, That ACEP support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care.

*Action:* Assigned to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP's policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care. Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

In October 2022, ACEP responded to a Department of Veterans Affairs (VA) interim final rule in which VA proposed to amend its medical regulations to establish exceptions to the exclusion on abortions and remove the exclusion on abortion counseling in the medical benefits package for veterans who receive care set forth in that package, and to expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries and remove the exclusion on abortion counseling.

In December 2022, ACEP provided input for the American Medical Association (AMA) Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted noting the passage of this resolution and iterating ACEP's commitment to support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

The Emergency Medicine Reproductive Health & Patient Safety Task Force developed a new and comprehensive policy statement "Access to Reproductive Healthcare in the Emergency Department" that includes and expands on the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy." The new policy statement is intended to focus on protecting the patient-physician relationship, which will allow it to be used to serve patients throughout the United States. The policy statement was approved by the Board in June 2023. Elements of the new policy statement were used in ACEP's response to HIPAA Privacy Rule to Support Reproductive Health Care Privacy, specifically regarding a proposed prohibition on use or disclosure of PHI, in accordance with the 3rd and 4th resolveds.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress includes "enact liability immunity for physicians providing EMTALA-mandated services, with considerations for reproductive health and patient safety related emergencies" and "monitor new guidance and proposed regulations released by the Administration on

reproductive health and patient safety related emergencies."

**Resolution 26 Promoting Safe Reproductive Health Care for Patients (as amended)**

RESOLVED, That ACEP encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; and be it further

RESOLVED, That ACEP continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and be it further.

RESOLVED, That ACEP support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

*Action:* Assigned to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP's policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care. Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

The Emergency Medicine Reproductive Health & Patient Safety Task Force developed a new and comprehensive policy statement "Access to Reproductive Healthcare in the Emergency Department" that includes and expands on the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy." The new policy statement is intended to focus on protecting the patient-physician relationship, which will allow it to be used to serve patients throughout the United States. The policy statement was approved by the Board in June 2023. Elements of the new policy statement were used in ACEP's response to HIPAA Privacy Rule to Support Reproductive Health Care Privacy, specifically in support of legal protections in accordance with the 3rd resolved.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress includes "enact liability immunity for physicians providing EMTALA-mandated services, with considerations for reproductive health and patient safety related emergencies" and "monitor new guidance and proposed regulations released by the Administration on reproductive health and patient safety related emergencies."

**Resolution 27 Equitable Access to Emergency Contraception in the ED**

RESOLVED, That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and be it further

RESOLVED, ACEP advocate for universal access to emergency contraception in the emergency department.

*Action:* Assigned first resolved to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP's policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care. Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

In October 2022, ACEP responded to a Department of Veterans Affairs (VA) interim final rule in which VA proposed to amend its medical regulations to establish exceptions to the exclusion on abortions and remove the exclusion on abortion counseling in the medical benefits package for veterans who receive care set forth in that package, and to expand the exceptions to the exclusion on abortions for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries and remove the exclusion on abortion counseling.

In December 2022, ACEP provided input for the American Medical Association (AMA) Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted noting the passage of this resolution and iterating ACEP's commitment to support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

The Emergency Medicine Reproductive Health & Patient Safety Task Force developed a new and comprehensive policy statement "Access to Reproductive Healthcare in the Emergency Department" that includes and expands on the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy." The new policy statement is intended to focus on protecting the patient-physician relationship, which will allow it to be used to serve patients throughout the United States. The policy statement was approved by the Board in June 2023.

**Resolution 28 Billing and Collections Transparency and Interaction with ACEP (as amended)**

RESOLVED, That ACEP advocate to establish the requirement that revenue cycle management entities will,

upon request, directly provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal, state, and local advocacy initiatives, in accordance with ACEP's policy statement "Emergency Physician Contractual Relationships" and the associated Policy Resource and Education Paper (PREP) supporting the rights of an emergency physician to review what is billed and collected in their name. ACEP continues to advocate for the importance of billings and collections transparency. One of the questions employers, including revenue cycle management entities, are asked as part of ACEP's Open Book project is to identify if, and how often, physicians in their group are provided with billing and collections data. . ACEP has raised and highlighted this policy with federal legislators in related discussions on transparency and billing practices and continues working to identify possible federal pathways to achieve these goals.

**Resolution 29 Buprenorphine is an Essential Medicine and Should be Stocked in Every ED**

RESOLVED, That ACEP advocate on behalf of its patients and members that the FDA add buprenorphine to its list of essential medications; and be it further

RESOLVED, That ACEP recommend and advocate that every emergency department stock buprenorphine and medications for opioid use disorder so that patients with opioid use disorder or in opioid withdrawal may receive the best evidence-based care; and be it further

RESOLVED, That ACEP work with the American Hospital Association, American Medical Association, state agencies, and federal agencies to promote availability of medications for opioid use disorder in emergency departments and hospital settings; and be it further

RESOLVED, That ACEP support hospitals and emergency physicians in initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder to enhance best evidence-based practices in emergency medicine throughout the United States.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Administration (DEA) issued guidance on the removal of the X-waiver on January 12, 2023. This is an ACEP priority that was included in the Consolidated Appropriations Act, 2023. **ACEP has advocated for years for Congress to repeal the X-waiver requirement, which was a significant barrier to the treatment of opioid use disorder and contributed to stigma around the disease. ACEP contacted** SAMSHA and the DEA immediately upon the passage of the legislation to request that they issue guidance effectuating the policy change as soon as possible. As stated in the guidance, **an X-waiver is no longer required to treat patients with buprenorphine for opioid use disorder**. Going forward, all prescriptions for buprenorphine will only require a standard DEA registration number. There are no longer any limits or patient caps on the number of patients a prescriber may treat for opioid use disorder with buprenorphine. Existing state laws or regulations still apply. SAMHSA also will no longer be accepting new waiver applications. Separately, the Consolidated Appropriations Act, 2023 also introduced new training requirements for all prescribers. These requirements were effective June 21, 2023. The DEA and SAMHSA are actively working to provide further guidance and DEA will follow up with additional information on the requirements. All physicians and other health care professionals with a regular DEA license can now prescribe buprenorphine. ACEP developed a BUPE point-of care tool and training courses to provide best practices and the most up-to-date evidence-based protocols regarding this treatment.

ACEP submitted a letter to the Food and Drug Administration (FDA) on February 15, 2023, asking the agency to add buprenorphine to the list of essential medicines. The FDA list is often used as a reference for what EDs are required to stock, and because buprenorphine is not currently recognized as an essential medicine, many EDs do not carry it and are not required to stock buprenorphine and other medications for opioid use disorder by accrediting bodies or government agencies. Also, since buprenorphine is classified as a "suspicious order" according to current Drug Enforcement Agency (DEA) regulations, many community pharmacies are hesitant to stock it, and there is a misperception that there are limits around how much of the medication pharmacies can carry at one time. Adding buprenorphine to the list of essential medicines would help address these barriers and ensure that individuals are able to access this important medication.

ACEP advocacy resulted in an additional $7.4 million in Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding for Emergency Department Alternative to Opioids (ALTO) programs and an additional $18.4 million for programs providing Medication-Assisted Treatment (MAT). ACEP developed, advocated for, and secured enactment of the law passed by Congress in 2018 to establish the ALTO grant program, and successfully advocated for follow-up legislation with a $2 million funding increase to make the emergency physician-led program permanent. We also strongly supported MAT expansion – including the recent repeal of the "X-waiver" to prescribe buprenorphine.

ACEP also supported a congressional letter sent to the FDA in January 2024, urging the FDA to add medications for opioid use disorder (MOUD) including buprenorphine and methadone to the List of Essential Medicines.

ACEP's legislative and regulatory priorities for the 119th Congress include:

1) Ensure the appropriate implementation of the mental health provisions within the "Consolidated Appropriations Act, 2023" including the removal of the X-waiver requirement and the addition of the new 8-hour education requirement, as well as ensuring appropriate access to medications for opioid use disorder (MOUD).
2) Work with FDA to reduce drug shortages/opioid use disorder.
3) Continue to work with other specialty societies/share efforts to reduce opioid use disorder and improve physician and public education on alternative forms of pain management.
4) As detailed in a December 2024 letter to congressional champions on improving buprenorphine access, ACEP continues advocating to ensure that buprenorphine is considered an essential medicine by the FDA, and to ensure that buprenorphine is not flagged as a "suspicious order" under the U.S. Drug Enforcement Administration (DEA) Suspicious Orders Report System (SORS). ACEP also endorses federal legislative efforts like the Broadening Utilization of Proven and Effective Treatment (BUPE) for Recovery Act (H.R. 9886/S. 5271 in the 118th Congress) to temporarily exempt buprenorphine from SORS during the public health emergency to help reduce barriers to buprenorphine stocking.

**Resolution 32 Supervised Consumption Facilities/Safe Injection Sites**

RESOLVED, That ACEP support the development and implementation of Supervised Consumption Facilities/Supervised Injection Sites (SCF/SIS) in the United States that would be designed, monitored, and evaluated to include additional data to inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harm and health care costs related to injection drug use.

*Action:* Assigned to the Public Health & Injury Prevention Committee to develop a policy statement in support of supervised consumption facilities/supervised injection sites. The committee developed the policy statement "Overdose Prevention Centers" and it was approved by the Board of Directors on October 6, 2023.

**Resolution 33 Telehealth Bridge Model for the Treatment of Opioid Use Disorder**

RESOLVED, That ACEP support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder care; and be it further

RESOLVED, That ACEP advocate for state and federal regulatory and legislative solutions that will permit the ongoing integration of opioid use disorder treatment including medication therapy through telehealth into the continuum of addiction care.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives and consult with the Emergency Telehealth Section.

ACEP responded on March 28, 2023, to a proposed rule issued by the DEA regarding the continued use of telehealth to prescribe buprenorphine in cases where patients have never before been treated in-person by the prescriber. Comments focused on: 1) ***Advocating for a 90-day instead of a 30-Day Prescription Limit:*** The DEA is proposing to continue to allow the use of telemedicine to initially prescribe buprenorphine for the treatment of MOUD. However, in these circumstances, the DEA is proposing a prescription limit of 30 days (it can be multiple prescriptions as long as the total number of days does not exceed 30), after which an in-person examination would be required in order to receive refills. ACEP has concerns about the 30-day limitation for buprenorphine prescriptions. We acknowledge the DEA's reasoning that obtaining an in-person medical appointment with a practitioner is often difficult due to the shortage of health care workers and various economic, geographical, sociological, and logistical limitations. However, these limitations are not entirely dissolved after 30 days. Many patients have transportation challenges and inflexible work schedules and must navigate finding an in-network provider that is accepting patients. It also takes significantly longer than 30 days to find an appointment in some areas. We therefore request that DEA extend the limit to 90 days so patients can more easily maneuver these logistical barriers. 2) ***Opposing the PDMP Restrictions:*** The DEA is requiring that prescribers consult a PDMP before writing the prescription. If they do not (even if the PDMP is down and is not the fault of the prescribers), the prescribers can only write a 7-day buprenorphine prescription (otherwise they can write up to a 30-day prescription). ACEP believes that PDMPs play an important role in addressing the opioid crisis as well as deaths related to other prescriptions drugs. Physicians should make good faith efforts to consult PDMPs before prescribing controlled substances. However, although instances in which a PDMP is inaccessible, such as a server outage, disconnect with the electronic medical record, or a ransomware attack, are rare, they are not impossible occurrences. Infrequent instances in which the PDMP is inaccessible should be documented but should not impede the ability to prescribe a greater supply of buprenorphine, which may cause a disruption in care. Practitioners and patients should not be punished for something out of their control, including non-operational PDMPs. Therefore, the DEA should omit this requirement from the final rule. 3) ***Pushing back against Diversion Rhetoric***: The DEA includes a discussion of buprenorphine

diversion in the proposed rule. We push back against the DEA's assertion that "diversion of buprenorphine and other prescription opioids remains an issue across the country." The DEA's evidence to make its assertions around diversion are based on findings prior to the COVID-19 public health emergency (PHE), in which flexibilities in prescriptions via telemedicine were granted. Therefore, we believe more investigation is necessary to analyze the effects of telemedicine prescribing of buprenorphine on diversion and health outcomes. There are numerous other studies that demonstrate that diversion is decreasing – and when diversion does occur, it appears from studies that individuals actually wind up using it for its intended purpose, and the only reason why it was diverted initially was because it was difficult to access through the proper channels.

In October 2023, the DEA, jointly with HHS, issued a separate temporary rule fully extending telehealth flexibilities through the end of 2024 while they consider comments received.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress include "Monitor regulations regarding telehealth in which CMS has extended waivers through the end of 2025 through the CY 2025 Physician Fee Schedule."

**Resolution 34 Emergency Department Safety**

RESOLVED, That ACEP work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

ACEP helped inform and supports the "Safety from Violence for Healthcare Employees (SAVE) Act," (H.R. 7961), bipartisan legislation re-introduced into the 118th Congress by Madeleine Dean (D-PA-04) and Larry Buschon MD (R-IN-08) in April 2023 that would establish federal criminal penalties for violence against health care workers (as this resolution seeks to do), based on federal penalties that already exist for violence against airline and airport employees. This legislation is also supported by the American Hospital Association. ACEP president Gillian Schmitz, MD, FACEP, was quoted in the press release issued previously by the sponsors of the legislation on June 7, 2022.

The "Safety from Violence for Healthcare Employees (SAVE) Act" was introduced in the Senate by Senators Marco Rubio (R-FL) and Joe Manchin (D-WV). The legislation establishes federal criminal penalties for individuals who assault health care workers and is modeled after existing protections for airline employees. This bill serves as the Senate companion to the previously-introduced House bill that ACEP advocated for during Hill visits at LAC23 in May. The Senate version is essentially identical in terms of the federal penalties language and who would be covered, but there are two key differences from the House version. The Senate bill strips out the grants for hospitals, and includes a new section requiring a GAO report on the effectiveness of criminal penalties and prosecutions for violence against health care workers. ACEP's letter of support can be found here, and ACEP President Christopher Kang, MD, FACEP, was quoted in the press release.

ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA) on January 30, 2024, as well as another briefing on July 31, 2024. ACEP also co-hosted another workplace violence congressional briefing with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA) on March 22, 2024 to highlight the issue.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress include

1) Advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED and secure new congressional champions.
2) Continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.
3) Support legislation and identify new opportunities to promote comprehensive violence prevention and intervention efforts, such as hospital-based violence intervention programs, increased community-specific resources, research funding, and educational initiatives.

ACEP has secured reintroduction of the legislative priorities we have developed and helped inform, including the bipartisan renamed "Save Healthcare Workers Act" (H.R. 3178/S. 1600), as well as the "Workplace Violence Prevention for Health Care and Social Service Workers Act" (H.R. 2531/S. 1232). ACEP federal advocacy staff continue to partner with relevant stakeholders, and will resume its workplace violence prevention coalition efforts in the second half of the first session of the 119th Congress and beyond.

**Resolution 35 Workplace Violence Towards Health Care Workers (as amended)**

RESOLVED, That ACEP advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

ACEP helped inform and supports the "Safety from Violence for Healthcare Employees (SAVE) Act," (H.R. 7961), bipartisan legislation re-introduced into the 118th Congress by Madeleine Dean (D-PA-04) and Larry Buschon MD (R-IN-08) in April, 2023 that would establish federal criminal penalties for violence against health care workers (as this resolution seeks to do), based on federal penalties that already exist for violence against airline and airport employees. This legislation is also supported by the American Hospital Association. ACEP president Gillian Schmitz, MD, FACEP, was quoted in the press release issued previously by the sponsors of the legislation on June 7, 2022.

The "Safety from Violence for Healthcare Employees (SAVE) Act" was introduced in the Senate by Senators Marco Rubio (R-FL) and Joe Manchin (D-WV). The legislation establishes federal criminal penalties for individuals who assault health care workers and is modeled after existing protections for airline employees. This bill serves as the Senate companion to the previously-introduced House bill that ACEP advocated for during Hill visits at LAC23 in May. The Senate version is essentially identical in terms of the federal penalties language and who would be covered, but there are two key differences from the House version. The Senate bill strips out the grants for hospitals, and includes a new section requiring a GAO report on the effectiveness of criminal penalties and prosecutions for violence against health care workers. ACEP's letter of support can be found here, and ACEP President Christopher Kang, MD, FACEP, was quoted in the press release.

ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA) on January 30, 2024, as well as another briefing on July 31, 2024. ACEP also co-hosted another workplace violence congressional briefing with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA) on March 22, 2024 to highlight the issue.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress include

1) Advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED and secure new congressional champions.
2) Continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.
3) Support legislation and identify new opportunities to promote comprehensive violence prevention and intervention efforts, such as hospital-based violence intervention programs, increased community-specific resources, research funding, and educational initiatives.

ACEP has secured reintroduction of the legislative priorities we have developed and helped inform, including the bipartisan renamed "Save Healthcare Workers Act" (H.R. 3178/S. 1600), as well as the "Workplace Violence Prevention for Health Care and Social Service Workers Act" (H.R. 2531/S. 1232). ACEP federal advocacy staff continue to partner with relevant stakeholders, and will resume its workplace violence prevention coalition efforts in the second half of the first session of the 119th Congress and beyond.

**Resolution 36 Emergency Medical Services Are Essential Services (as amended)**

RESOLVED, That ACEP advocate for EMS to be considered and funded as an essential service; and be it further

RESOLVED, That ACEP work with the American Medical Association, the American Hospital Association, the National Association of EMS Physicians, and other stakeholder organizations to actively promote the inclusion of Emergency Medical Services among federally and locally funded essential services, including efforts to educate the public in this regard.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

ACEP continues to advocate for EMS to be considered an essential service and ensure adequate funding and resources to support EMS, including joining coalition efforts to increase funding for the federal Emergency Medical Services for Children (EMSC) program. ACEP has also incorporated advocacy for EMS into our emergency department boarding advocacy, highlighting how the ED boarding crisis affects EMS and hinders access to this essential service in communities across the country.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress include "Support federal funding for EMS and post-crash care, EMS data systems, and inclusion of EM, other health care providers, and first responders, in development of crafting state plans under federal transportation/infrastructure efforts." Improving access to EMS has also been a core piece of ACEP's advocacy in the ongoing effort to reauthorize the Pandemic and All-Hazards Preparedness Act (PAHPA).

**Resolution 37 Enhance Patient Safety and Physician Wellness**

RESOLVED, That ACEP support the protection of all participants in discussions of cases of potential medical error, whether Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), or any patient safety forum, from legal discovery; and be it further

RESOLVED, That ACEP encourage and support state chapters in identifying pending or existing state laws limiting free discussion of cases of potential medical error in quality assurance/quality improvement, Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), and similar environments, and in lobbying against them.

*Action:* Assigned first resolved to the Medical-Legal Committee to develop a policy statement. Assigned second resolved to Advocacy & Practice Affairs staff for federal and state advocacy initiatives and to assist chapters with identifying pending or existing state laws.

The State Legislative/Regulatory Committee created a state legislative dashboard to identify existing state laws and well as pending and future legislation. The dashboard specifically looks at tort reform, mental health, healthcare staff and patient safety measures and ways to alleviate violence in the ED, as well as unnecessary and unfunded mandates on ED physicians.

The Medical-Legal Committee developed the policy statement "Legal Protection of Participants in Peer Review" and it was approved by the Board in January 2025.

**Resolution 38 Focus on Emergency Department Patient Boarding as a Health Equity Issue (as amended)**

RESOLVED, That ACEP, through legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; and be it further

RESOLVED, That ACEP publish best-practice action plans for hospitals to improve emergency department capacity; and be it further

RESOLVED, That ACEP work to define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

*Action:* Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

Assigned second and third resolveds to the ED Boarding Task Force created by ACEP President Christopher Kang, MD, FACEP. Objectives also include: 1) create an agenda for a boarding summit along with recommendations for organizations to be represented; and 2) create a list of potential solutions to boarding with an emphasis on what the state/federal government can do to reduce boarding.

ACEP President Christopher Kang, MD, FACEP, met with senior officials of the Biden Administration in mid-October 2022 to discuss several issues and specifically recommended that the White House host a summit on ED boarding and workforce issues that would bring together key stakeholders from the clinician, hospital, nursing home, emergency medical services (EMS), and patient communities to discuss potential solutions. ACEP sent a letter to the White House calling attention to the boarding problems in the U.S. and formally asked the Administration to convene a meeting of stakeholders to identify immediate and long-term solutions. Many other medical organizations signed on to the letter. ACEP also sent a letter sent to the National Governors Association on November 9, 2022, that included a copy of the White House boarding letter. A template letter was also created for ACEP chapters to share the White House letter with their individual governors. ACEP began a communications campaign in November 2022 to keep members informed of the initiatives underway to address boarding. A resource page was created on acep.org and a digital storybook to highlight many of the stories ACEP collected.

The Emergency Medicine Practice Committee developed an ED Boarding Toolkit that will be available on the ACEP Website once it is finalized. The committee also revised the "Boarding of Admitted and Intensive Care Patients in the Emergency Department" policy statement and it was approved by the Board in February 2023.

On June 21, 2023, ACEP hosted a standing-room-only congressional briefing on Capitol Hill, along with the Emergency Nurses Association and the National Alliance on Mental Illness (NAMI), entitled "A Nation in Crisis: Emergency Department Boarding."

ACEP hosted a Boarding Summit on September 27, 2023. Attendees included representatives from the Agency for Healthcare Research and Quality (AHRQ), Health & Human Services' Administration for Strategic Preparedness & Response-Biomedical Advanced Research and Development Authority (ASPR-BARDA), nursing homes/post-acute care, hospitals, psychiatry, nursing, emergency nursing, patients, National Governors' Association, Association for State and Territorial Health Officials, and others. The summit participants identified what they perceived as the causes of boarding, discussed barriers to overcome them, and then reached group consensus on areas to prioritize for addressing. The next steps include writing up a report of the Summit and creating a listserv for continued collaboration with the group and others, as appropriate, for advocating at the state and federal level. A full report of the Summit's proceedings was made available online on October 20, 2023.

ACEP has also helped develop several federal bills, including the "Improving Mental Health Access from the Emergency Department Act," that will help address various aspects of the ED boarding crisis.

HHS announced in January 2024 that it will convene stakeholders through the Agency for Healthcare Research & Quality (AHRQ) to address boarding in the ED. The AHRQ Summit on Boarding was held on October 8, 2024, and was a

direct result of ACEP advocacy.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress include:

1) Develop and promote legislative efforts to address ED boarding and crowding crisis, including increased, adequate reimbursement for pediatric mental health admissions and payment for boarding of children for whom there is no other medical necessity for hospital care.
2) Continue to advocate to CMS and other agencies for measures, reimbursement changes, and other regulatory strategies to help address the boarding and crowding crisis.
3) Seek expansion of outpatient and inpatient psychiatric bed availability and services to reduce psychiatric boarding in the ED, improve coordination of care between EDs and mental health services within communities, and promote establishment of new and innovative models of care for acute psychiatric emergencies.
4) Support innovative initiatives and models to reduce psychiatric boarding in the ED.

In the 119th Congress, ACEP also secured introduction of new ACEP-developed bipartisan legislation based upon the output of the boarding summit and AHRQ roundtable, introduced by Reps. John Joyce (R-PA) and Debbie Dingell (D-MI) and Senators Chris Coons (D-DE), Dave McCormick (R-PA), and Angus King (I-ME). The bill, the "Addressing Boarding and Crowding in the Emergency Department (ABC-ED) Act," utilizes existing an existing federal health data modernization grant to support development and implementation of real-time hospital bed tracking and hospital capacity management systems with a focus on ED boarding, supports innovative care models through Medicare pilot programs focused on improving geriatric emergency care and psychiatric emergency care and transfers, and commissions a GAO study to identify best practices for hospital capacity tracking and its effect on boarding, wait times, and EMS offload delays.

**Resolution 39 Signage at Emergency Departments With Onsite Emergency Physicians (as amended)**

RESOLVED, That ACEP encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

*Action:* Assigned to communications staff to work with ABEM to disseminate ABEM-developed messaging and/or other tools that can be utilized by EDs to promote their staffing of board certified/board eligible emergency physicians.

Throughout the spring of 2023, ABEM piloted a campaign promoting the value of board certification in three markets (urban, suburban, and rural) that included billboards and other environmental ads, a digital campaign, and pre- and post-campaign surveys. Enduring materials for the campaign are available to diplomates and the public on the ABEM website, which includes video content provided by ACEP. Co-branded advertisements from the campaign were displayed in Philadelphia, PA, concurrent with ACEP23.

**Resolution 40 Support for Medicaid Expansion**

RESOLVED, That ACEP develop a policy statement in support of the expansion of Medicaid to the levels allowable by federal law in recognition of the benefit of increasing health care access to eligible patients, including some of our most vulnerable, while decreasing the uncompensated care provided by emergency physicians; and be it further

RESOLVED, That ACEP develop a toolkit to assist ACEP state chapters in their efforts to advocate for such expansion of Medicaid in their states.

*Action:* Assigned to the State Legislative/Regulatory Committee to develop a policy statement and toolkit. A draft policy statement was submitted to the Board of Directors for consideration at their September 26, 2024, meeting. The Board provided feedback for additional language to include in the policy statement. The Board approved the policy statement "Medicaid Expansion" in January 2025. The committee also developed the toolkit to assist chapters as directed in the second resolved.

**Resolution 41 Addressing Stigma in the Emergency Department (as amended)**

RESOLVED, That ACEP develop an educational resource on identifying and addressing stigma in the emergency department that can be provided to emergency physicians and residency programs, highlighting the role of important practices such as person-first language.

*Action:* Assigned to the Public Health & Injury Prevention Committee to develop an educational resource and work with the Pain Management & Addiction Medicine Section and the Social Emergency Medicine Section. Seek input from EMRA and CORD regarding the type of resource that is needed. Review the Substance Use Disorder Emergency Medicine Residency Curriculum that was developed by ACEP, ABEM, CORD, and EMRA and recommend revisions to the curriculum if needed.

The SUD Emergency Medicine Residency Curriculum was reviewed, and multiple modules were updated and approved for CME for the period June 30, 2023, through June 19, 2026. The curriculum is available as a member benefit with CME in the ACEP online learning center.

**Resolution 43 Endorsing ED Resident Competency in Buprenorphine Initiation (as amended)**

RESOLVED, That ACEP support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and be it further

RESOLVED, That ACEP coordinate with other organizations in emergency medicine (Council of Residency Directors in Emergency Medicine, Society for Academic Emergency Medicine, and the American Board of Emergency Medicine) to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency and should focus on identification of patients with opioid use disorder and initiation of buprenorphine treatment as well as sharing harm reduction information and resources.

*Action:* Assigned to the Academic Affairs Committee to develop strategies to address the resolution and seek input from EMRA. The committee worked with ABEM, CORD, EMRA, and SAEM to develop the policy statement "Incorporation of Buprenorphine Training and Harm Reduction Skills in Emergency Residency Education" and it was approved by the ACEP Board of Directors on October 6, 2023.

ABEM plans to review "The Model of the Clinical Practice of Emergency Medicine in 2025. ACEP recommended to ABEM that buprenorphine training and harm reduction skills be included.

**Resolution 45 Onsite Supervision of Nurse Practitioners and Physician Assistants**

RESOLVED, That the ACEP policy statement "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" [sic] be revised so that onsite emergency physician presence to supervise nurse practitioners and physician assistants is stated as the gold standard for staffing all emergency departments.

*Action:* Assigned to the Emergency Medicine Practice Committee to revise the policy statement. The Board of Directors approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" in June 2023.

**Resolution 46 Safe Staffing for Nurse Practitioner and Physician Assistant Supervision (as amended)**

RESOLVED, That ACEP investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

*Action:* Assigned to the Emergency Medicine Practice Committee. The committee developed a policy statement that will be discussed by the Board during their April 30, 2025, meeting.

**Resolution 47 Independent Agency Report for Nurse Practitioner Schools (as amended)**

RESOLVED, That ACEP work with the American Medical Association to provide recommendations for nurse practitioner education reform to improve the quality and standards of nurse practitioner training for the purpose of improving physician-led patient care.

*Action:* Assigned to the AMA Section Council on Emergency Medicine.

The American Medical Association Advocacy Resource Center is studying each of the states that granted independent practice authority to NPs, although this is not a formal academic study. The study is tracking metrics for quality and patient safety and watching for information demonstrating why a physician-led team would have potentially had a better outcome.

**Resolution 50 Supporting Emergency Physicians to Work in Rural Settings (as amended)**

RESOLVED, That ACEP support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; and be it further

RESOLVED, That ACEP help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work in rural settings; and be it further

RESOLVED, That ACEP support working with the Accreditation Council for Graduate Medical Education and Centers for Medicare and Medicaid Services to increase resident exposure and remove regulatory barriers to rural emergency medicine.

*Action:* Assigned to the Academic Affairs Committee to develop strategies to address the resolution. The committee is continuing to work on the resolution during the 2024-25 committee year.

**Resolution 51 Implementation of Social Determinants of Health Evaluation in the ED (as amended)**

RESOLVED, That ACEP support evaluation of social determinants of health in the emergency department; and be it further

RESOLVED, That ACEP advocate for national, state, and local resources and responses to be paired with the evaluation for social determinants of health.

*Action:* Assigned first resolved to the Public Health & Injury Prevention Committee to work with the Social Emergency Medicine Section and review ACEP's policy statements "Safe Discharge from the Emergency Department" and "Social Work and Case Management in the ED" to determine if revisions are needed to address the first resolved or if a separate policy statement, PREP, and/or other resources are needed. Seek input from the Emergency Medicine Practice Committee if policy revisions are recommended. Assigned second resolved to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

The Public Health & Injury Prevention Committee and the Social Emergency Medicine Section determined that the policy statement "Safe Discharge from the Emergency Department" did not require any revisions and the "Social Work and Case Management in the Emergency Department" required revisions to the content and language, including changing the title. The Board approved the revised policy statement "Social Services and Care Coordination in the Emergency Department" in October 2023. The policy statement has an accompanying Policy Resource & Education Paper (PREP) that is undergoing review by the committee to determine if additional changes are needed beyond changing the title to correspond to the policy statement.

The Social Emergency Medicine Section developed the information paper "Recommended Minimum Standards of Care for Health-Related Social Needs in the ED" and it was reviewed by the Board of Directors in January 2024. The information paper was revised based on comments from the Board and a final version was reviewed by the Board in June 2024. The paper will be available on the ACEP website once it is finalized.

ACEP has repeatedly addressed and continues to address the issue of addressing social determinants of health in our responses to various Medicare and Medicaid regulations and requests for information, and responses to Congressional inquiries. In these responses, we have educated regulators and legislators about the role emergency physicians play in identifying and screening for social risk factors, as well as some of the tools being used in the ED to help identify barriers to health such as transportation and access to food and housing.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress include: "Promote legislative options and solutions to identify and eliminate health disparities and implement broad, systemic solutions to address social determinants of health that create disparities, address structural racism, and improve health equity in the health care system." ACEP continues to evaluate how to best address these issues in the context of the current 119th Congress and Administration.

**Resolution 56 Policy Statement on the Corporate Practice of Medicine (as amended)**

RESOLVED, That ACEP work with relevant experts to develop a policy statement opposing the corporate practice of medicine.

*Action:* Assigned to the Emergency Medicine Practice Committee to review ACEP's "Statement on Private Equity and Corporate Investment in Emergency Medicine" and develop a policy statement as directed in the resolution. The committee developed the policy statement "Corporate Practice of Medicine" and it was approved by the Board of Directors in June 2023. ACEP issued a press release on July 14, 2023, announcing the policy statement. A dedicated page on the topic of Corporatization was added to the ACEP website.

**Resolution 57 Recognized Bodies for Emergency Physician Board Certification (as amended)**

RESOLVED, That ACEP amend its policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine" to reflect that no certifying organizations beyond those already listed in the policy statement are recognized by ACEP.

*Action:* Assigned to the Academic Affairs Committee to revise the policy statement. The Board of Directors approved the revised policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine" in April 2023.

**Resolution 58 Removing Intrusive Medical Exams and Questionnaires from Employment Contracts (as amended)**

RESOLVED, That ACEP support the cessation of intrusive medical evaluation exams and questionnaires that may unduly and unnecessarily invade the privacy of emergency medicine physicians seeking and continuing employment

beyond that necessary to confirm ability to perform duties associated with the individual's role as hired.

*Action:* Assigned to the Emergency Medicine Practice Committee to determine if revisions are needed to ACEP's policy statement "Physician Impairment" or whether a separate policy statement or other resources are needed to address the resolution. The committee plans to submit a revised policy statement to the Board for consideration at their April 30, 2025, meeting.

**Resolution 59 In Memory of Brian Robb, DO, MBA, FACEP**

RESOLVED, That the American College of Emergency Physicians recognize and salute Brian Robb, DO, MBA, FACEP, and offer our heartfelt condolence to his wife of 43 years, Sharon, his three children, and many grandchildren.

*Action:* A framed resolution was sent to Dr. Robb's family.

**Resolution 60 In Memory of James R. Roberts, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of James R. Roberts, MD, FACMT, FAAEM, FACEP, who was a pioneer in the specialty and dedicated himself to his patients, to his profession, and to his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extend to his partner Lydia (Forte) to whom he was married for over 40 years, daughter Martha, son Matthew, his grandchildren Eleanor Cronin and Liam Roberts, his brother George Roberts, his sister Mary Peterlin, nieces, nephews, and family-in-law gratitude for his tremendous service as one of the pillars of emergency medicine, a consummate clinician and educator, as well as for his dedication and commitment to the specialty of emergency medicine.

*Action:* A framed resolution was sent to Dr. Robert's family.

**Resolution 61 In Memory of Douglas D. Rockacy, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Douglas D. Rockacy, MD, FACEP, who dedicated himself to his patients, to his trainees, to his profession, and to his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extend to his wife Wendy, daughter Claire, and son Russell gratitude for his tremendous service as one of the finest emergency physicians the University of Pittsburgh has ever seen, as well as for his dedication and commitment to the specialty of emergency medicine.

*Action:* A framed resolution was sent to Dr. Rockacy's family.

**Resolution 62 In Memory of Robert J. Teichman, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Robert J. Teichman, MD, PhD, and extends condolences and gratitude to his wife, Geri Young, MD, of Kapa'a, Kaua'i, and his sons Kurt Teichman of Brooklyn, NY and Grant Teichman of Honolulu, Hawaii, and other family members for his service to the community, his patients, his students, and the specialty of emergency medicine.

*Action:* A framed resolution was sent to Dr. Teichman's family.

**Resolution 63 In Memory of Jason M. White, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Jason M White, MD, FACEP, to the specialty of emergency medicine and extends the College's condolences to his wife of almost 40 years, Carol, and also to their sons and daughters, Ken, Christopher, Brittany, and Allison, and grandchildren Olivia, Finn, Rosalyn, Easton, and Cassius.

*Action:* A framed resolution was sent to Dr. White's family.

**Resolution 64 In Memory of J. David Barry, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by J. David Barry, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of J. David Barry MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of the Department of Defense, Veteran's Affairs, and the United States.

*Action:* A framed resolution was sent to Dr. Barry's family.

---

## Resolutions Referred to the Board of Directors

### Resolution 10 Candidate Members in the ACEP Council – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 2.3 – Candidate Members, paragraph two be amended to read:

"The rights of candidate members at the chapter level are as specified in their chapter's bylaws. At the national level, candidate members shall not be entitled to hold office, but ~~physician members~~ may serve on the Council. Candidate members appointed to national committees shall be entitled to vote in committees on which they serve."; and be it further

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 1 – Composition of the Council, paragraph one, of the ACEP Bylaws be amended to read:

"Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such chartered chapter. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the membership rolls of the College on December 31 of the preceding year. However, a member holding memberships simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one chapter. Councillors shall be elected or appointed from regular and candidate ~~physician~~ members in accordance with the governance documents or policies of their respective sponsoring bodies."

*Action:* Assigned to the Bylaws Committee to review and work with the Membership Committee to provide a recommendation to the Council Steering Committee and the Board of Directors regarding the advisability of implementing the resolution.

The Bylaws Committee reviewed the resolution and concluded that the resolution does not conflict with any other portions of the Bylaws and the resolution language is appropriate as prepared from a Bylaws standpoint. The Bylaws Committee also discussed what had been presented as a possible amendment at Reference Committee A: limiting candidate student member eligibility only to the EMRA delegation. However, without knowing the authors intent going forward, the Bylaws Committee did not believe it was within their purview to discuss the merits of a potential new resolution and deferred that determination to the Membership Committee to provide a membership prospective. The Membership Committee was asked to address whether or not resubmitting the resolution for the Council to consider is in the best interests of the membership. The Membership Committee recommended that the existing language limiting Council representation to physician members be reaffirmed. While student input on matters pertaining to the Council and the profession is always welcomed and appreciated, it was determined that since they have not yet made a commitment to emergency medicine, as evidenced by acceptance into an EM residency program, they may not be fully invested and/or reasonably informed in the outcome of decisions being made. In addition, it was expressed that they often would lack the full context necessary to understand the long-term impact. The Membership Committee encouraged EMRA to continue to involve student members in the Council process as appropriate and to create opportunities for exposure that can help guide them into future leadership pathways. The Board of Directors affirmed that no further action is needed regarding Referred Resolution 10(22) Candidate Members in the ACEP Council based on the review by the Bylaws Committee and Membership Committee.

### Resolution 20 Expert Consultation for Employee Contracts

RESOLVED, That ACEP provide, as a member benefit at no charge, legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

*Action:* Assigned to membership and legal staff to work with EMRA to review the resolution and provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution, including potential cost estimates.

ACEP and EMRA recognize the importance of equipping all emergency physicians, especially those new to practice, with the resources and tools needed to ensure that any potential contracts they consider include fair compensation and benefits, adequate due process, and protection for themselves and their patients during the course of

medical practice. There are a growing number of resources available on the ACEP website dedicated to the topics of employment contracts and other practice and legal issues, including a checklist to negotiate the best contract and an on-demand course on standard contract provisions. The site also includes a list of local attorneys available to review contracts and assist with other legal matters. In addition, ACEP partnered with Resolve, a well-established physician contract review service, in March 2023, to provide all ACEP members a 20% discount on contract review services, ranging in price from $499 to $1,999 based on the complexity of review required. Resolve also provides insight into compensation data and the competitiveness of other terms in the contract. The service was tested by two ACEP members needing contract review for their real-life employment agreements prior to finalizing the partnership and both members had positive feedback about their experiences. EMRA representatives reviewed the referred resolution and concluded that the financial burden of creating and implementing a free contract review service for residents would outweigh the benefits received. While it would likely be utilized by some EMRA's members, EMRA leadership determined it is reasonable to expect that physicians will pay for this type of service. The ACEP Board of Directors affirmed in June 2023 that no further action was needed to address the referred resolution based on analysis by ACEP and EMRA staff and the new partnership with Resolve for discounted contract review.

**Resolution 22 State Chapter Funding**

RESOLVED, That ACEP return 10% of national dues to each chapter calculated by 0.1 x number of state dues-paying members every year.

*Action:* Assigned to member engagement and state government relations staff to review and provide a recommendation to the Board of Directors regarding the advisability and cost implications of implementing the resolution.

The high-level fiscal impact of returning 10% of national dues revenue to state chapters for advocacy would be $1,218,567.87 in expense added to the bottom line. This number would change slightly on an annual basis as dues revenue fluctuates. Given the wide variation between chapters, it is possible that not all chapters will have the staff and/or volunteer capacity or the knowledge to use these funds effectively toward state advocacy efforts. Additional unbudgeted staff resources would be required to administer a formal grant program or oversee accountability of spending the funds toward their dedicated purpose, as well as accounting for calculation and payment of the funds on a monthly or annual basis. ACEP has moved the state government affairs functions from the Clinical Affairs line of service to the Public Affairs line of service to ensure better alignment and coordination across ACEP's federal and state advocacy initiatives. Past state and federal advocacy efforts had, at times, been siloed and fragmented, leading to missed opportunities for stronger advocacy impact and victories. ACEP has invested in resources to increase support for chapter engagement in state advocacy with a dedicated state government relations staff member, continued budget for state public policy grants and plans to simplify the application process and increase awareness of the program, expanded grassroots efforts beyond federal actions to include state-level actions, new toolkits and advocacy resources specifically for state chapters, and financial support to the American Medical Association's Scope of Practice Partnership.

ACEP does not have purview over or approval of the member dues rates set at the chapter level. Chapters that wish to raise funds for advocacy initiatives could consider a variety of options that would allow them to allocate greater resources in that area. ACEP is willing to provide operational assistance or subject matter expertise with the establishment of PACs, volunteer committees, or other sustainable methods of increasing a chapter's ability to impact legislation. ACEP staff are available to assist chapters with implementing chapter specific financial programs such as Virginia ACEP's Statewide Action Trust (STAT) and California ACEP's California Emergency Medicine Advocacy Fund to generate non-dues related financial support for state advocacy. ACEP does not currently have the financial resources to fulfill the resolution nor does it have the staff resources to administer a formal grant program or to ensure that the funds are spent toward their dedicated purpose. ACEP will continue to provide and refine support provided to chapters to meet their state advocacy needs. That support includes, but is not limited to:

- a dedicated staff member for chapter engagement in state advocacy
- state-level grassroots alerts
- state public policy grants
- financial support to the American Medical Association's Scope of Practice Partnership
- collaboration with the State Legislative/Regulatory Committee
- continued development of toolkits and advocacy resources specifically for chapters
- operational assistance or subject matter expertise with the establishment of:
  - PACs,
  - Advocacy Funds,
  - volunteer committees,
  - or other sustainable methods of increasing a chapter's ability to impact legislation,
- expanded educational opportunities on state policy issues and tools and tips for grassroots and political action

The Board affirmed in June 2023 that initiatives already in place meet the intention of the referred resolution.

**Resolution 53 Law Enforcement and Intoxicated Patients in the ED**

RESOLVED, That ACEP investigate alternative care models to evaluate patients in police custody, such as telehealth, to determine necessity of an in-person evaluation; and be it further

RESOLVED, That ACEP encourage law enforcement to stay with any patient they choose to bring to the ED who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed.

*Action:* Assigned to the Emergency Medicine Practice Committee to work with the Tactical Emergency Medicine Section and provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution. The committee is continuing to work on the resolution in the 2024-25 committee year.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

# President-Elect Candidates

Scientific Assembly

SALT LAKE CITY 25

Scientific Assembly SALT LAKE CITY 25

# 2025 President-Elect Candidates



**Jeffrey M. Goodloe, MD, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



**Gabe D. Kelen, MD, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



**Ryan A. Stanton, MD, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

## Jeffrey M. Goodloe, MD, FACEP

***Question #1:*** **How will you best support members, especially trainees, navigate the upcoming changes in emergency medicine training and certification?**

Support begins with ardent listening.

Uncertainty surrounds potential changes to the emergency medicine training journey. At the time of answering this question, we do not know the final form that ACGME revisions will take. We do have a draft roadmap and what is clear already is that people care deeply as individual emergency physicians or trainees as well as in representing institutions and organizations about what is at stake, especially regarding the minimum length of emergency medicine residency.

The anxiety is real. These changes impact more than curriculum; they touch personal finances, family decisions, and career planning. That is why, at this moment, our first responsibility is to listen more and speak with care. If a fourth year of training is added to the majority of training programs, we must simultaneously advocate for additional resources and support. These challenges are also moments of opportunity, for ACEP and for all of us. We have roles in which we must succeed: identifying best practices, creating accessible educational tools, and building training experiences that ensure residents excel, not just survive.

It is also important to acknowledge what ACEP *can* and *cannot* do. We do not control ACGME, and that reality must ground us. What we *can* do is powerful. We can collaborate - with CORD, SAEM, EMRA, and others - to shape the tools and environments that help programs and people thrive. If new curricular or experiential mandates are finalized, we will meet that challenge with innovation, efficiency, and empathy.

In times like these, transparency, and actionable support matter most. So let us continue to listen deeply, acknowledge that within and beyond our control, replicate what works, and boldly build what is missing. That is how we best support our members today and ensure our specialty's strength tomorrow.

***Question #2:*** **Describe your leadership style and how do you think that distinguishes you from the other president-elect candidate?**

I am a servant-oriented, empowering others leader. I grew up on simple, yet profoundly inspiring values modeled by my parents. Picture one of Norman Rockwell's iconic paintings of the family physician and you have pictured my upbringing. No appointments and no payment if unable were required. Such was life in small town Oklahoma primary care, the only care in town at that.

My father was a physician-pharmacist. My mother was a surgical nurse. X-rays, basic labs, and a pharmacy were all in their clinic to make life easier for the patient. I often remind myself of those childhood days, particularly when representing you with federal and state legislators, as your liaison to the American College of Surgeons Committee on Trauma, or when high-stakes issues are notably complicated in Board of Directors deliberations.

Stay humble. Work hard. Serve others. Empower the otherwise overlooked. A wise leader impressed upon me that the door to success swings on the hinges of integrity. These are the foundation and cornerstones of the leadership style I embrace and that I most respect in others.

As to how that distinguishes me from "the other president-elect candidate" is an assessment that I humbly place to you, the councillor/voter, to discern.

I have said throughout my tenure to date on the Board of Directors, including in both prior campaigns to become your next President-Elect and in multiple campaigns for board officer positions, that the positivity of ACEP elections culture must be protected. In a cynical society at large, habitually deluged with ad hominem politics, we should celebrate what we have created and steadfastly fostered in the College – elections in which candidates speak to their strengths without speaking in negativity of other candidates.

The College is blessed with multiple leaders willing to work, willing to serve, willing to campaign in elections. Let us focus upon the copious good that is shared more than that which distinguishes. I am honored to be in this campaign.

***Question #3:*** **In one sentence, describe what you would like your legacy to be at the conclusion of your term as president and then explain why.**

Emergency physicians are beyond essential – we are exceptional!

I don't want that as *my* legacy; I want that as *our* legacy. A shared legacy where we, as emergency physicians, reclaim value that has been stripped from our profession over decades. Why does this matter? Because every issue we fight for - fair reimbursement, workplace safety, scope of practice, and professional dignity, to highlight those among many - hinges on how we are valued.

Since 2001, our reimbursement has dropped by 33% when adjusted for inflation. That is not just a number, it is a stark measure of how our education, training, skill, and commitment have been systematically undervalued by both government and commercial payers. And that loss ripples out: it affects our ability to repay educational loans, care for our families, contribute to our communities, and plan for our futures.

We practice in overcrowded emergency departments, forced to do more with less, while our voices are too often ignored by health systems focused elsewhere. We are treated as interchangeable, as line items on a staffing grid, at risk of being replaced not only by other physicians, but by less-trained providers given legislative authority to supplant us. That's not just a staffing issue; it is a threat to patient safety and the integrity of our profession.

This erosion did not happen overnight, and recovery will not either. The recent RAND report is a helpful validation in our cause to strengthen the future of emergency physicians and emergency systems of care across America.

During my over 20 years in ACEP leadership, including serving as Secretary-Treasurer, Vice-President of Communications, and Chair of the Board of Directors, I have come to believe that this challenge is our call to action. We must collectively rebuild the recognition that we are proven leaders in crisis and stewards of safety. While we may embody the last line of defense in championing patient care, we are so much more. We are the frontline of diagnostic excellence and efficiency, delivered with humanity in a complicated, often unraveling healthcare system.

To secure a better future for emergency medicine, we need to restore the respect, investment, and opportunities our profession deserves. Not for personal gain primarily, but for the future of the specialty we love, and for the patients who rely on us. Great missions are never individual; they are collective. Let us build that future, our future, together.

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, OK Highway Patrol; OK Attorney General; American Airlines Tulsa M&E Base
Past Professional Positions:
Item Writer, EMS Examination & myEMSCert modules; Item Writer & Co-Editor, EMS LLSA, ABEM
Attending Emergency Physician – St. John Medical Center & Saint Francis Hospital - Tulsa, OK
Attending Emergency Physician – Medical Center of Plano – Plano, TX
Medical Director, Plano Fire Department – Plano, TX & Allen Fire Department – Allen, TX

***Education (include internships and residency information)***

EMS Fellowship – University of Texas Southwestern Medical Center at Dallas (1998-99)
Emergency Medicine Residency – Methodist Hospital of Indiana/Indiana Univ School of Medicine (1995-98)
The Medical School at University of Texas Health Science Center at San Antonio (1991-95)
Baylor University – Waco, TX (1987-91)

***Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified).***

ABEM Emergency Medicine Initial Certification 1999, Recertification 2009 & 2019; MOC current for 2029
ABEM EMS Medicine Initial Certification 2013; MOC current for 2027 (extended due to Subboard service)

***Professional Societies***

ACEP member since 1991 (medical student, resident, fellow, active, FACEP)
OCEP (Oklahoma College of Emergency Physicians), AMA, NAEMSP (FAEMS), SAEM, ACHE
Prior memberships in Texas College of Emergency Physicians, Indiana ACEP Chapter

***National ACEP Activities – List your most significant accomplishments***

Vice President - Communications, ACEP Board of Directors (2024-present)
Chair, ACEP Board of Directors (2023-2024)
Secretary-Treasurer, ACEP Board of Directors (2021-2022)
Member, ACEP Board of Directors (2019-present; elected 2019; re-elected 2022)
Member, Council Steering Committee; Chair & Member, Reference Committee, ACEP Council
Councillor, Oklahoma College of Emergency Physicians & EMRA
ACEP Liaison to American College of Surgeons, Committee on Trauma
ACEP Liaison to American Academy of Emergency Nurse Practitioners
Board Liaison to committees: Bylaws, Finance, Audit, Communications, Membership, EMS, Pediatric EM
Board Liaison to sections: Pediatric EM, EMS, Event Medicine, Tactical & Law Enforcement Medicine, Sports Medicine, Cruise Ship Medicine, Trauma & Injury Prevention, Geriatric EM
Board Liaison to task forces: Rural Emergency Medicine, Hyperactive Delirium with Severe Agitation
Board Liaison to internal governance: Geriatric Emergency Department Accreditation Board of Governors
Chair & Member, EMS Committee; Member, Bylaws Committee

***ACEP Chapter Activities – List your most significant accomplishments***

President, Vice-President, Councillor, Board Member, Oklahoma College of Emergency Physicians

***Practice Profile***

***Total hours devoted to emergency medicine practice per year:*** **3120** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **45** % Research **5** % Teaching **10** % Administration **40*** %

Other: ***Predominantly EMS medical oversight & national ACEP duties** ____ %

***Describe current emergency medicine practice. (e.g., type of employment, type of facility, single or multi-hospital group, etc.)***

I am employed full time by the University of Oklahoma School of Community Medicine. My roles include serving as core faculty in the emergency medicine residency and medical school faculty, both as professor of emergency medicine. I work a monthly average of ten shifts clinically as an attending faculty physician in the Hillcrest Medical Center Emergency Center (Comprehensive Stroke Center, full-service cardiovascular institute site – including ECMO and VAD surgeries, Level III Trauma Center, regional burn center for geographical areas of four states, Level III NICU) supervising residents in Emergency Medicine, Internal Medicine, Family Medicine, OB/GYN, fellows in Pediatric Emergency Medicine, and medical students. The University of Oklahoma Department of Emergency Medicine faculty partially staffs four emergency departments in Tulsa and Oklahoma City, employing a university academic group/regional democratic private group collaborative structure. I am staff credentialed at Hillcrest Medical Center in Tulsa, the base hospital for the EM residency, though I have been staff credentialed in prior years at two other teaching community hospitals in Tulsa. I also serve as the Chief Medical Officer for the EMS System for Metropolitan Oklahoma City and Tulsa, clinically leading over 2,800 credentialed EMS professionals working in an ambulance service, fire departments, law enforcement agencies, industrial emergency response teams or emergency communications centers, collectively answering over 265,000 medical 911 calls per year. I further serve as a tactical emergency physician and Medical Director for the Oklahoma Highway Patrol, responding to emergency tactical missions across the entire state. Additional practice roles include special events medical support planning for metropolitan Oklahoma City and Tulsa and as an educational program medical director for EMT and Paramedic education at Tulsa Community College. I also frequently lecture at national educational meetings, such as the EMerald Coast Conference (multiple ACEP state chapter annual conference in Florida), multiple other ACEP chapter conferences, and EMS State of the Science – A Gathering of Eagles.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Professor, EMS Section Chief, Director of the Oklahoma Center for Prehospital & Disaster Medicine, Head of Faculty Development, Attending Physician, Core Faculty Member – Department of Emergency Medicine, University of Oklahoma School of Community Medicine – Tulsa, OK

***Expert Witness Experience***

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert 1 Cases** **Plaintiff Expert 0 Cases**

No expert witness work since election to the ACEP Board of Directors in 2019, following longstanding internal policy to decline expert witness invitations while serving on the national board of directors.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Jeffrey M. Goodloe, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: University of Oklahoma School of Community Medicine

Address: Department of Emergency Medicine, 1111 South Saint Louis Ave

Tulsa, OK 74120

Position Held: Professor; EMS Section Chief; Director – OK Ctr for Prehospital/Disaster Med

Type of Organization: Medical School

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: American College of Emergency Physicians

Address: 4950 W. Royal Ln

Irving, TX 75063

Type of Organization: Medical Specialty Society

Leadership Position: Vice President – Communications; Chair; Secretary-Treasurer & Member Board of Directors

Term of Service: 2024-present (VP Communications); 2023-2024 (Chair); 2021-2022 (Sec-Treas); 2019-present (Member)

Organization: Emergency Medicine Foundation

Address: 4950 W. Royal Ln

Irving, TX 75063

Type of Organization: 501(c)3 Nonprofit Organization for Funding Emergency Medicine Research

Leadership Position: Chair & Member, Board of Trustees

Term of Service: 2018-present (Member);2021 (Treasurer);2022 (Chair);2023 (Immed Past Chair)

Organization: Emergency Medical Services Authority

Address: 6205 S. Sooner Road

Oklahoma City, OK 73135

Type of Organization: Public Utility Model Ambulance Service

Leadership Position: Ex-officio as Chief Medical Officer/Medical Director

Term of Service: 2009-present

Organization: American Board of Emergency Medicine

Address: 3000 Coolidge Road

East Lansing, MI 48823

Type of Organization: Medical Specialty Board Certification Organization

Leadership Position: Member, Item Writer & LLSA Co-Editor, EMS Subboard

Term of Service: 2019-2022 (Member & Item Writer); 2022 (LLSA Co-Editor)

Organization: Oklahoma College of Emergency Physicians

Address: No physical office address for OCEP

Executive Director is Gabe Graham at gabegraham11@gmail.com

Type of Organization: State Chapter of ACEP

Leadership Position: Immediate Past President & Member, Board of Directors

Term of Service: 2007-present (Member); 2012-2016 (Vice President); 2016-2019 (President); 2019-2023 (Immediate Past President)

Organization: Emergency Medicine Residents' Association

Address: 4950 W. Royal Ln

Irving, TX 75063

Type of Organization: Professional Medical Association

Leadership Position: Past President & Past Member, Board of Directors

Term of Service: 1995-1998 (Member); 1995-1996 (President-Elect); 1996-1997 (President); 1997-1998 (Immediate Past President)

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE

☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Jeffrey M. Goodloe, MD, FACEP** Date June 3, 2025

Oklahoma College of EMERGENCY PHYSICIANS

July 24, 2025

Dear Councillors,

The Oklahoma College of Emergency Physicians (OCEP) enthusiastically endorses the election of Dr. Jeffrey M. Goodloe as ACEP's next President-Elect.

Dr. Goodloe is well known nationally within ACEP due to his dynamic servant leadership. Dr. Goodloe's fellow board members agree, electing him to multiple officer positions, including Vice President – Communications during this year of extraordinary legislative and regulatory change, Board Chair during last year's pivotal time in College executive leadership, and Secretary-Treasurer in his first Board term.

Results-focused, team-building, clear-speaking leadership is a decades-long "Jeff Goodloe hallmark." He has been a 15-year plus active councillor, serving on the Council Steering Committee and reference committees, including chairing a reference committee.

Dr. Goodloe is relentlessly active in advocacy at both state and federal levels, respected among Oklahoma's State and US Representatives and Senators. Tellingly, both Representative Kevin Hern (OK-01) and Senator Markwayne Mullin (OK) have designated him as the "emergency medicine expert" on their respective healthcare panels. Dr. Goodloe has personally hosted both legislative leaders at his local emergency department, including arranging time with emergency medicine residents at the University of Oklahoma School of Community Medicine. Sen. Mullin counts on Dr. Goodloe's insights to help frame his own advocacy for constituents struggling with opioid use disorder and following a convincing Hill visit at this year's LAC, co-sponsored the ABC-ED bill to effectively address our boarding crisis. With Dr. Goodloe at his immediate side in multiple town halls in Oklahoma, then Rep. Mullin pointed out, "Clearly, emergency medicine is not the problem; they (emergency medicine physicians) are part of our answer!"

Jeff Goodloe's critical thinking and ability to manage dynamic situations has been trusted by generations of ACEP leaders, including multiple ACEP presidents, evidenced in part by a committee chair appointment, multiple appointments to other committees and task forces, and as our national liaison voice to multiple professional organizations, including the American College of Surgeons Committee on Trauma and the American Academy of Emergency Nurse Practitioners to name just a few.

Within The Sooner State, Dr. Goodloe has effectively led OCEP as a Board Member since 2007 and as our President in 2016-2019, helping create a resurgence in engaged chapter membership. Jeff's tireless encouragement of chapter members to be involved in OCEP and ACEP is a difference maker. Further, Jeff led OCEP in electing our first resident member to full Councillor status with concurrent election to our board of directors. We are excited to promote the next generation of emergency medicine leaders in Oklahoma. I submit to you that it is hard to find a more giving, humble leader with unquestionable integrity and ethics.

**Board of Directors**

| **President** | **Vice-President** | **Treasurer** | **Immediate Past President** |
|---|---|---|---|
| Kurtis A. Mayz, MD, JD, MBA, FACEP | Cecelia Guthrie, MD, FACEP | Derek Martinez, MD | James R. Kennedye, MD, MPH, FACEP |

**Members**

Jeffrey Johnson, MD, FACEP  Aimee Blagovich, DO, FACEP  Craig Sanford, MD, FACEP  Jeffrey M. Goodloe, MD, FACEP

**Executive Director**

Gabe Graham, CPA gabegraham11@gmail.com

Oklahoma College of EMERGENCY PHYSICIANS

Dr. Goodloe is an active promoter of Emergency Medicine's future, speaking candidly and passionately about the importance of emergency physicians and their career fulfillment to the health of our communities and nation. He is dependably a "first call" by ACEP's public relations team when complicated, politically charged issues need a scientifically sound and layperson relatable voice amidst the chaos. Repeatedly, Jeff has proven that resource that we need to reassure our patients and the public that emergency physicians are their allies in health. When much of our society is understandably cynical, it is a trusted leader like Dr. Goodloe that we need speaking as our national President.

In closing, OCEP respectfully and strongly encourages the ACEP Council to elect Jeffrey M. Goodloe, MD, FACEP as ACEP President-Elect, becoming the first Oklahoma-based President-Elect in ACEP history.

Kindest professional regards,



Kurtis A. Mayz, JD, MD, MBA, RP, FAAP, FCLM, FAAEM, FACEP
President, Oklahoma College of Emergency Physicians

**Board of Directors**

| **President** | **Vice-President** | **Treasurer** | **Immediate Past President** |
|---|---|---|---|
| Kurtis A. Mayz, MD, JD, MBA, FACEP | Cecelia Guthrie, MD, FACEP | Derek Martinez, MD | James R. Kennedye, MD, MPH, FACEP |

**Members**

| | | | |
|---|---|---|---|
| Jeffrey Johnson, MD, FACEP | Aimee Blagovich, DO, FACEP | Craig Sanford, MD, FACEP | Jeffrey M. Goodloe, MD, FACEP |

**Executive Director**
Gabe Graham, CPA gabegraham11@gmail.com

# Jeffrey M. Goodloe, MD, FACEP

Councillors,

We as emergency physicians are invaluable AND undervalued. We must highlight the former as we change the latter.

Reputation matters when speaking for us. Character matters more. Reputation is the photo; character is the action movie. Reputation is the prepared speech without questions to follow. Character is the effective response when we are attacked.

Hard work is not an achievement. Hard work is the admission price for the opportunity to serve in leadership. Payment is due daily.

Fairness to all persons is not a worn-out idea. Fairness to all is the thread count of an ethical leader's cloth. "All persons" does not mean all that agree with a leader's own view; all means all. Disagree with a wise leader and therein becomes the opportunity for a wise leader to become wiser by listening, by leaning into the otherwise unheard, and by learning.

Wisdom through consensus drives energy in relentlessly pursuing what is right and just.
What is right and just for emergency physicians?

Fair reimbursement through laws that promote covered access to our care and then holding payers accountable to that coverage.

Reasonable professional liability protection that enables the efficient care our patients need while reducing the defensive documentation and testing that adds to our ED workload and to the patient length of stay.

Empowering our own mental and physical wellbeing as we devote ourselves to our patients' wellbeing. Resources must freely exist when we need to "ring the bell" without restricting the future of our careers.

Expanding opportunities for employment and entrepreneurial pursuits that leverage the emergency physician skillset, creating greater potential for all emergency physicians.

If these beliefs ring as true to you, I ask for your vote.

I would be honored to serve you humbly, faithfully, and passionately as your next ACEP President-Elect.

Jeffrey M. Goodloe, MD, FACEP

# JEFFREY M. GOODLOE, MD, FACEP

## For Election as ACEP President-Elect

**Accountable**
to mission success
**Consensus**
builder
**Energized**
by advocacy
**Proven**
leadership



**Proudly endorsed by:**

Oklahoma College of EMERGENCY PHYSICIANS

**Trusted National Board Leadership**

- Chair (2023–2024)
- Vice President – Communications
- Secretary-Treasurer (2021–2022)
- Elected Member (2019 & 2022)

**Broad Committee & Task Force Service**

- Task Forces: Hyperactive Delirium, Rural Practice
- Committees: Membership, Finance, Audit, Bylaws, EMS, Communications, Pediatric EM
- Sections: EMS, Pediatric EM, Tactical, Geriatric EM, Sports Med

**Solid Representation & Advocacy**

- American College of Surgeons Committee on Trauma
- Geriatric ED Accreditation Board of Governors
- Past Committee Chair: EMS & Council Reference Committee
- Past Member: Council Steering Committee
- Past President & Councillor: Oklahoma College of Emergency Physicians
- Past President & Councillor: EMRA
- Dependable ACEP Spokesperson

**1111 S. St. Louis Ave | Tulsa, OK 74120|918-704-3164 (Cell)**
***jeffrey-goodloe@ouhsc.edu | jeffreygoodloe911@gmail.com***

# Jeffrey Michael Goodloe, MD, NRP, FACEP, FAEMS, LSSBB

**Address:** Department of Emergency Medicine
The University of Oklahoma School of Community Medicine
1145 South Utica Avenue, 6th Floor
Tulsa, Oklahoma 74104

**Telephone:** (918) 579-2364 (Department Office)
(918) 704-3164 (Cell)
**Fax:** (918) 579-2369 (Department Fax)

**E-mail:** jeffrey-goodloe@ouhsc.edu (EMS/EM/University)
jeffreygoodloe911@gmail.com (ACEP/Special Projects)

## II. EDUCATION

| School/College | Field of Study | Degree Earned | Year |
|---|---|---|---|
| The University of Texas Medical School at San Antonio | Medicine | MD | 1991-95 |
| Baylor University Waco, Texas | Biology | BS, cum laude | 1987-91 |
| Scott & White Memorial Hospital Texas A&M University Health Science Center Temple, Texas | EMS | EMT-Paramedic | 1990 |
| Oklahoma City Community College Oklahoma City, Oklahoma | EMS | EMT-Intermediate | 1989 |
| McLennan Community College Waco, Texas | EMS | EMT-Basic | 1988 |

**POST-DOCTORAL TRAINING:**

| | | | |
|---|---|---|---|
| The University of Texas Medical School at Southwestern Medical Center at Dallas | EMS | Fellowship | 1998-99 |
| Indiana University School of Medicine Methodist Hospital of Indiana Indianapolis, Indiana | Emergency Medicine Residency | | 1995-98 |

## III. PROFESSIONAL EXPERIENCE

### 1. Academic:

2012-Present Professor and EMS Section Chief
Director - Center for Prehospital and Disaster Medicine
Department of Emergency Medicine
The University of Oklahoma School of Community Medicine

2007-2012 Associate Professor and EMS Division Director
Department of Emergency Medicine
The University of Oklahoma School of Community Medicine

2004-2014 Clinical Assistant Professor
Division of Emergency Medicine, Department of Surgery
The University of Texas Medical School
Southwestern Medical Center at Dallas

1998-1999 Assistant Instructor
Division of Emergency Medicine, Department of Surgery
The University of Texas Medical School
Southwestern Medical Center at Dallas
Faculty Clinical Duties at Parkland Memorial Hospital

1994-1995 Clinical Instructor
Department of Emergency Medical Technology
School of Allied Health
The University of Texas Health Science Center at San Antonio

1994-1995 Instructor
Emergency Medicine Collaborative Teaching Program
Department of Emergency Medicine
The University of Texas Medical School
The University of Texas Health Science Center at Houston

### 2. Administrative:

2018-Present Medical Director – Oklahoma Highway Patrol
2010-2016 Special Response Teams (Tactical, EMS Unit
Riot Control, Bomb, Dive

2014-Present Medical Director
Tulsa Community College
Emergency Medical Services Education Program

2011-Present Emergency Medicine Advisor
Oklahoma City Thunder Professional Basketball Club
National Basketball Association

2010-Present Medical Director
Special Operations Medical Oversight and Support (SOMOS)
Department of Emergency Medicine, EMS Section
University of Oklahoma School of Community Medicine

2009-Present Chief Medical Officer & Medical Director
Medical Control Board, Emergency Medical Services System for
Metropolitan Oklahoma City & Tulsa, Oklahoma
Metropolitan Medical Response System

2008-2009 Associate Medical Director
Medical Control Board, Emergency Medical Services System for
Metropolitan Oklahoma City & Tulsa, Oklahoma
Metropolitan Medical Response System

2003-2007 EMS Medical Director
Allen Fire Department
Allen, Texas

2001-2007 Medical Director, Emergency Response Team
Plano Police Department
Plano, Texas

2000-2007 Medical Director, Automated External Defibrillation Program
City of Plano, Texas

2000-2007 Medical Director, Emergency Medical Technician Education
Plano Independent School District
Plano, Texas

1999-2007 EMS Medical Director
Plano Fire Department
Plano, Texas

1996-1998 Associate EMS Medical Director
Hendricks County EMS Consortium (Avon Fire Department,
Brownsburg Fire Department, Danville Fire Department,
Plainfield Fire Department)
Hendricks County, Indiana

**3. Hospital/Agency**

2011-Present Hillcrest Medical Center, Tulsa, Oklahoma
Emergency Medicine Residency Faculty & Emergency Physician

| | |
|---|---|
| 2009-2011 | St. John Medical Center, Tulsa, Oklahoma<br>Emergency Medicine Residency Faculty & Emergency Physician |
| 2007-2009 | St. Francis Hospital, Tulsa, Oklahoma<br>Emergency Medicine Residency Faculty & Emergency Physician |
| 2006-2011 | International Hot Rod Association, Norwalk, Ohio<br>Track Rescue Team Physician |
| 2000-2019 | Texas Motor Speedway/North Hills Track Hospital<br>Fort Worth, Texas<br>Track Physician for:<br>NASCAR Monster Energy Cup Series<br>NASCAR Xfinity Series<br>NASCAR Camping World Truck Series<br>IndyCar Series |
| 1999-2007 | Medical Center of Plano, Plano, Texas<br>Emergency Physician |
| 1997-1998 | Indianapolis Motor Speedway/Hanna Emergency Medical Center<br>Track Physician for:<br>Indy Racing League & NASCAR Winston Cup Series |
| 1996-1998 | Hendricks Community Hospital, Danville, Indiana<br>Emergency Resident Physician |
| 1996-1998 | Indianapolis Raceway Park, Clermont, Indiana<br>Track Physician for:<br>National Hot Rod Association US Nationals |
| 1996-1998 | Methodist Hospital of Indiana, Methodist Health Group<br>Indianapolis, Indiana<br>LifeLine Helicopter EMS, Flight Physician |
| 1992-1995 | American Medical Transport, Rural/Metro Corporation<br>Pasadena, Texas<br>EMT-Paramedic |
| 1989-1991 | American Medical Transport, Rural/Metro Corporation<br>Waco, Texas<br>EMT-Intermediate & Paramedic |

## IV. MILITARY EXPERIENCE

None

## V. BOARD CERTIFICATION

Emergency Medicine, American Board of Emergency Medicine
Initial Certification 1999; Recertification 2009, 2019 (expires 12/31/2029)
Emergency Medical Services Medicine, American Board of Emergency Medicine
Initial Certification 2013 (expires 12/31/2027)

## VI. LICENSES/CERTIFICATIONS

Physician Licenses:

| | |
|---|---|
| July 1996 - Present | Indiana |
| August 1998 - Present | Texas |
| July 2007 - Present | Oklahoma |

EMS Licenses/Certifications:
National Registry of Emergency Medical Technicians
Paramedic (active status)
EMT-Tactical (active status)

Lean/Six Sigma Certifications (accredited by IASSC):
Black Belt
Creative Insights, Inc.
Green Belt
University of Oklahoma Gallogly College of Engineering
White/Yellow Belt – Fundamentals of Lean/Six Sigma
University of Oklahoma Gallogly College of Engineering

## VII. RESEARCH AND SCHOLARSHIP

### 1. Grants/Funded Projects

**a.** 2015 EMS Medical Director Course and CQI Practicum. Principal Instructor and Course Coordinator for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Section. Under contract with Rogers EMS Consulting. Project was completed in June 2015 and entailed delivery of the State of Oklahoma EMS Medical Director Course and CQI Practicum in Antlers, Altus, and Fairview. Direct funding at $6,000 by Rogers EMS Consulting.

**b.** 2014 EMS Medical Director Course and Practicum. Principal Instructor and Course Coordinator for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Section. Under contract with Rogers EMS Consulting. Project was completed in June 2014 and entailed delivery of the State of Oklahoma EMS Medical Director Course and Practicum in Ardmore and Lawton. Direct funding at $12,500 by Rogers EMS Consulting.

**c.** 2013-14 Update State of Oklahoma EMS Treatment Protocols and EMS Medical Director Course and Practicum. Principal Developer for University of Oklahoma School of Community Medicine, Department

of Emergency Medicine, EMS Section. Under contract with the Oklahoma State Department of Health Protective Health Services EMS/Trauma Division. Project was completed in April 2014 and entailed development of EMS treatment protocols that are endorsed as the official 2014 State of Oklahoma EMS treatment protocols for use by all ground-based EMS agencies. Additional deliverable components included development of update methodologies and curriculum refinement and delivery of the State of Oklahoma EMS Medical Director Course and Practicum in Muskogee and Stillwater. Direct funding at $40,000 by Oklahoma State Department of Health.

**d.** 2011-12 Development of State of Oklahoma EMS Treatment Protocols and EMS Medical Director Course and Practicum. Principal Developer for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Division. Under contract with the Oklahoma State Department of Health Protective Health Services EMS/Trauma Division. Project was completed in September 2012 and entailed development of EMS treatment protocols that are endorsed as the official State of Oklahoma EMS treatment protocols for use by all ground-based EMS agencies. Additional deliverable components included development of update methodologies and curriculum refinement and delivery of the State of Oklahoma EMS Medical Director Course and Practicum. Direct funding at $169,000 by Oklahoma State Department of Health.

**e.** 2010-11 Development of a white paper on EMS System Design. Principal Editor for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Division. Project was completed in July 2011 with deliverable exceeding expectation of commissioning entity. Authors were personally recruited from Los Angeles, Salt Lake City, Indianapolis, Birmingham, and Charlotte. Co-Editor is Dr. Stephen H. Thomas. Direct funding at $27,000 by Emergency Medical Services Authority in Tulsa, Oklahoma.

**2. Research Projects**

**a.** IRB Waived/662445. Paramedic Compliance with a Novel Defibrillation Strategy in a Large, Urban EMS System in the United States. Principal Investigator. Accepted for poster presentation at Canadian Association of Emergency Physicians 2017 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involves one EM resident.

**b.** IRB Waived/662516. Morbid Obesity Association with Return of Spontaneous Circulation from Sudden Cardiac Arrest Treated in a Large, Urban EMS System in the United States. Principal Investigator. Accepted for poster presentation at Canadian Association of Emergency Physicians 2017 Annual Meeting. Abstract

published in Canadian Journal of Emergency Medicine. Project involves one EM resident.

**c.** IRB Waived/603842. Prevalence and Survival Impact of Bystander Cardiopulmonary Resuscitation in Sudden Cardiac Arrest Victims Treated by a Large, Urban EMS System in North America. Principal Investigator. Accepted for oral presentation at Canadian Association of Emergency Physicians 2015 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine.

**d.** IRB Waived/603842. Demographics of Twenty-One Years of Sudden Cardiac Arrest Victims Treated by a Large, Urban EMS System in North America. Principal Investigator. Accepted for poster presentation at Canadian Association of Emergency Physicians 2015 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine.

**e.** IRB Waived/603842. The Prevalence and Impact of Ventricular Fibrillation as the Initial Cardiac Arrest Dysrhythmia over Twenty Years in a Large, Urban EMS System. Principal Investigator. Accepted for poster presentation at National Association of EMS Physicians 2015 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for poster presentation at Canadian Association of Emergency Physicians 2015 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine.

**f.** Other IRB Waived. The Effect of CPR Quality: A Potential Confounder of CPR Clinical Trials and Important National Healthcare Issue. Co-Investigator. Accepted for poster presentation at National Association of EMS Physicians 2015 Annual Meeting. Abstract published in Prehospital Emergency Care.

**g.** IRB Waived/3472. Epinephrine Usage for Allergic Reactions and Anaphylaxis in a Large, Urban EMS System. Principal Investigator. Accepted for poster presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Accepted for poster presentation at International Conference on Emergency Medicine 2014. Project involves one medical student and one EM resident.

**h.** IRB Waived/3319. Tourniquet Utilization in a Large, Urban EMS System. Principal Investigator. Accepted for poster presentation at National Association of EMS Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for poster presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Accepted at International Conference on Emergency Medicine 2014. Project involves one EM resident.

**i.** IRB Waived/3330. Airway Management in Adult, Non-Traumatic Cardiopulmonary Arrest in a Large, Urban EMS System. Principal

Investigator. Accepted for poster presentation at National Association of EMS Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for 2 poster presentations at Canadian Association of Emergency Physicians 2014 Annual Meeting. Both abstracts published in Canadian Journal of Emergency Medicine. Accepted for 2 poster presentations at International Conference on Emergency Medicine 2014. Project involves one undergraduate student, one medical student, and one EM resident.

**j.** IRB Waived/3320. Adenosine Usage for PSVT Cardioversion in a Large, Urban EMS System. Principal Investigator. Accepted for poster presentation at National Association of EMS Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for poster presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Accepted for poster presentation at International Conference on Emergency Medicine 2014. Project involves two undergraduate students.

**k.** IRB Approved. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Longitudinal Analysis of Contributing Factors and Resultant Injuries. Senior Investigator. Poster presentation at National Association of EMS Physicians 2013 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involves one medical student.

**l.** IRB Approved 16247/1256. Emergency Medical Technician Acquisition and Transmission of 12-Lead ECG Using a Novel Device (ReadyLink). Principal Investigator. Project involves one EM resident and one medical student. Poster presentation at American College of Cardiology 2013 Annual Meeting. Abstract published in Journal of the American College of Cardiology. Poster presentation at Society for Academic Emergency Medicine 2013 Annual Meeting. Poster presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Manuscript in progress. Project involves one undergraduate student and one EM resident.

**m.** IRB Waived. US Metropolitan Municipalities EMS Medical Directors Consortium (Eagles) Traumatic Shock and Hemorrhage Control Standards of Care Survey. Principal Investigator.

**n.** IRB Waived. US Metropolitan Municipalities EMS Medical Directors Consortium (Eagles) Neurologic Emergencies Standards of Care Survey. Principal Investigator.

**o.** IRB Approved 16038. Prehospital Barriers to the Use of Therapeutic Hypothermia for Cardiac Arrest. Senior Investigator. Poster

presentation at National Association of EMS Physicians 2012 Annual Meeting. Abstract published in Prehospital Emergency Care. Oral presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involved one EM resident and one medical student.

**p.** IRB Waived. Parenteral Dextrose Utilization in a Large, Urban Emergency Medical Services System. Senior Investigator. Poster presentation at National Association of EMS Physicians 2012 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involved one EM resident that presented the poster and one medical student.

**q.** IRB Waived. US Metropolitan Municipalities EMS Medical Directors Consortium (Eagles) State of Cardiopulmonary Resuscitation Practices Survey. Principal Investigator. Poster presentation at Society for Academic Emergency Medicine 2012 Annual Meeting and American College of Cardiology 2012 Annual Meeting. Oral presentation at Canadian Association of Emergency Physicians 2013 Annual Meeting. Abstract published in Canadian Journal of Emergency Medicine. Project involved one EMS fellow.

**r.** IRB Approved. A Statewide Survey of Emergency Department Standards of Care for Acute Coronary Syndromes - Variability and Opportunity for Advancement. Senior Investigator. Poster presentation at American College of Cardiology 2012 Annual Meeting. Project involved two EM residents and two medical students.

**s.** IRB Approved 15336. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Descriptive Analysis of Contributing Factors and Resultant Injuries. Principal Investigator. Poster presentation at National Association of EMS Physicians 2011 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster Presentation at OU-Tulsa 2011 Research Day. Poster presentation at the Texas Department of State Health Services 2011 EMS Conference Research Forum. Manuscript completed and published in EM International – Special Edition Focus on Prehospital Care. Project involved a medical student that presented the poster and wrote the first draft of the manuscript as well.

**t.** IRB Approved 15335. Use of an Ambulance Siren Low Frequency Enhancer, Howler™ in a Large, Urban Emergency Medical Services (EMS) System - Do Collision Rates Decrease? Principal Investigator. Poster presentation at National Association of EMS Physicians 2011 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster Presentation at OU-Tulsa 2011 Research Day. Poster

presentation at the Texas Department of State Health Services 2011 EMS Conference Research Forum. Project involved an EM resident that presented the poster as well.

**u.** IRB Approved. A Statewide Survey of Emergency Medical Services Standards of Care for Acute Coronary Syndromes - Variability and Opportunity in a State without Mandatory Statewide Treatment Protocols. Principal Investigator. Poster presentation at National Association of EMS Physicians 2011 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster Presentation at OU-Tulsa 2011 Research Day. Poster presentation at the Texas Department of State Health Services 2011 EMS Conference Research Forum. Project involved an EM resident.

**v.** IRB Approved 14838. EMS Override of Emergency Department EMS Diversion Requests for Clinically Stable Patients with Pre-Existing Health Care Network Relationships - Effects of an Administrative Change. Principal Investigator. Poster Presentation at OU-Tulsa 2010 Research Day. Project involved an EM resident.

**w.** IRB Approved 14839. Timeliness of post-intubation capnography application - effects of educational intervention on paramedic performance. Principal Investigator. Poster Presentation at National Association of EMS Physicians 2010 Annual Meeting. Abstract published in Prehospital Emergency Care. Poster Presentation at OU-Tulsa 2010 Research Day. Project involved an EM resident that presented the poster and wrote a first draft manuscript.

**3. Teaching Materials Developed**

**a.** State of Oklahoma EMS Medical Director Course and Practicum for Oklahoma State Department of Health. Full course developed and delivered in Muskogee, Stillwater, Ardmore, and Lawton in March – June 2014, McAlester, Tulsa, Lawton, and Enid in July/August 2012. Beta course developed and delivered in Oklahoma City in June 2010.

**b.** Oklahoma Trauma Education Program (OTEP) 2008. Materials on multi-systems trauma management and transfer, and hand injury management and transfer. Peer reviewed within the Department of Emergency Medicine.

**4. Invited Participation in Academic Conferences**

**a.** Low Titer O+ Whole Blood in The EMS System for Metropolitan Oklahoma City and Tulsa (System Keynote Presentation). National Whole Blood Academy – San Antonio, Texas (June 2024)

**b.** EMS & Financial Principles of Medical Oversight. University of Iowa, Department of Emergency Medicine, Division of EMS, EMS Fellowship Visiting Professorship (Virtual Format). (December 2023)

**c.** National EMS Board Certification Review Course – Dallas, Texas (August 2017 & September 2015), Tucson, Arizona (January 2014), Seattle, Washington (October 2013), and Las Vegas, Nevada (September 2013). Sponsored by ACEP and NAEMSP. Served as course curriculum developer and faculty lecturer.

**b.** National EMS Medical Director's Course – Bonita Springs, Florida – (January 2013). Sponsored by NAEMSP. Served as faculty lecturer, panelist, and case study discussion leader.

**c**. National EMS Information System (NEMSIS) 3.0 Development Review in Conjunction with EMS Benchmarking in ST Elevation Myocardial Infarction, Out of Hospital Cardiac Arrest, and Stroke – Atlanta, Georgia - (March 2010). Sponsored by the CDC and EMS Performance Improvement Center at University of North Carolina Chapel Hill. Served as an expert opinion contributor, representing The US Metropolitan Municipalities EMS Medical Directors Consortium.

**d.** Patient Safety in EMS Roundtable - Niagara Falls, Ontario, Canada - (June 2009). Sponsored by The Canadian Patient Safety Institute (CPSI), the Emergency Medical Services Chiefs of Canada (EMSCC), the Calgary EMS Foundation, and members from a pan-Canadian Patient Safety in EMS Advisory Group. Served as an expert opinion contributor and led discussion group.

**5. Other Academic Activity**

**a.** Massive Gastrointestinal Bleeding at Surgical Anastomosis. Poster presentation. Aughe-Flores F (resident) and **Goodloe JM**. OU REACH-OUT Poster Forum. April 2024 – Tulsa, Oklahoma.

**b.** Staphylococcal Toxic Shock Syndrome: Forgotten Foreign Body. Poster presentation. Scarborough J (resident) and **Goodloe JM**. OU Clinical Vignettes Symposium. May 2020 – Tulsa, Oklahoma.

**c.** Gradenigo's: A Forgotten Syndrome. Oral presentation. Milman B (resident) and **Goodloe JM**. OU Clinical Vignettes Symposium. May 2019 – Tulsa, Oklahoma. Awarded most outstanding oral presentation.

**d.** 2nd Annual Oklahoma Resuscitation Academy – April 2015, Oklahoma City. Course Coordinator for 2-day national resuscitation conference.

**e.** Mass Gathering Medical Care in a Motorsports Event-Based Collaborative Training Program**.** Accepted for poster presentation at Innovations in EMS Fellow Education Symposium at National

Association of EMS Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for oral presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Physicians.

**f.** Tactical Emergency Medicine Care in a Military Medicine, Law Enforcement, and Emergency Medicine Collaborative Training Program**.** Accepted for poster presentation at Innovations in EMS Fellow Education Symposium at National Association of EMS Physicians 2014 Annual Meeting. Abstract published in Prehospital Emergency Care. Accepted for oral presentation at Canadian Association of Emergency Physicians 2014 Annual Meeting. Abstract published in Canadian Journal of Emergency Physicians.

**g.** Oklahoma Resuscitation Academy – April 2014, Oklahoma City. Course Coordinator for 2-day national resuscitation conference.

## VIII. PUBLICATIONS

### 1. Peer-Reviewed

2024 Johnson JP, Oliphant BW, Dodd J, Duckworth RL, Goodloe JM, Lyng JW, Sagraves SG, Fischer PE. Prehospital Antibiotic Administration for Suspected Open Fractures: Joint COT/OTA/ACEP/NAEMSP/NAEMT Position Statement. Prehosp Emerg Care. 2024;28(8):1063-1067. doi: 10.1080/10903127.2024.2409380. Epub 2024 Oct 14. PMID: 39356234.

Marin JR, Lyons TW, Claudius I, Fallat ME, Aquino M, Ruttan T, Daugherty RJ; AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine, Section on Radiology; AMERICAN COLLEGE OF RADIOLOGY; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee (**Goodloe JM** – Board Liaison). Optimizing Advanced Imaging of the Pediatric Patient in the Emergency Department. Technical Report. Pediatrics. 2024 Jul;154(1):e2024066855. doi: 10.1542/peds.2024-066855. PMID: 38932719.
See also:
Policy statement. Pediatrics. 2024 Jul;154(1):e2024066854. doi: 10.1542/peds.2024-066854. PMID: 38932710.

Lurie K, Moore J, **Goodloe J**, Holley J, Porter R, Campensa R, Bachista K. Head Up Position CPR: A Complementary Option for Out-of-Hospital Cardiac Arrest. Prehosp Emerg Care. 2024;28(5):748-750. doi: 10.1080/10903127.2024.2359506. Epub 2024 Jun 10. PMID: 38776428.

Schoenfeld DW, Thomas CE, Palmer L, Justice W, Hwang E, Zimmerman KD, **Goodloe JM**, Shecter JD, Thomas SH. Nation-Wide Variation in Presence of Legislation or Protocols for EMS Care of Operational Canines. Prehosp Disaster Med. 2024 Feb;39(1):59-64. doi: 10.1017/S1049023X24000074. Epub 2024 Feb 15. PMID: 38356384.

2023 Saidinejad M, Duffy S, Wallin D, Hoffmann JA, Joseph MM, Schieferle Uhlenbrock K, Brown K, Waseem M, Snow S, Andrew M, Kuo AA, Sulton C, Chun T, Lee LK; AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee (**Goodloe JM** – Board Liaison); EMERGENCY NURSES ASSOCIATION Pediatric Committee. Policy Statement; Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children. The Management of Children and Youth With Pediatric Mental and Behavioral Health Emergencies. Ann Emerg Med. 2023 Sep;82(3):e97-e105. doi: 10.1016/j.annemergmed.2023.06.003. PMID: 37596031
See also:
Pediatrics. 2023 Sep 1;152(3):e2023063255. doi: 10.1542/peds.2023-063255. PMID: 37584147.
See also:
Pediatrics. 2023 Sep 1;152(3):e2023063256. doi: 10.1542/peds.2023-063256. PMID: 37584106.

Berry C, Gallagher JM, Goodloe JM, Dorlac WC, Dodd J, Fischer PE. Prehospital Hemorrhage Control and Treatment by Clinicians: A Joint Position Statement. Prehosp Emerg Care. 2023;27(5):544-551. doi: 10.1080/10903127.2023.2195487. Epub 2023 Jun 20. PMID: 36961935.

Medrano NW, Villarreal CL, Price MA, Bixby PJ, Bulger EM, Eastridge BJ; MIMIC Study Group (**Goodloe JM**). Access to trauma center care: A statewide system-based approach. J Trauma Acute Care Surg. 2023 Aug 1;95(2): 242-248. doi: 10.1097/TA.0000000000004002. Epub 2023 May 8. PMID: 37158782.

Ross SW, Campion E, Jensen AR, Gray L, Gross T, Namias N, Goodloe JM, Bulger EM, Fischer PE, Fallat ME. Prehospital and emergency department pediatric readiness for injured children: A statement from the American College of Surgeons Committee on Trauma Emergency Medical Services Committee. J Trauma Acute Care Surg. 2023 Aug1;95(2):e6-e10. doi: 10.1097/TA.0000000000003997. Epub 2023 May 1. PMID: 37125944.

Callahan JM, Baldwin S, Bodnar C, Fuchs S, Krug S, Lightfoot C, Raskas M, Weinberg S; AMERICAN ACADEMY OF PEDIATRICS; Committee on Pediatric Emergency Medicine; Council on Clinical Information

Technology; Council on Children and Disasters; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; Pediatric Emergency Medicine Committee (**Goodloe JM – Board Liaison**); Policy Statement; Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children. Access to Critical Health Information for Children During Emergencies: Emergency Information Forms and Beyond. Ann Emerg Med. 2023 Mar;81(3):e27-e36. doi: 10.1016/j.annemergmed.2022.12.005. PMID: 36813444.
See also:
Pediatrics. 2023 Mar 1;151(3):e2022060970. doi: 10.1542/peds.2022-060970.PMID: 36807981

2022 Dodson CA, **Goodloe JM**. Headache and weakness in a young adult female. J Am Coll Emerg Physicians Open. 2022 Jun 30;3(4):e12772. doi: 10.1002/emp2.12772. PMID: 35782347; PMCID: PMC9244344.

Aldeeb B, **Goodloe JM**. Abdominal pain in an adolescent female. J Am Coll Emerg Physicians Open. 2022 Jun 2;3(3):e12759. doi: 10.1002/emp2.12759. PMID: 35662898; PMCID: PMC9161699.

Kupas DF, Zavadsky M, Burton B, Baird S, Clawson JJ, Decker C, Dworsky PI, Evans B, Finger D, **Goodloe JM**, LaCroix B, Ludwig GG, McEvoy M, Tan DK, Thornton KL, Smith K, Wilson BR. Joint Statement on Lights & Siren Vehicle Operations on Emergency Medical Services Responses. Prehosp Emerg Care. 2022 May-Jun;26(3):459-461. doi: 10.1080/10903127.2022.2044417. PMID: 35475941.

Newgard CD, Fischer PE, Gestring M, Michaels HN, Jurkovich GJ, Lerner EB, Fallat ME, Delbridge TR, Brown JB, Bulger EM; Writing Group for the 2021 National Expert Panel on Field Triage (**Goodloe JM**). National guideline for the field triage of injured patients: Recommendations of the National Expert Panel on Field Triage, 2021. J Trauma Acute Care Surg. 2022 Aug 1;93(2):e49-e60. doi: 10.1097/TA.0000000000003627. Epub 2022 Apr 27. PMID: 35475939; PMCID: PMC9323557.

Medrano NW, Villarreal CL, Mann NC, Price MA, Nolte KB, MacKenzie EJ, Bixby P, Eastridge BJ; MIMIC Study Group (**Goodloe JM**). Activation and On-Scene Intervals for Severe Trauma EMS Interventions: An Analysis of the NEMSIS Database. Prehosp Emerg Care. 2023;27(1):46-53. doi: 10.1080/10903127.2022.2053615. Epub 2022 Apr 15. PMID: 35363117.

2021 **Goodloe JM**, Topjian A, Hsu A, Dunne R, Panchal AR, Levy M, McEvoy M, Vaillancourt C, Cabanas JG, Eisenberg MS, Rea TD, Kudenchuk PJ, Gienapp A, Flores GE, Fuchs S, Adelgais KM, Owusu-Ansah S, Terry M, Sawyer KN, Fromm P, Panczyk M, Kurz M, Lindbeck G, Tan DK,

Edelson DP, Sayre MR. Interim Guidance for Emergency Medical Services Management of Out-of-Hospital Cardiac Arrest During the COVID-19 Pandemic. Circ Cardiovasc Qual Outcomes. 2021 Jul;14(7):e007666. doi: 10.1161/CIRCOUTCOMES.120.007666. Epub 2021 Jun 23. PMID: 34157848; PMCID: PMC8288195.

Brown KM, Ackerman AD, Ruttan TK, Snow SK; AMERICAN ACADEMY OF PEDIATRICS, Committee on Pediatric Emergency Medicine; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, Pediatric Emergency Medicine Committee (**Goodloe JM – Board Liaison**); EMERGENCY NURSES ASSOCIATION, Pediatric Committee; 2019 Pediatric Committee Members; Policy Statement; Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children. Access to Optimal Emergency Care for Children. Ann Emerg Med. 2021 May;77(5):523-531. doi: 10.1016/j.annemergmed.2021.03.034. PMID: 33902828. Also published in Pediatrics. 2021 May;147(5):e2021050787. doi: 10.1542/peds.2021-050787. PMID: 33883245.

2020 Woolridge D, Homme J, Amato CS, Pauze D, Rose E, Valente J, Ishimine P, Friesen P, Baldwin S, Joseph M, Saidinejad M, Perina D, **Goodloe JM**. Optimizing the workforce: a proposal to improve regionalization of care and emergency preparedness by broader integration of pediatric emergency physicians certified by the American Board of Pediatrics. J Am Coll Emerg Physicians Open. 2020 Jul 8;1(6):1520-1526. doi: 10.1002/emp2.12114

Moore B, Shah M, Owusu-Ansah S, Gross T, Brown K, Gausche-Hill M, Remick K, Adelgais K, Lyng J, Rappaport L, Snow S, Wright-Johnson C, Leonard J, American Academy of Pediatrics Committee on Pediatric Emergency Medicine, Section on Emergency Medicine EMS Committee and Section on Surgery; American College of Emergency Physicians Emergency Medical Services Committee (**Goodloe JM – Chair**); Emergency Nurses Association Pediatric Committee; National Association of Emergency Medical Services Physicians Standards and Clinical Practice Committee; National Association of Emergency Medical Technicians Emergency Pediatric Care Committee. Pediatric Readiness in Emergency Medical Services Systems. Prehosp Emerg Care. 2020 Mar-Apr;24(2):175-179. Also published in Ann Emerg Med. 2020 Jan;75(1):e1-e6. doi: 10.1016/j.annemergmed.2019.09.012. Also published in Pediatrics. 2020 Jan;145(1):e20193307. doi: 10.1542/peds.2019-3307.

Delbridge TR, Dyer S, **Goodloe JM**, Mosesso VN, Perina DG, Sahni R, Pons PT, Rinnert KJ, Isakov AP, Kupas DF, Gausche-Hill M, Joldersma KB, Keehbauch JN. The 2019 Core Content of Emergency Medical Services Medicine. Prehosp Emerg Care. 2020 Jan-Feb;24(1):32-45.

Moore B, Shah MI, Owusu-Ansah S, Gross T, Brown K, Gausche-Hill M, Remick K, Adelgais K, Lyng J, Rappaport L, Snow S, Wright-Johnson C, Leonard JC; AMERICAN ACADEMY OF PEDIATRICS, Committee on Pediatric Emergency Medicine and Section on Emergency Medicine EMS Subcommittee; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, Emergency Medical Services Committee (**Goodloe JM – Board Liaison**); EMERGENCY NURSES ASSOCIATION, Pediatric Committee; NATIONAL ASSOCIATION OF EMERGENCY MEDICAL SERVICES PHYSICIANS, Standards and Clinical Practice Committee (**Goodloe JM – Member**); NATIONAL ASSOCIATION OF EMERGENCY MEDICAL TECHNICIANS, Emergency Pediatric Care Committee; Pediatric Readiness in Emergency Medical Services Systems; POLICY STATEMENT; Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children. Pediatric Readiness in Emergency Medical Services Systems. Ann Emerg Med. 2020 Jan;75(1):e1-e6. doi: 10.1016/j.annemergmed.2019.09.012. PMID: 31866028. (

2019 Lyng JW, White CC 4th, Peterson TQ, Lako-Adamson H, **Goodloe JM**, Dailey MW, Clemency BM, Brown LH. Non-Auto-Injector Epinephrine Administration by Basic Life Support Providers: A Literature Review and Consensus Process. Prehosp Emerg Care. 2019 Nov-Dec;23(6):855-861.

Evidence-Based Guidelines for EMS Administration of Naloxone. Williams K, Lang ES, Panchal AR, Gasper JJ, Taillac P, Gouda J, Lyng JW, **Goodloe JM**, Hedges M. Prehosp Emerg Care. 2019 Nov-Dec;23(6):749-763.

Duval S, Pepe PE, Aufderheide TP, **Goodloe JM**, Debaty G, Labarère J, Sugiyama A, Yannopoulos D. Optimal Combination of Compression Rate and Depth During Cardiopulmonary Resuscitation for Functionally Favorable Survival. JAMA Cardiol. 2019; 4(9):900-908.

2018 Goolsby C, Jacobs L, Hunt RC, Goralnick E, Singletary EM, Levy MJ, **Goodloe JM**, Epstein JL, Strauss-Riggs K, Seitz SR, Krohmer JR, Nemeth I, Rowe DW, Bradley RN, Gestring ML, Kirsch TD. Stop the Bleed Education Consortium: Education program content and delivery recommendations. J Trauma Acute Care Surg. 2018 Jan;84(1):205-210.

2017 **Goodloe JM**, Idris AH. Metrics Save Lives: Value and Hurdles Faced. Curr Opin Crit Care. 2017 Jun;23(3):204-208.

**Goodloe JM**, Knoles CL, McAnallen D, Cox ML, Howerton DS. When Is the Need for Speed? A Data Driven Approach to Response Time Reform. Journal of Emergency Medical Services. 2017 Feb; 42(2):30-38.

Lurie K, Frascone RJ, **Goodloe JM**. Resuscitation GEMS. Resuscitation Outcomes Consortium (ROC) Studies Dig Deep into the Science of CPR. Journal of Emergency Medical Services. 2017 Jan; 42(1): 28-32.

2016 Fischer PE, Bulger EM, Perina DG, Delbridge TR, Gestring ML, Fallat ME, Shatz DV, Doucet J, Levy M, Stuke L, Zietlow SP, **Goodloe JM**, VanderKolk WE, Fox AD, Sanddal ND. Guidance Document for the Prehospital Use of Tranexamic Acid in Injured Patients. Prehosp Emerg Care. 2016 Sep-Oct;20(5):557-9.

2015 Yannopoulos D, Aufderheide TP, Abella BS, Duval S, Frascone RJ, **Goodloe JM**, Mahoney BD, Nadkarni VM, Halperin HR, O'Connor R, Idris AH, Becker LB, Pepe PE. Quality of CPR: An Important Effect Modifier in Cardiac Arrest Clinical Outcomes and Intervention Effectiveness Trials. Resuscitation. 2015 Sept; 94:106-13.

**Goodloe JM** and Gerecht R. TXA in the USA. Tranexamic Acid's Potentially Bright Future Relies on Collaborative Data. Journal of Emergency Medical Services, 2015 Apr; 40(4):30-5.

2014 **Goodloe JM.** Stay on Time. A Conversation about the Importance of Count and Cadence of Chest Compressions. Journal of Emergency Medical Services, 39(11) Nov Suppl:36-40.

**Goodloe JM**, Wayne M, Proehl J, Levy MK, Yannopoulos D, Thigpen K, O'Connor RE. Optimizing Neurologically Intact Survival from Sudden Cardiac Arrest: A Call to Action. West J Emerg Med. 2014 Nov:15(7)803-7.

**Goodloe JM**, Dailey MW, Heightman AJ. Armed with Naloxone. Journal of Emergency Medical Services, 39(8) Aug 28-33.

**Goodloe JM**. Not So Fast on Naloxone? There's Growing Support for Non-Paramedic Use but Keep These Cautions in Mind. (Cover Article). EMS World, 43(5):51-52.

2013 **Goodloe JM**, Purser J. Praxis for Anaphylaxis: Critical Updates in Assessment and Management of Anaphylactic Shock. Journal of Emergency Medical Services, 38(10) Oct 52-56.

**Goodloe JM**, Purser J. ABCs of Epinephrine Autoinjectors. Journal of Emergency Medical Services, 38(10) Oct 54.

**Goodloe JM**, Howerton DS, McAnallen D, Reed H. How Can Tranexamic Acid Help in EMS? TXA Offers New Hope for an Old Challenge in Traumatic Hemorrhagic Shock EMS World, 42(5): I5-6.

**Goodloe JM**, Howerton DS, McAnallen D, Reed H. TXA: A Difference-Maker for Trauma Patients? Role of Tranexamic Acid in EMS & Preoperative Trauma Management. Journal of Emergency Medical Services, 38(4) Apr 60-65.

2013 **Goodloe JM**, Howerton DS, Appleby T. Putting Standards on the Map: Oklahoma Leaders Create Comprehensive Set of Evidence-Based Protocols. Journal of Emergency Medical Services, 38(2) Feb 36-38.

2012 **Goodloe JM.** Review of Bobrow et al. Research Manuscript on Layperson Compression-Only CPR. 2013 Lifelong Learning and Self-Assessment Study Guide. EB Medicine.

Whelan LJ, Justice WA, **Goodloe JM**, Dixon JD, Thomas SH. Trauma Ultrasound in Civilian Tactical Medicine. Emergency Medicine International, 2012; 2012:781570. Epub Nov 15.

**Goodloe JM**, Reginald TJ, Howerton DS, Winham JO, Appleby T. Attacking Cardiac Arrest, Part II: Feedback-Driven Team Performance Impacts Survival. Journal of Emergency Medical Services, 37(9) Sept, 34-39.

**Goodloe JM**, Reginald TJ, Howerton DS, Winham JO, Appleby T. Attacking Cardiac Arrest: Good Science & Enthusiasm Drive Survival Rates in Oklahoma. Journal of Emergency Medical Services, 37(8) Aug, 52-57.

Arthur AO, **Goodloe JM**, Thomas SH. Subcutaneous Fluid Administration: A Potentially Useful Tool in Prehospital Care. Emergency Medicine International, 2012; 2012:904521. Epub May 9.

Deal KE, Synovitz CK, **Goodloe JM**, King B, Stewart CE. Tulsa Oklahoma Oktoberfest Tent Collapse Report. Emergency Medicine International, 2012; 2012:729795. Epub May 9.

Howerton DS, Winham JO, Reginald TJ, **Goodloe JM**. Beyond Basic Training: How EMT-Basics Can Assist in 12-Lead EKG Acquisition and Transmission. EMS World, 41(5) May 2012 EMS Innovations Supplement, I4-I5.

Justice W, Massie K, **Goodloe JM**. Prepared for the Worst: Tactical Training Offers Many Benefits to EMS. Journal of Emergency Medical Services, 37(5) May, 46-50.

**Goodloe JM**, Crowder CJ, Arthur AO, and Thomas SH. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Descriptive Analysis

of Contributing Factors and Resultant Injuries. Emergency Medicine International, 2012; 2012:745706. Epub Apr 23.

2012 Holder P, Arthur AO, Thiems G, Redmon T, Thomas M, **Goodloe JM**, Reginald TJ, Thomas SH. Patients Refusing Prehospital Transport Are Increasingly Likely to Be Geriatric. Emergency Medicine International, 2012; 2012:905976. Epub Feb 19.

**Goodloe JM.** Basic Capnography: Advancing BLS Patient Assessment & Management. Journal of Emergency Medical Services, 37(3) March, Rapid Results Capnography: A Key Patient Assessment Tool Supplement, S4-S7.

2011 **Goodloe JM**. Drug Shortages. Tips to Turn Dilemmas into Discoveries. Journal of Emergency Medical Services, 36(12) December, 36-37.

**Goodloe JM.** Inventory Management Tips Might Improve Effects of Drug Shortage. jems.com. December 1.

2010 **Goodloe JM**. The STEMI Care Race (La course de relais de la prise en charge des patients STEMI). 3SM Magazine du Service de Santé et de Secours Médical des Sapeurs-Pompiers. December 2010 No. 7.

Soliman CE, **Goodloe JM**, Thomas SH. Prehospital trauma analgesia. Reanoxyo: Revue du Club des Anesthésistes-Réanimateurs et Urgentists Militaires 2010; Volume 26(2): 38-39.

**Goodloe JM** and Reginald TJ. Chill Factor: Why the Hottest Thing in EMS is Cold. Journal of Emergency Medical Services, 35(2) February, 44-53.

Mechem CC, **Goodloe JM**, Richmond NJ, Kaufman BJ, Pepe PE. Resuscitation Center Designation: Recommendations for Emergency Medical Services Practices. Prehospital Emergency Care, 14(1), 51-61.

2008 **Goodloe JM**, Stewart CE, Synovitz CK, Deal KE. Big Top Incident: Tulsa EMS Responds to Tent Collapse. Journal of Emergency Medical Services, 33(9) September, 42-44.

Myers JB, Slovis CM, Eckstein M, **Goodloe JM**, Isaacs SM, Loflin JR, Mechem CC, Richmond NJ, Pepe PE. Evidence Based Performance Measures for Emergency Medical Services Systems: A Model for Expanded EMS Benchmarking. Prehospital Emergency Care, 12(2), 141-151.

**Non-peer reviewed**

2021 **Goodloe JM**. COVID-19 Updates. Accessible at okctulomd.com

2020 **Goodloe JM**. COVID-19 Updates. Accessible at okctulomd.com

2016 **Goodloe JM**. Emergency Physicians Encouraged to Draw Attention to Pharmaceutical Drug Shortages. ACEP Now Newsletter. March 16. Accessible at acepnow.com

2014 The Mobile Integrated Healthcare Practice Collaborative including **Goodloe JM**. "Program Evaluation" Principles for Establishing a Integrated Healthcare Practice. Medtronic Philanthropy. Accessible at mihpresources.com

2009 **Goodloe JM**. The STEMI Care Race: Gunder Haag and Roger Bannister must surely be proud of EMS. Eye of the Eagle Column. jems.com.July30.

**2. Chapters in Textbooks**

2022 **Goodloe JM** and Soulek JJ. "Foreign Bodies" Rosen's Emergency Medicine - Concepts and Clinical Practice: 10th Edition. Walls R, Hockberger R, Gausche-Hill M, Erickson TB, Wilcox SR(Eds) Mosby.

2021 Hinchey PR and **Goodloe JM**. "Principles of Finance" NAEMSP Emergency Medical Services: Clinical Practice and Systems Oversight: 3rd Edition. Cone DC, Brice JH, Delbridge TR, Myers JB (Eds) Wiley-Blackwell. Hoboken, USA.

2017 **Goodloe JM**. "Bronchitis, Pneumonia, and SARS" Tintinalli's Emergency Medicine Manual: 8th Edition. Cline DC, Ma OJ, Cydulka RK, Meckler GD, Handler DA, Thomas ST (Eds) McGraw Hill. New York, USA.

Thomas SH and **Goodloe JM**. "Foreign Bodies" Rosen's Emergency Medicine - Concepts and Clinical Practice: 9th Edition. Marx J, Hockberger R, Walls R (Eds) Mosby.

(IN PRESS) Goodloe **JM**, Lippmann M, Fowler R. "Evidence Based EMS Medicine" Paramedic Textbook. Navarro K and Hsieh A (Eds) FA Davis, Philadelphia, USA.

2015 Seth NB and **Goodloe JM**. "EMS Finance" Cooney's EMS Medicine. Cooney DR (Ed) McGraw Hill. New York, USA.

Hogue TD and **Goodloe JM**. "Measuring Performance" Cooney's EMS Medicine. Cooney DR (Ed) McGraw Hill. New York, USA.

Braithwaite SA and **Goodloe JM**. "Blunt Trauma Considerations" Emergency Medical Services: Clinical Practice and Systems Oversight. Brice J, Cone D, Delbridge T, Myers B (Eds) Wiley. Hoboken, New Jersey, USA.

2015 Hinchey PR and **Goodloe JM**. "Finance" Emergency Medical Services: Clinical Practice and Systems Oversight. Brice J, Cone D, Delbridge T, Myers B (Eds) Wiley. Hoboken, New Jersey, USA.

2013 Thomas SH and **Goodloe JM**. "Foreign Bodies" Rosen's Emergency Medicine - Concepts and Clinical Practice: 8th Edition. Marx J, Hockberger R, Walls R (Eds) Mosby.

**Goodloe JM**. "Pneumonia, Bronchitis, and Upper Respiratory Tract Infection" Tintinalli's Emergency Medicine: Just the Facts, Third Edition. Cline DC, Ma OJ (Eds) McGraw Hill. New York, USA.

2012 **Goodloe JM**. "Avoid Hyperventilation in the Intubated Patient" and "Don't Underestimate Continuous Waveform Capnography in the Intubated Patient" Avoiding Common Errors in Prehospital Medicine. Lawner B, Slovis C, Fowler R, Pepe P, Mattu A, Marcucci L(Eds).

**Goodloe JM**. "Bronchitis, Pneumonia, and SARS" Tintinalli's Emergency Medicine Manual: 7th Edition. Cline DC, Ma OJ, Cydulka RK, Meckler GD, Handler DA, Thomas ST (Eds) McGraw Hill. New York, USA.

**Goodloe JM** and Biddinger PD. "Prehospital care and emergency medical services" An Introduction to Clinical Emergency Medicine: 2nd Edition. Mahadevan SV and Garmel GM (Eds) Cambridge University Press, Cambridge, UK.

**Other:**

**a. Abstracts or Posters**

2025 Schoenfeld D, Thomas SA, Akinosho K, Dunn K, Racht E, **Goodloe J**, Bailey A, Shecter J, Fritz C, Rosen C, Thomas S. Alloimmunization Risk: Assessing the Number of EMS-Initiated Transfusions Administered to Females of Childbearing Potential. Poster Presentation at National Association of EMS Physicians Annual Meeting, San Diego, CA. January 2025. Published in Prehosp Emerg Care, 29 (1) Supp1: S61.

Schoenfeld D, Thomas SA, Schweitzer N, Dunn K, Racht E, **Goodloe J**, Bailey A, Shecter J, Blumen I, McCartin M, Fritz C, Rosen C, Thomas S. Good to the Last Drop: Assessing Completion of EMS-Initiated Transfusion. Poster Presentation at National

Association of EMS Physicians Annual Meeting, San Diego, CA. January 2025. Published in Prehosp Emerg Care, 29 (1) Supp1: S64.

2025 Schoenfeld D, Thomas SA, Dunn K, Racht E, **Goodloe J**, Bailey A, Shecter J, Fritz C, Rosen C, Thomas S. Five-Year Trends (2020-2024) in EMS-Instituted Transfusions in the US. Poster Presentation at National Association of EMS Physicians Annual Meeting, San Diego, CA. January 2025. Published in Prehosp Emerg Care, 29 (1) Supp1: S78.

Bailey A, Howerton D, Knoles C, McAnallen D, Cox M, **Goodloe J**. Implementing a Basic Life Support (BLS) Tiered Ambulance Response in Metropolitan Oklahoma City and Tulsa. Poster Presentation at National Association of EMS Physicians Annual Meeting, San Diego, CA. January 2025. Published in Prehosp Emerg Care, 29 (1) Supp1: S124.

2024 Moore JC, Bachista K, Quinn R, Salverda B, Emanuelson L, **Goodloe JM**, Reynolds J, Cole J, Crawford WE, Siegel L, Williamson C, Antevy P, Holley JE, Pepe PE, Debaty G, Scheppke K. The Rapid Use of Automated Head and Thorax Elevation with Automated Active Compression Decompression Cardiopulmonary Resuscitation and an Impedance Threshold Device Compared with National Outcome Data. Poster Presentation at National Association of EMS Physicians Annual Meeting. Austin, TX. January 2024. Published in Prehosp Emerg Care, 28(1) Supp1: S18.

Shecter JD, Schoenfeld D, Thomas CE, Palmer L, Justice W, Hwang E, Zimmerman K, **Goodloe JM**, Thomas SH. Nationwide Variation in Presence of Legislation or Protocols for EMS Care of Operational Canines. Poster Presentation at National Association of EMS Physicians Annual Meeting. Austin, TX. January 2024. Published in Prehosp Emerg Care, 28(1) Supp1: S24.

2022 Fleegler M, Albright D, Wadman M, Findley S, Sampson C, Sanson T, Goodloe J, Wilkinson B, Rimple D. Rural Emergency Medicine: The State of Rural Rotations in Residency Training Programs. Poster Presentation at ACEP Research Forum at ACEP 23, San Francisco, CA, September/October 2022. Published in Ann of EM, 80 (4), Supplement.
DOI: https://doi.org/10.1016/j.annemergmed.2022.08.406

2020 Medrano NW, Villareal CL, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Statewide System-Based Geographic Approach to Trauma Care Access. Abstract Poster Presentation at

American Association for the Surgery of Trauma (Virtual Annual Conference). September.

2020 Medrano NW, Villareal CL, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Statewide System-Based Geographic Approach to Trauma Care Access. Abstract Online Poster Presentation at Esri User Conference (Virtual Annual Conference). July.

Villareal CL, Medrano NW, Remenapp CM, Wang Z, MacKenzie EJ, Nolte KB, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Evaluating Inter-rater Reliability When Determining Pre-Hospital Injury Survivability. Abstract Poster Presentation at U.S. Military Health System Research Symposium (Virtual Annual Conference).

Villareal CL, Medrano NW, Remenapp CM, Wang Z, MacKenzie EJ, Nolte KB, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Evaluating Inter-rater Reliability When Determining Pre-Hospital Injury Survivability. Abstract Poster Presentation at Military City USA Trauma Collaborative Research Conference (Virtual Annual Conference).

Villareal CL, Medrano NW, Remenapp CM, Wang Z, MacKenzie EJ, Nolte KB, Price MA, Eastridge BJ, MIMIC Study Group (**Goodloe JM**). Examining Differences in Injury Survivability Determinations Between Medical Examiners and Trauma Surgeons Evaluating Pre-Hospital Trauma Deaths. Abstract Podium Presentation at National Association of Medical Examiners Conference (Virtual Annual Conference).

Eastridge BJ, Nolte KB, MacKenzie EJ, Stewart FM, Villareal CL, Medrano NW, Price MA, Davis GG, Maxson RT, Mazuchowski EL, MIMIC Study Group (**Goodloe JM**). Preliminary Analysis of the Multi-Institutional Multidisciplinary Injury Mortality Investigation in the Civilian Pre-Hospital Environment (MIMIC). Abstract Podium Presentation at Western Trauma Association Meeting.

2017 **Goodloe JM** (presenter), Vinson LD (EM resident), Cox, ML, Burns BD. Paramedic compliance with a novel defibrillation strategy in a large, urban EMS system in the United States. Poster presentation. Canadian Association of Emergency Physicians Annual Meeting, Whistler, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2017; 19 Suppl 1, S98.

**Goodloe JM** (presenter), Vinson LD (EM resident), Cox, ML, Burns BD. Morbid obesity association with return of spontaneous circulation from sudden cardiac arrest treated in a large, urban EMS system in the United States. Poster presentation. Canadian Association of Emergency Physicians Annual Meeting, Whistler, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2017; 19 Suppl 1, S97-98.

2016 Duval S, Pepe PE, **Goodloe JM**, Sugiyama A, Yannopoulos D. The CPR "Sweeter Spot": A Target Combination of Optimal Chest Compression Rate and Depth to Achieve Survival with Favorable Neurological Function After Out of Hospital Cardiac Arrest. [abstract] Circulation 2016;134 Suppl 1: A19230.

2015 **Goodloe JM** (presenter), Arthur AO, Arthur EN (high school student), Reed H. Prevalence and Survival Impact of Bystander Cardiopulmonary Resuscitation in Sudden Cardiac Arrest Victims Treated by a Large, Urban EMS System in North America. Oral Presentation. Canadian Association of Emergency Physicians Annual Meeting, Edmonton, Alberta. Abstract in Canadian Journal of Emergency Medicine 2015; 17 Suppl 2, S22-3.

**Goodloe JM** (presenter), Arthur AO, Arthur EN (high school student), Reed H. Demographics of Twenty-One Years of Sudden Cardiac Arrest Victims Treated by a Large, Urban EMS System in North America. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Edmonton, Alberta. Abstract in Canadian Journal of Emergency Medicine 2015; 17 Suppl 2, S64-5.

**Goodloe JM** (presenter), Arthur AO, Arthur EN (high school student), Braithwaite SA, Reed H. The Prevalence and Impact of Ventricular Fibrillation as the Initial Cardiac Arrest Dysrhythmia Twenty Years in a Large, Urban EMS System. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Edmonton, Alberta. Abstract in Canadian Journal of Emergency Medicine 2015; 17 Suppl 2, S64. Poster Presentation. National Association of EMS Physicians Annual Meeting, New Orleans, Louisiana. Abstract in Prehospital Emergency Care 19(1), 156.

Mahoney B, Yannopoulos D, Aufderheide T, Abella B, Duval S, Frascone R, **Goodloe J**, Nadkarni V, Halperin H, O'Connor R, Idris A, Pepe P, Becker L. The Effect of CPR Quality: A Confounder of CPR Clinical Trials and Important National Healthcare Issue. Poster Presentation. National Association of

EMS Physicians Annual Meeting, New Orleans, Louisiana. Abstract in Prehospital Emergency Care 19(1), 156.

2014 **Goodloe JM** (presenter), Martinez M (EM resident/presenter), Arthur AO, Parker S (undergraduate student), Thomas SH. Tourniquet Utilization Patterns & Impacts on Hemostasis in a Large, Urban EMS System. Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 18(1), 161-162. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S52. Poster Presentation. International Conf for Emergency Medicine, Hong Kong, China.

**Goodloe JM** (presenter), Arthur AO, Holder P (EM resident), Murry W (medical student), Witmer JW, Higgins L (undergraduate student), Thomas SH. Airway Management Practices in Adult Non-Traumatic Cardiac Arrest in a Large, Urban EMS System. Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 18(1), 136-137. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S88. Poster Presentation. International Conf for Emergency Medicine, Hong Kong, China.

**Goodloe JM** (presenter), Arthur AO, Holder P (EM resident), Murry W (medical student), Witmer JW, Higgins L (undergraduate student), Thomas SH. Endotracheal Intubation in Adult Non-Traumatic Cardiac Arrest in a Large, Urban EMS System. Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 18(1), 136-137. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S88. Poster Presentation. International Conference for Emergency Medicine, Hong Kong, China.

**Goodloe JM** (presenter), Arthur AO, Letson C (undergraduate student), Witmer JW, Thomas SH. Adenosine Utilization and Effect on Supraventricular Tachycardia in a Large, Urban EMS System. Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 18(1), 128. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency

Medicine 2014; 16 Suppl 1, S87-88. Poster Presentation. International Conf for Emergency Medicine, Hong Kong, China.

2014 **Goodloe JM** (presenter), Arthur AO, Cory B (EM resident), McNitt W (medical student), Thomas SH. Presentation of Acute Allergic Reactions in a Large, Urban EMS System. Poster Presentation. Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S88-89. Poster Presentation. International Conference for Emergency Medicine, Hong Kong, China.

**Goodloe JM** (presenter), Arthur AO, Genzel R, Burns BD (presenter), Thomas SH. Mass Gathering Medical Care in a Motorsports Event-Based Collaborative Training Program. Innovations in EMS Fellowship Education Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 18(2). Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S35.

**Goodloe JM** (presenter), Arthur AO, Justice W, Massie K, Burns BD (presenter), Thomas SH. Tactical EMS Care in a Military Medicine, Law Enforcement, and Emergency Medicine Collaborative Training Program. Innovations in EMS Fellowship Education Poster Presentation. National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 18(2). Poster Presentation. Canadian Association of Emergency Physicians Annual Meeting, Ottawa, Ontario. Abstract in Canadian Journal of Emergency Medicine 2014; 16 Suppl 1, S66-67.

2013 Beck EH (presenter), White L, **Goodloe J**, Myers B, Moy H, Tan D, Bourne S, Beeson J, Craig A, Racht E, Mellor J. Mobile Integrated Healthcare Practice: Improving Population Health Through Innovative Alignment of Existing Mobile Health Infrastructure. Poster Presentation. American Public Health Association Annual Meeting, Boston, Massachusetts.

**Goodloe JM** (presenter), Arthur AO, Rhoades T (medical student), Holder P (EM resident), Winham JW, Thomas SH. EMT-Basic Acquisition and Transmission of 12-lead ECG Using a Novel Device (ReadyLink™). Poster Presentation, Canadian Association of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S44.

Kallsen T (medical student), Arthur AO, Thomas SH, **Goodloe JM** (presenter). EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Longitudinal Analysis of Contributing Factors and Resultant Injuries. Poster Presentation, Canadian Association of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S59-60.

2013 Crane RD (EM resident), Arthur AO, Dunn K (medical student), Thomas ST, **Goodloe JM** (presenter). Emergency Medical Services Initiation of Therapeutic Hypothermia in Post-Return of Spontaneous Circulation from Cardiac Arrest: Chillingly Low Rates and Contributing Factors. Oral Presentation, Canadian Association of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S18-19.

**Goodloe JM** (presenter), Lehrfeld D (EMS fellow), Schrank K. A Nationwide Survey of Emergency Medical Services Standards of Care for Cardiac Arrest – Variability Amongst America's Largest Urban Systems. Oral Presentation, Canadian Association of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S19.

Williams E (EM resident), Reginald TJ, Likens J, Arthur AO, Notley D (medical student), Thomas ST, **Goodloe JM** (presenter). Parenteral Dextrose Utilization in a Large, Urban EMS System. Poster Presentation, Canadian Association of Emergency Physicians Annual Meeting, Vancouver, British Columbia. Abstract in Canadian Journal of Emergency Medicine 2013; 15 Suppl 1, S59.

**Goodloe JM**, Arthur AO (presenter), Rhoades T (medical student), Holder P (EM resident), Winham JW, Thomas SH. EMT-Basic Acquisition and Transmission of 12-lead ECG Using a Novel Device (ReadyLink™). Poster Presentation, Society for Academic Emergency Medicine Annual Meeting, Atlanta, Georgia. Abstract in Academic Emergency Medicine, 20(5), Suppl 1, S272.

**Goodloe JM** (presenter), Arthur AO, Rhoades T (medical student), Holder P (EM resident), Winham JW, Thomas SH. EMT-Basic Acquisition and Transmission of 12-lead ECG Using a Novel Device (ReadyLink™). Poster Presentation, American College of Cardiology Annual Meeting, San Francisco, California. Abstract in Journal of American College of Cardiology (JACC), March 12, 61(10_S), Supplement A.

2013 Kallsen T (medical student/presenter), Arthur AO, Thomas SH, **Goodloe JM**. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Longitudinal Analysis of Contributing Factors and Resultant Injuries. Poster Presentation, National Association of EMS Physicians Annual Meeting, Bonita Springs, Florida. Abstract in Prehospital Emergency Care 17(1), 109-110.

Dixon JD, Arthur AO, Williams E (EM resident), **Goodloe JM** (presenter), Thomas SH. Ambulance Patients are More (or Less) Likely to be Insured. Poster Presentation, National Association of EMS Physicians Annual Meeting, Bonita Springs, Florida. Abstract in Prehospital Emergency Care 17(1), 132.

2012 Crane RD (EM resident), Arthur AO, Dunn K (medical student), Thomas ST, **Goodloe JM** (presenter). Emergency Medical Services Initiation of Therapeutic Hypothermia in Post-Return of Spontaneous Circulation from Cardiac Arrest: Chillingly Low Rates and Contributing Factors. Poster Presentation, Texas Department of State Health Services 2012 EMS Conference, Austin, Texas.

Williams E (EM resident), Reginald TJ, Likens J, Arthur AO, Notley D (medical student), Thomas ST, **Goodloe JM** (presenter). Parenteral Dextrose Utilization in a Large, Urban EMS System. Poster Presentation, Texas Department of State Health Services 2012 EMS Conference, Austin, Texas.

**Goodloe JM**, Lehrfeld D (EMS fellow/presenter), Schrank K, Pepe PE. A Nationwide Survey of Emergency Medical Services Standards of Care for Cardiac Arrest – Variability Amongst America's Largest Urban Systems. Poster Presentation, Society for Academic Emergency Medicine Annual Meeting, Chicago, Illinois. Abstract in Academic Emergency Medicine, 19(4), Suppl 1, S260.

**Goodloe JM** (presenter), Lehrfeld D (EMS fellow), Schrank K. A Nationwide Survey of Emergency Medical Services Standards of Care for Cardiac Arrest – Variability Amongst America's Largest Urban Systems. Poster Presentation, American College of Cardiology Annual Meeting, Chicago, Illinois. Abstract in Journal of the American College of Cardiology (JACC), March 27, 59(13), Supplement A, A87.

**Goodloe JM** (presenter), Hartline J (medical student), Crane RD (EM resident), Johnson KV (medical student), Reddick EA (EM resident), Synovitz CK. A Statewide Survey of Emergency Department Standards of Care for Acute Coronary Syndromes -

Variability and Opportunity for Advancement. Poster Presentation, American College of Cardiology Annual Meeting, Chicago, Illinois. Abstract in Journal of the American College of Cardiology (JACC), March 27, 59(13), Supplement A, A113

2012 Hatfield J (EM resident), Arthur AO, Reddick E (EM resident/ presenter), Shear M (medical student), Stilwell A (student), **Goodloe JM**, Thomas ST. Availability of On-Site Helipads Among Acute Care Facilities in Oklahoma. Poster Presentation, National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 16(1), 160.

Arthur AO, Thomas ST, **Goodloe JM**, Reginald TJ, Thiems G (medical student), Redmon T (medical student), Holder P (medical student/presenter). Patients Refusing Prehospital Transport are Increasingly Likely to be Geriatric. Poster Presentation, National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 16(1), 164.

Reginald TJ, Crane RD (EM resident), Arthur AO, Dunn K (medical student), Thomas ST, **Goodloe JM** (presenter). Emergency Medical Services Initiation of Therapeutic Hypothermia in Post-Return of Spontaneous Circulation from Cardiac Arrest: Chillingly Low Rates and Contributing Factors. Poster Presentation, National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 16(1), 182.

Williams E (EM resident/presenter), Reginald TJ, Likens J, Arthur AO, Notley D (medical student), Thomas ST, **Goodloe JM**. Parenteral Dextrose Utilization in a Large, Urban EMS System. Poster Presentation, National Association of EMS Physicians Annual Meeting, Tucson, Arizona. Abstract in Prehospital Emergency Care 16(1), 187.

2011 **Goodloe JM** (presenter), Winham JO, Reginald TJ, Howerton DS, Appleby T, Arthur AO, Roper ED (EM resident), Thomas SH. A Statewide Survey of Emergency Medical Services Standards of Care for Acute Coronary Syndromes - Variability and Opportunity in a State Without Mandatory Statewide Treatment Protocols. Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

**Goodloe JM** (presenter), Crowder CJ (medical student), Arthur AO, Thomas SH. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Descriptive Analysis of Contributing Factors and Resultant Injuries. Poster Presentation, Texas

Department of State Health Services EMS Conference Research Forum. Austin, Texas. Second Place Poster Award.

2011 **Goodloe JM** (presenter), Swope MS (EM resident), Arthur AO, Thomas SH. Use of an Ambulance Siren Low Frequency Enhancer, Howler™ in a Large, Urban Emergency Medical Services (EMS) System - Do Collision Rates Decrease? Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

**Goodloe JM**, Winham JO, Reginald TJ (presenter), Howerton DS, Appleby T, Arthur AO, Roper ED (EM resident), Thomas SH. A Statewide Survey of Emergency Medical Services Standards of Care for Acute Coronary Syndromes - Variability and Opportunity in a State Without Mandatory Statewide Treatment Protocols. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

**Goodloe JM**, Crowder CJ (presenter/medical student), Arthur AO, Thomas SH. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Descriptive Analysis of Contributing Factors and Resultant Injuries. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

**Goodloe JM**, Swope MS (presenter/EM resident), Arthur AO, Thomas SH. Use of an Ambulance Siren Low Frequency Enhancer, Howler™ in a Large, Urban Emergency Medical Services (EMS) System - Do Collision Rates Decrease? Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

**Goodloe JM**, Hartline J (medical student), Crane RD (presenter/EM resident), Johnson KV (medical student), Reddick EA (EM resident), Synovitz CK. A Statewide Survey of Emergency Department Standards of Care for Acute Coronary Syndromes - Variability and Opportunity for Advancement. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.
Brown EJ (presenter/EM resident), Synovitz CK, Gilpen J,

**Goodloe JM**, Burns BD, Justice W, Halcome C. Residents Gain Confidence in Trauma Skills During Special Operations Medical Specialist Course. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

2011 Brown B (presenter/EM resident), Reginald TJ, Williams E (medical student), **Goodloe JM**. Missed STEMI by ECG Software Analysis. Case Report Poster Presentation. University of Oklahoma - Tulsa Annual Research Forum.

G**oodloe JM** (presenter), Winham JO, Reginald TJ, Howerton DS, Appleby T, Arthur AO, Roper ED (EM resident), Thomas SH. A Statewide Survey of Emergency Medical Services Standards of Care for Acute Coronary Syndromes - Variability and Opportunity in a State Without Mandatory Statewide Treatment Protocols. Poster Presentation, National Association of EMS Physicians Annual Meeting. Bonita Springs, Florida. Abstract in Prehospital Emergency Care 15(1), 131-2.

**Goodloe JM**, Crowder CJ (presenter/medical student), Arthur AO, Thomas SH. EMS Stretcher "Misadventures" in a Large, Urban EMS System: A Descriptive Analysis of Contributing Factors and Resultant Injuries. Poster Presentation, National Association of EMS Physicians Annual Meeting, Bonita Springs, Florida. Abstract in Prehospital Emergency Care 15(1), 116.

**Goodloe JM**, Swope MS (presenter/EM resident), Arthur AO, Thomas SH. Use of an Ambulance Siren Low Frequency Enhancer, Howler™ in a Large, Urban Emergency Medical Services (EMS) System - Do Collision Rates Decrease? Poster Presentation, National Association of EMS Physicians Annual Meeting, Bonita Springs, Florida. Abstract in Prehospital Emergency Care 15(1), 115-6.

2010 **Goodloe JM** (presenter), Dixon J, Reginald TJ, Phillips M (EM resident), Sacra JC, Thomas, SH. EMS Override of Emergency Department Diversion Requests - Effects of An Administrative Change. Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

Reginald TJ, Phillips M (EM resident), **Goodloe JM** (presenter), Thomas SH. Timeliness of post-intubation capnography application - effects of educational intervention on paramedic performance. Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

**Goodloe JM** (presenter), Dixon J, Reginald TJ, Phillips M (EM resident), Sacra JC, Thomas, SH. EMS Override of Emergency Department Diversion Requests - Effects of An Administrative Change. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

2010 Reginald TJ, Phillips M (presenter/EM resident), **Goodloe JM**, Thomas SH. Timeliness of post-intubation capnography application - effects of educational intervention on paramedic performance. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.

Reginald TJ, Phillips M (presenter/EM resident), **Goodloe JM**, Thomas SH. Timeliness of post-intubation capnography application - effects of educational intervention on paramedic performance. Poster Presentation, National Association of EMS Physicians Annual Meeting, Phoenix, Arizona. Abstract in Prehospital Emergency Care 14(S1), 32.

2009 Stewart CE (presenter), Synovitz C, **Goodloe JM**, King B, Deal KE, Munn J. Octoberfest Tent Collapse. Poster Presentation, World Congress on Disaster and Emergency Medicine, Victoria, British Columbia.

2008 Stewart CE (presenter), Synovitz CK, **Goodloe JM**, King B, Deal KE, Munn J. Octoberfest Tent Collapse, Poster Presentation, University of Oklahoma, College of Medicine, Tulsa, OK.

1999 **Goodloe JM** (presenter/EMS fellow), Rinnert KJ, Zachariah BS. Attitudes of Urban and Suburban Paramedics Toward EMS Physician Field Response. Poster Presentation, National Association of EMS Physicians Annual Meeting, Marco Island, Florida. Abstract in Prehospital Emergency Care 3(1), 90.

1998 **Goodloe JM** (presenter/EM resident), Zachariah BS, Davis S (medical student). Emergency Medical Services at a Major International Airport: A Descriptive Analysis and Pilot Study to Assess Injury Prevention and Control Capabilities. Poster Presentation, National Association of EMS Physicians Mid-Year Meeting, Lake Tahoe, Nevada. Abstract in Prehospital Emergency Care 2(3), 237. Oral presentation, Emergency Medicine Research Day, Indiana Univ School of Medicine/Methodist Hospital of Indiana.

**b. Editorials, position papers, background papers**

2021 Hatten BW, Bonney C, Dunne RB, Hail SL, Ingalsbe GS, Levy MK, Millin M, Myers JB, Shih, RD, **Goodloe JM**. ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings. Accessed at https://www.acep.org/by-medical-focus/hyperactive-delirium/

2020 Wadman MC, Camargo CA, Cullen J, Findley S, Fletcher, D, Fleegler M, Gibbons Hallman M, Jameson S, Morrisette L, Rimple D, Sampson C, Sanson T, Wilkinson B, **Goodloe JM**. ACEP Rural Emergency Care Task Force Report. Accessed at: https://www.acep.org/rural/rural-newsroom/rural-news-articles/january-2021/rural-task-force-summary/

2012 Thomas SH, Colwell C, Dyer S, **Goodloe JM**, Deslandes JC. Prehospital Care. Emergency Medicine International, 2012; 2012:965480. Epub Jul 11.

**Goodloe JM** and Thomas SH. Focusing Energies on Chest Compression Fraction: It's the Forest, Not the Trees. Resuscitation, 83, 535-536.

**c. Original invited lectures and presentations published for distribution**

2025 Kelly J (moderator), Spangler J, Parker T, Sequeira J, Cirillo LA, Shoemaker J, **Goodloe JM**. Legislative Update Panel – VACEP25. Virginia College of Emergency Physicians Annual Meeting – Hot Springs, Virginia (February).

Kroboth C and **Goodloe JM**. Mastering Capnography in EMS – Overcoming Monitoring Challenges. ems1 Webinar. Online (February) Accessible on 3/1/25 at https://www.ems1.com/capnography/webinar-mastering-capnography-in-ems-overcoming-monitoring-channges

1) **Goodloe JM**, Knoles CL, Howerton DS, Bailey A. Safety in Numbers! Strategically Prioritizing EMS System Response by Call Type and Patient Acuity Analysis – Protecting Those That Protect Patients.
2) **C**ozzi NP, Ahmed A, Coffey S, **Goodloe JM**. Providing Online Medical Consultation After Sudden Sleep Interruption: Pitfalls to Avoid and Tips for Success.
3) **Goodloe JM**, Knoles CL, Howerton DS, Bailey A. Reds, Whites, and Blu…Make That Plasma! – Two Years of Low Titer O+ Whole Blood in EMS aka "The Big Low O in Oklahoma City EMS."
National Association of EMS Physicians Annual Meeting – San Diego, California (January)

2024 **Goodloe JM**. Politics in EMS and the ED. EMS: Interface Between Out-of-Hospital & Hospital-Based Providers. Online CME Course (November). Harvard Medical School and Harvard Affiliated EM Residencies. Agenda Accessible on 3/1/25 at https://cmecatalog.hms.harvard.edu/ems-hospital-based-provider.

2024 1) **Goodloe JM**. The Two-Year Fare of Bleeding Care: What Did We Learn In OKC about Prehospital Transfusion?;
2) Jenkins D, Pepe PE, **Goodloe JM**. Panel on Hemorrhagic States;
3) **Goodloe JM**. CPC-2 in the Rear-View Mirrow. Is "Neuroprotective CPR" Actually Bettering Cardiac Arrest Neuro Outcomes?;
4) **Goodloe JM**, Donofrio-Odmann J, Molloy M. Up Against the Wall, EMS'ers! What Are the Economics of Ambulance Ramping & Delaying Transfer of Care?;
5) Donofrio-Odmann J, **Goodloe JM**, Molloy M. How Many Stakeholders Does It Take? (to Change the Perpetuated Perennial Pattern)? What Liabilities Are Created in Responding to High-End EMS Utilizers? Any New Solutions Either Here or Abroad?;
6) Augustine J, Schnieder S, **Goodloe JM**, Kupas DF. The Matrix of Metropolitan Medical Mavens. How Has the Coalition of Large City EMS Medical Directors Affected You and Your Community in Recent Years?
American College of Emergency Physicians Annual Meeting EMS Eagles Track – Las Vegas, Nevada (September/October).

**Goodloe JM**. Essentials of Capnography. EMS World. National Association of EMTs Annual Conference – Las Vegas, Nevada (September)

Cirillo LA, Stanton R, **Goodloe JM**, Slesinger TL (moderator). Hot Topics in Emergency Medicine Panel. Symposium by the Sea 2024. Florida College of Emergency Physicians. Miami Beach, Florida (July)

1) Cirillo LA, Stanton R, Kelen G, **Goodloe JM**. ACEP Update Panel.
2) **Goodloe JM**. To 2025 & Beyond! Where EMS (Evidence, Mobile Integrated Healthcare, Success AND Sanity) in EMS is Going.
EMerald Coast Conference. Miramar Beach (Sandestin) Florida (June)

**Goodloe JM**. ACEP Update. Maine State Chapter of ACEP Annual Meeting. (Virtual Attendance) Portland, Maine (April)

Pepe PE, O'Donnell D, Augustine J, Zuver C, Miramontes DA, **Goodloe JM**. Eagles Panel. FDIC. Indianapolis, Indiana (April)

2024 Parker T, Sequeira J, Cirillo LA, Stanton R, **Goodloe JM**. Legislative Update Panel – VACEP24. Virginia College of Emergency Physicians Annual Meeting – Hot Springs, Virginia (February).

**Goodloe JM**, Carney E, Bronsky E, Cozzi N. Maximizing the "Net" in Medical Oversight Networking.
National Association of EMS Physicians Annual Meeting – Austin, Texas (January)

2023 Fischer P and **Goodloe JM**. Optimal Hemorrhage Control in EMS. EMS World. National Association of EMTs Annual Conference – New Orleans, Louisiana (September)

**Goodloe JM**. ACEP Update and Navigating Challenges in Smaller State ACEP Chapters. Iowa State Chapter of ACEP Annual Meeting. (Virtual Attendance) Iowa City, Iowa (July)

1) Pepe PE, Miramontes DA, Holley JE, **Goodloe JM**, Scheppke KA, Colwell CB, Crowe RP, Pruett KM, DiBernardo TJ. How About Them Non-Shocking Results That Have Broken the Futility Barrier? Neuroprotective CPR Panel.
2) Jui J and **Goodloe JM**. Sharing Some Sanguine Situational Sensitivities – on Starting Up a Prehospital Blood Program Today.
3) **Goodloe JM**. Is Anger Really a 4-Letter Word? Delicately Dealing with Difficult Dilemmas, Dubious Diagnoses, and "Don't Wanna-Go's"
4) **Goodloe JM**. Advancing Through the Basics: Impressive Results, Better Morale, and Better Care.
EMS State of the Science XXIV: A Gathering of Eagles – Hollywood, Florida (June). The US Metropolitan Municipalities EMS Medical Directors Consortium.

1) Stanton R, Shoemaker, J, and **Goodloe JM**. ACEP Update Panel.
2) Khoury R, Stanton R, Shoemaker J, and **Goodloe JM**. "Ask Me Anything (About Emergency Medicine) Panel.
3) **Goodloe JM**. Success in EMS 2023 – Best Practices for Emergency Physicians Working with EMS.
EMerald Coast Conference. Miramar Beach (Sandestin) Florida (June)

Pepe PE, Marino M, O'Donnell D, Augustine J, Miramontes DA, **Goodloe JM**. Eagles Panel. FDIC. Indianapolis, Indiana (April)

2022 1) **Goodloe JM**. The ACEP Task Force Report on Hyperactive Delirium.
2) **Goodloe JM** and Kumar L. Field Triage and Bleeding Control with a New Twist: New Stop the Bleed and Field Triage Guidelines (from ACS COT, ACEP, NAEMSP and others).
3) **Goodloe JM**, Bronsky E, Kumar L, Miller B, Persse DE. Don't Fear the Tier: Why Many EMS Systems are now Following Classic BLS/ALS Deployment Strategies.
EMS State of the Science XXIII: A Gathering of Eagles – Hollywood, Florida (June). The US Metropolitan Municipalities EMS Medical Directors Consortium.

**Goodloe JM**. Best Practices in Online EMS Consults for Emergency Physicians. EMerald Coast Conference. Miramar Beach (Sandestin) Florida (June).

**Goodloe JM**. EMS Patient Refusals – Isn't It Just Have the Medics Get a Signature? Visiting Professorship/Grand Rounds. Western Michigan University Homer Stryker MD School of Medicine, Department of Emergency Medicine. (June)

1) **Goodloe JM** and Wampler D. Optimal Hemorrhage Control in EMS and Utilization of Whole Blood in EMS. 2) Myers JB, Dunn W, Antevy P, **Goodloe JM**, Bourn S. Hyperactive Delirium in EMS Panel Discussion. ESO Wave Conference. Austin, Texas (April)

**Goodloe JM**. Hot or Not? Rethinking the RLS Response. National EMS Quality Improvement Partnership. Reducing Lights-and-Siren Use in EMS. Webinar (February)

2021 **Goodloe JM**. Grand Rounds/Visiting Professorship. FDNY/Northwell Health EMS Fellowship. Life Advice for an EMS Physician. Webinar (August)

**Goodloe JM**. Until Help Arrives. American College of Emergency Physicians Seminar Program. Irving, Texas. (August)

Augustine JJ, **Goodloe JM**, Roach JP. Cutting Edge Remarks: What Are The Best Practices for Field Amputation – and Could EMS Do Them? **Goodloe JM**. Prevent Deaths from "Natural" Causes: Why is Preparation for Natural Disasters More Than Just a Priority? EMS State of the Science XXII: A Gathering of Eagles – Hollywood, Florida (June). The US Metropolitan Municipalities EMS Medical Directors Consortium.

2021 **Goodloe JM**, Gallagher JM, Duerring S, Ferguson W. EMS Panel Discussion. EMerald Coast Conference. Miramar Beach (Sandestin) Florida (June).

2019 **Goodloe JM**. 1) Sweetening Up the CPR Sweet Spot: Identifying Optimal Combinations of Compression Rate & Depth. 2) Concise Device Advice: Examining CPR Quality-Device Interactions. 2nd Annual International State of the Future of Resuscitation Conference. Paris, France (October)

**Goodloe JM**. Tornadoes in Oklahoma: Implications for "Vulnerable" Populations. SAEM Regional Conference UT Southwestern Medical Center – Dallas, Texas (September)

**Goodloe JM**, Gallagher JM, Duerring S, Ferguson W. EMS Panel Discussion. EMerald Coast Conference. Miramar Beach (Sandestin) Florida (June).

Weber JM, Mason CF, Bronsky ES, **Goodloe JM**. Different Strokes for Different Folks: 2019 On-Going Issues in Stroke Care. Balancing the Scales, 1-Stroke Handicaps & Mobile Cerebral Telepathy. **Goodloe JM** and Pepe PE. Alternative Motives: Destinations Other Than Traditional Hospital-Based EDs. EMS State of the Science XXI: A Gathering of Eagles - Dallas, Texas (March). The US Metropolitan Municipalities EMS Medical Directors Consortium.

**Goodloe JM**, Knoles C, Howerton DS. Reimagining and Engineering Airway Management in EMS Systems. Pepe PE, Racht E, **Goodloe JM**, Levy MK, McCoy AM, Augustine J, Scheppke K, Banerjee P. The Eagles Panel. EMS Today – Washington, DC (February). The Journal of Emergency Medical Services Annual Conference.

**Goodloe** JM. Does Anybody Really Know What Time It Is (That Makes a Clinical Difference AND a People Difference in 2019!). Advanced Topics in Medical Direction Pre-Conference. National Association of EMS Physicians Annual Meeting – Austin, Texas (January)

2018 **Goodloe JM**. 1) Bi-Cycling Pumps: Using Active Compression Decompression (ACD) in CPR. 2) MONA Goes LISA: Changing the Fine Art of STEMI Management. 3) Alternative Motives: Destinations other than Traditional Hospital-Based Emergency Departments. 4) One Stroke Handicap: Escaping the Web of Best Practices in Stroke Care. 1st Annual EMS State of the Science

2018: A Gathering of Seagles Conference. Memorial Healthcare System. Hollywood, Florida (November)

**Goodloe JM**. Advanced Concepts of "Basic" Airway Management in EMS Medicine. Emergency Medical Services Authority Conference – Advancing the Art & Science of EMS Medicine. Edmond, Oklahoma (October)

**Goodloe JM**. Termination of Cardiac Arrest Resuscitation – Do We Known When to Say When? Hillcrest Medical Center Fall CME Symposium. Kansas City, Missouri (September)

**Goodloe JM**, Jobrack J. "EMS Update on Anaphylaxis" 2018 Indiana Emergency Response Conference. Indianapolis, Indiana (September)

**Goodloe JM**, Gearhart D, Cody P. EMS Medicine Update for the Emergency Physician and Primary Care Physician. Panel Discussion. 21st Annual Emergency Medicine Review Conference. Oklahoma State University Center for Health Sciences, College of Osteopathic Medicine. Tulsa, Oklahoma (June)

**Goodloe JM**, Gallagher JM, Nafziger S. Things That Drive Me Crazy About EMS and What Can I Do About Them? Panel Discussion. SEC/BIG 12 ACEP Chapters Educational Conference: Emergency Medicine Then & Now. Miramar Beach (Sandestin) Florida (June).

**Goodloe JM**. 1) The Ranges of Ch-Ch-Ch-Changes! How Often Do Eagle Medical Directors Modify Protocols? 2) MONA Goes LISA: Changing the Fine Art of STEMI Management. 3) Nixing the Nickel and Dime ("5 to 10") Paradigm: A Reality Check on Scene and Transport Time Intervals. EMS State of the Science XX: A Gathering of Eagles - Dallas, Texas (March). The US Metropolitan Municipalities EMS Medical Directors Consortium.

**Goodloe JM** (panel moderator), Myers JB, Youngquist S, Jacobs M. The Pressure is on Resuscitation (Intrathoracic Pressure Regulation); Dickinson E, Kivlehan S, Shepherd M, Youngquist S, **Goodloe JM**. Cardiac Arrest: Resuscitation Latest Advances; Pepe PE, Persse D, **Goodloe JM**, Levy M. Youngquist S, Scheppke K, Richmond N. "Does Anybody Really Know What Time It Is…That Makes a Clinical Difference AND a People Difference in 2018" as part of The Eagles Unplugged - Lightning Round. EMS Today – Charlotte, North Carolina (February). The Journal of Emergency Medical Services Annual Conference.

2018 Fowler R, **Goodloe** JM. Stop the Bleed Education Debate. Advanced Topics in Medical Direction Pre-Conference; Gallagher JM, **Goodloe JM**, Howerton DS. Credentialing Pearls: Tales of Bumps, Bruises, & Success. National Association of EMS Physicians Annual Meeting – San Diego, California (January)

2017 **Goodloe JM**. 1) Catalyst for Analysis: Cardiac Arrest Resuscitation Analytic Discoveries. 2) Active Compression Decompression CPR: Bi cycling the Pump in Intrathoracic Pressure Regulation. 3) Tipping the Scales in Defibrillation: Leveraging Weight-Based Energies & Vectors. Eagles Pre-Conference and Eagles Track in Main Conference with Pepe PE, Scheppke K, Antevy P, Colwell C, Elder J, Persse D. Emergency Cardiovascular Care Update (ECCU) 2017 – New Orleans, Louisiana (December).

**Goodloe JM**. Advances in Sudden Cardiac Arrest Care – Outside & Inside the Hospital. Hillcrest Medical Center Fall CME Symposium. Dallas, Texas (October)

**Goodloe JM**. Progressive Resuscitation: Advances in Cardiac Arrest & Stroke Care. Saint Francis Hospital Trauma & Stroke Symposium. Tulsa, Oklahoma (September)

**Goodloe JM.** EMS Response: Hot or Not? Does Anybody Really Know What Time It Is That Makes a Clinical Difference in 2016 AND That Makes a Personnel Difference in 2017? St. Vincent Hospital Emergency Medicine Symposium. Indianapolis, Indiana (May)

**Goodloe JM**. 1) Demystifying Dialysis Disasters: Best Practices in EMS Care for the Renal Failure Patient. 2) Hematology and Oncology Emergencies in EMS: You Mean There Are Cancer Emergencies? 3) Active Compression/Decompression CPR: Can Doubling Up the Historical One-Stroke Compression Cycle Save More Lives? Wesley K, **Goodloe JM**, Richmond N, Escott MEA. Is It the Holy Grail or Not? The Case Against Ketamine; Pepe PE, Slovis CM, Taillac PP, Holley JE, **Goodloe JM**, Ellis C, Manifold C. Eagles Lightning Round. EMS Today – Salt Lake City, Utah (February). The Journal of Emergency Medical Services Annual Conference.

**Goodloe JM**. 1) Tallying Total Task Time to Tacitly Tender the Team – Building a Better Scene Coordination Protocol to Improve Morale. 2) An Inversion to the Incursion of Diversion: An Alternative Approach to Re-routing Requests. EMS State of the Science XIX: A Gathering of Eagles - Dallas, Texas (February).

The US Metropolitan Municipalities EMS Medical Directors Consortium.

2017 **Goodloe JM.** 1) Code 3 Response: Hot or Not? Does Anybody Really Know What Time It Is That Makes a Clinical Difference in 2016 AND That Makes a Personnel Difference in 2017? Advanced Topics in Medical Direction Pre-Conference. Sahni R, Gallagher JM, Goodloe JM, Rostykus P, Schoenwetter D. Ask the Experts Panel. National Association of EMS Physicians Annual Meeting – New Orleans, Louisiana (January)

2016 **Goodloe JM**. 1) New Insights into the Future of EMS and ACEP EMS Updates. Advanced EMS Practitioners Forum and Workshop. American College of Emergency Physicians 16 – Las Vegas, Nevada (October)

**Goodloe JM**. Optimal Cardiopulmonary Resuscitation Practices and Active Compression-Decompression CPR. Hillcrest Medical Center Grand Rounds – Tulsa, Oklahoma (July).

**Goodloe JM**. Optimal Cardiopulmonary Resuscitation Practices and Active Compression-Decompression CPR. Oklahoma EMT Association Annual Conference – Tulsa, Oklahoma (July).

Lurie KG and **Goodloe JM**. Active Compression Decompression CPR. Pepe PE, Slovis CM, Ornato J, Persse DE, **Goodloe JM**, Levy MK, Taillac PP, Colwell CB, Holley JE, Miramontes DA. Lightning Rounds. Ask the Eagles. Update from the Eagles Conference. National Urban EMS Medical Directors. **Goodloe JM** 1) Flash Pulmonary Edema: Drowning in Dogma or Death Defying in Discovery? 2) EMS TXA in the 2016 USA. EMS Today - Baltimore, Maryland (February). The Journal of Emergency Medical Services Annual Conference.

**Goodloe JM**. 1) Please Take Time Out: Challenging the Perennial Obsession with Response Intervals. 2) (w. Holley JE co-presenting) Taking the Guessing Out of Decompressing the Pressing: Post-FDA Experience with ACD-ITD CP. EMS State of the Science XVIII: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

2015 **Goodloe JM**. Put a Cork in It. Tranexamic Acid and Hemostatic Agents. Code 3 Conference. Washington University School of Medicine – St. Louis, Department of Emergency Medicine – St. Charles, Missouri (October).

**Goodloe JM**, Howerton DS, and McAnallen D. Optimal Cardiopulmonary Resuscitation Practices and Active Compression-Decompression CPR. Oklahoma EMT Association Annual Conference – Tulsa, Oklahoma (July).

**Goodloe JM**. 1) 10 "Take-Homes" from 10 Tense Days of Tornadoes. 2) Tranexamic Acid in EMS Medicine. South Texas Regional Advisory Council (STRAC) Regional Emergency Healthcare Systems Conference – San Antonio, Texas (May).

**Goodloe JM**. 10 "Take-Homes" from 10 Tense Days of Tornadoes. Keynote Session. **Goodloe JM**, McAnallen D. Optimal Team Dynamics of Pre-Hospital Cardiac Arrest Resuscitation. Tulsa Community College Public Safety and EMS Symposium. Tulsa, Oklahoma (March).

**Goodloe JM**. Not Much Pause Should Be Your Cause: 2015 Ways to Analyze Cardiac Arrest Performance. EMS State of the Science XVII: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

**Goodloe JM.** Hot Topics: Naloxone Administration by EMTs & Law Enforcement Officers – Panacea or Pandora? National Association of EMS Physicians Annual Meeting - New Orleans, Louisiana (January).

2014 Beck E, Racht E, Beeson J, **Goodloe JM**. Pinnacle Power Seminars. Making Integration Happen: A Playbook for Getting Your MIHP Up & Running. Pinnacle EMS Leadership Conference – Scottsdale, Arizona (July)

Ossmann E, **Goodloe JM**, Braithwaite SA. Pinnacle Power Seminars. How Evidence-Based Medicine will Reshape the Practice of EMS: A Clinical Update. Pinnacle EMS Leadership Conference – Scottsdale, Arizona (July)

**Goodloe JM**, Beck EH, and Racht E. 1) Cardiac Arrest Analytics: Constructing and Reading the Dashboard. 2) Optimal Team Dynamics of Pre-Hospital Cardiac Arrest Resuscitation. Emergency Cardiovascular Care Update (ECCU) 2014 – Las Vegas, Nevada (June).

**Goodloe JM**. 1) 10 "Tentative Take-Homes" from 10 Tense Days of Tenacious Tornadoes…That Took Tens of Homes – All in a Ten-Minute Talk. 2) Drugs Falling into the Wrong Hands – or Not? Naloxone Use by Non-EMS Personnel. EMS State of the

Science XVI: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

Beck EH and **Goodloe JM**. Cardiac Arrest Team Dynamics: Yes, We Can Save More Lives. **Goodloe JM.** The DNA & ETA of EMS Tranexamic Acid – Where Are We? Beck EH, Myers JB, Beeson J, **Goodloe JM**, Bourne S, White L. New Perspectives and Next Steps: Translating Mobile Integrated Healthcare into Policy. EMS Today – Washington, DC (February). The Journal of Emergency Medical Services Annual Conference & Exposition.

**Goodloe JM.** 1) Hot Topics: Tranexamic Acid in EMS. 2) Blown Away: 10 Days of Tornados. 3) Tranexamic Acid in EMS – Advanced Topics in Medical Direction Pre-Conference. National Association of EMS Physicians Annual Meeting – Tucson, Arizona (January)

2013 **Goodloe JM**. 1) The EMS Praxis for Anaphylaxis. 2) High-Risk Patients: Case Studies to Keep You on the Leading Edge. 3) Team Dynamics in Cardiac Arrest Resuscitation: Can We Save More Lives? Yes, We Can! North Lake Tahoe Fire Protection District 18th Annual Paramedic Refresher and CE Program – Incline Village, Nevada (December)

**Goodloe JM**. Pearls in Out of Hospital Mechanical Ventilation. Pre-Conference/Satellite Symposium, Air Medical Transport Conference – Virginia Beach, Virginia (October)

**Goodloe JM**. 1) A New Praxis for Anaphylaxis: Re-Thinking Its Presentation & Treatment Concepts. 2) A New Twist on the Bleeding Control Issue: Recent Civilian Experiences with Tourniquets. 3) Whatever You Do, Please Don't Be Late! EMS Use of Tranexamic Acid. Advanced EMS Practitioners Forum and Workshop. American College of Emergency Physicians 13 – Seattle, Washington (October)

**Goodloe JM**. 1) The EMS Praxis for Anaphylaxis. 2) Team Dynamics in Cardiac Arrest: Can We Save More Lives? Yes, We Can! 3) TRANscending a new EXAMination & Understanding of an old ACID: The Role of Tranexamic Acid in EMS – The Ravens Medical Directors/Advisors Pre-Conference. 7th Annual Anchorage RACI Conference: The State of the Art in Cardiac Resuscitation and Critical Care Intervention. Loren Marshall Foundation – Anchorage, Alaska (May)

2013 **Goodloe JM**. 1) The EMS Praxis for Anaphylaxis. 2) We Don't Know How It Works, But It Works! TRANscending a new EXAMination & Understanding of an old ACID: The Role of Tranexamic Acid in EMS. EMS State of the Science XV: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

**Goodloe JM**. The EMS Praxis for Anaphylaxis. American Medical Response eGrand Rounds National Webinar – January.

**Goodloe JM**. 1) EMS System Design. 2) Political Pitfalls in EMS Medical Direction Panel Forum. 3) EMS Case Study Curriculum Discussion Leader. National EMS Medical Director's Course (NAEMSP) – Bonita Springs, Florida (January)

2012 **Goodloe JM**. 1) Basic Training: BLS Use of the 12-Lead Electrocardiograph. 2) Gadgets, Gizmos of Life-Saving Device: Should We Budget for All Those CPR Adjuncts? 3) Sticking Your Neck Out in Trauma Care: Is Spinal Immobilization Elemental or Detrimental? 4) Basic EMS Capnography: Building Blocks for Airway Management and Patient Assessment. 5) Expanding the BLS Scope of Practice. 6) Advanced EMS Capnography: Where are we? Where can we go? 7) Team Dynamics in Cardiac Arrest Resuscitation: Can We Save More Lives? You Bet Your Keister We Can! Texas EMS Conference – Austin, Texas (November). Texas Department of State Health Services.

**Goodloe JM**. 1) It Ain't Over till It's Over: 2012 Ways for Terminating Resuscitative Efforts. 2) We're Just Getting Started: Post-Resuscitation Management – Constructing and Navigating the Dashboard for Survival. Emergency Cardiovascular Care Update (ECCU) 2012 – Orlando, Florida (September). Citizen CPR Foundation.

**Goodloe JM**. TRANscending a New Understanding through EXAMination of an Old ACID: The Role of Tranexamic Acid (TXA) in Preoperative Trauma Management. Fifth Annual EMS Conference - Tulsa, Oklahoma (August). EMS Section, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

**Goodloe JM**. 1) EMS Termination of Resuscitation: Best Practices for a Difficult Task**.** 2) Patient Refusals: Isn't It Just Sign on the Line? 3) Evidenced Based State EMS Protocols – State of Kansas EMS Medical Director's Course. Featured National Speaker. Last Blast of Summer Conference – Wichita, Kansas (August). Kansas EMS Association.

2012 **Goodloe JM**. 1) High-Risk Patients: Case Studies to Keep You on the Leading Edge. 2) Patient Refusals: Isn't It Just Sign on the Line? 3) Trauma Triage: New CDC/NHTSA Helicopter Guidelines – Conference Keynote Presentation, co-presented with Thomas SH. Missouri State EMS Conference – Branson, Missouri (August). Missouri EMS Association.

**Goodloe JM**. 1) Basic Training: BLS Use of the 12-Lead Electrocardiograph. 2) It Ain't Over till It's Over: 2012 Ways to End Resuscitative Efforts. 3) We're Just Getting Started: Using a Post-Resuscitation Efforts Dashboard. EMS State of the Science XIV: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

**Goodloe JM**. EMS Standards of Care Alterations in Response to Snowstorm. Mid-America Regional Council Emergency Rescue Committee Meeting – Kansas City, Missouri (February).

**Goodloe JM.** Regional Centers. Advanced Topics in Medical Direction Conference. National Association of EMS Physicians Annual Meeting & Scientific Assembly – Tucson, Arizona (January).

2011 **Goodloe JM**. 1) EMS Capnography 2011 - Where are we? Where should we be? Texas EMS Conference - Austin, Texas (November). Texas Department of State Health Services.

**Goodloe JM**, Reginald TJ, Winham JO, Howerton DS. Protocol Development for Advancing Oklahoma's EMS Standards: The 2013 State of Oklahoma EMS Treatment Protocols Journey. Fourth Annual EMS Conference - Tulsa, Oklahoma (August). EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

**Goodloe JM**. EMS Standards of Care Alterations in Response to Snowstorm. National Urban Area Security Initiative (UASI) & Homeland Security Conference - San Francisco, California (June). UASI and Department of Homeland Security.

**Goodloe JM**. 1) To Tube or Not to Tube: The Role of Intubation in Resuscitation. 2) When to Stop: Termination of Resuscitation Decisions. EMS Regional Conference - Resuscitation Excellence: Building Upon Past Success via the Implementation of the 2010 American Heart Association Guidelines - New York, New York (May). Fire Department New York (FDNY)/FDNY Foundation.

2011 **Goodloe JM**. The Importance of Regional Collaboration. Heart Alert: Southwest Texas Regional Advisory Council for Trauma Regional Cardiac Summit - San Antonio, Texas (February).

**Goodloe JM**. 1) It's Important to Make Waves: $EtCO_2$ Analysis as the Airway Gold Standard. 2) Rockin' the Stockin': OK(lahoma) Approaches to Tracking Drug Utilization. EMS State of the Science XIII: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

**Goodloe JM** and Thomas SH. Hypothermie thérapeutique en préhospitalier, experience américaine. Thomas SH and **Goodloe JM**. Prehospital analgesia. Secours Santé – Nice, France (February). Journeés scientifiques européennes du service médical des sapeurs-pompiers.

2010 **Goodloe JM**. 1) EMS Termination of Resuscitation: Best Practices for a Difficult Task. 2) EMS Capnography 2010 - Where are we? Texas EMS Conference - Austin, Texas (November). Texas Department of State Health Services

**Goodloe JM**. 1) The State of the State of EMS Emergency Cardiovascular Care in Oklahoma. 2) Panel Discussion: You're Doing What? Best Practices in EMS. 3) EMS: Trapeze Artists, Lion Tamers, & Ringmasters: Sharing Our Circus Without Suiting Up as Human Cannonballs. EMS Medical Directors Seminar - Austin, Texas (October). Texas College of Emergency Physicians. **Goodloe JM**, Winham JO, Reginald TJ, Howerton DS. The State of the State of EMS Emergency Cardiovascular Care in Oklahoma. Third Annual EMS Conference - Tulsa, Oklahoma (August). EMS Division, Department of Emergency Medicine,
The University of Oklahoma School of Community Medicine.

**Goodloe JM**. Patient Refusals: Isn't It Just Sign on the Line? **Goodloe JM** and Howerton DS. High Risk Patients: Case Studies to Keep You on the Leading Edge. Medic Update - Enid, Oklahoma (July). Oklahoma EMT Association Annual Conference.

**Goodloe JM**. The Science & Art of Prehospital Trauma Care - What Does "Clinically Important" Time Management Really Mean? Trauma Symposium: A New Decade of Trauma Care Oklahoma City, Oklahoma (May). OU Medical Center

**Goodloe JM** and Winham JO. Needlestick at 0300. What Will You Do to Keep Your Personnel (and Yourself!) Safe? **Goodloe**

**JM** and Howerton DS. High Risk Patients: Case Studies to Keep You on the Leading Edge. Pepe PE, Fowler R, **Goodloe JM**, Beeson J. Update from the Eagles Conference - What's Hot? What's Not? Pepe PE, Slovis CM, Fowler R, **Goodloe JM**, Beeson J. Lightning Rounds - Ask the Eagles. National Urban EMS Medical Directors. EMS Today - Baltimore, Maryland (March). The Journal of Emergency Medical Services Annual Conference

2010 **Goodloe JM**. Getting a Head in Cycle Somatic Injuries: OK(lahoma) Ways to Remove a Helmet. EMS State of the Science XII: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium

2009 **Goodloe JM**. 1) Patient Refusals: Isn't It Just Sign on the Line? 2) Ventilations and Compressions: The Science Behind Blowing Slow and Pumping Fast. Texas EMS Conference - Fort Worth, Texas (November). Texas Department of State Health Services

Thomas SH and **Goodloe JM**. Update in EMS Literature: What's Hot and What's Not? Burstein J and **Goodloe JM**. ALS Versus BLS: What Does the Evidence Say? Scientific Assembly - Boston, Massachusetts (October). American College of Emergency Physicians.

**Goodloe JM**. EMS Termination of Resuscitation: When We Know That We Know When It's When to Say When (or Do We?). EMS Medical Directors Seminar - Galveston, Texas (September). Texas College of Emergency Physicians.

**Goodloe JM**. H1N1 Flu: Implications for EMS. Flu Facts for the Frontline Symposium - Tulsa, Oklahoma (September). Oklahoma Institute for Disaster and Emergency Medicine, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

**Goodloe JM**, Reginald TJ, Howerton DS. The State of the State of Therapeutic Hypothermia in Oklahoma. Second Annual EMS Conference - Tulsa, Oklahoma (August). EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

Slovis CM, Persse D, Schrank K, Locasto D, **Goodloe JM**. Report from the Eagles Panel - What's Hot? What's Not? Slovis CM, Schrank K, Persse D, **Goodloe JM**. Lightning Rounds - Ask the

Eagles. EMS Today - Baltimore, Maryland (March). The Journal of Emergency Medical Services Annual Conference.

2009 **Goodloe JM**. The Importance of Tidal Waves: Continuous Capnography and Patient Safety. EMS State of the Science XI: A Gathering of Eagles - Dallas, Texas (February). The US Metropolitan Municipalities EMS Medical Directors Consortium.

2008 **Goodloe JM**. Patient Refusals: Best Practices When Patients Don't Want You. EMS Medical Directors Seminar - San Antonio, Texas (September). Texas College of Emergency Physicians

**Goodloe JM**, Reginald TJ, Howerton DS. Capnography. First Annual EMS Conference - Oklahoma City, Oklahoma (August). Oklahoma Institute for Disaster and Emergency Medicine, Department of Emergency Medicine, The University of Oklahoma College of Medicine-Tulsa.

2007 **Goodloe JM**. Advancing the System: Credentialing and Evaluating Personnel. EMS Medical Directors Seminar - Dallas, Texas (September). Texas College of Emergency Physicians

2006 **Goodloe JM** and Griffin R. Needlestick at 0300. What Will You Do to Keep Your Personnel (and Yourself!) Safe? EMS Medical Directors Seminar - Galveston, Texas (September). Texas College of Emergency Physicians.

2005 **Goodloe JM**. Cardiac Arrest 2005: The Advancing Science and Art of Resuscitation. Controversies in EMS Conference - Temple, Texas (November). Department of Emergency Medicine, Texas A&M Health Science Center/Scott & White Hospital.

**Goodloe JM**. Cardiac Arrest 2005: The Advancing Science and Art of Resuscitation. EMS Medical Directors Seminar - San Antonio, Texas (September). Texas College of Emergency Physicians.

2000 **Goodloe JM**. Pediatric Airway Management & Rapid Sequence Intubation. Medical City Hospital of Dallas Annual EMS Conference. Dallas, Texas (March). Medical City of Hospital of Dallas.

## IX. TEACHING ACTIVITIES

1. **Scheduled Teaching Assignments**, 2007-Present
   - **a.** Medical Student & Resident Teaching
     - i. Bedlam Clinic Attending Shifts

ii. OU Medical Student Interest Group – Invited speaker on EMS
iii. OU Medical Student Emergency Medicine Rotation – attending supervision and teaching in emergency department
iv. Basic Disaster Life Support Course
v. Advanced Disaster Life Support Course
vi. Emergency Resident Core Orientation course on ECGs – 4 hours
vii. Emergency Resident Core Orientation course on EMS – 4 hours
viii. Emergency Medicine attending supervision and teaching, 10+ ED shifts/month, 10 hours/shift, 4-6 residents/shift, 1-4 medical students/shift.

**2. Teaching Initiatives**

**a.** Faculty Teaching

2025 TERMINATION OF CARDIAC ARREST RESUSCITATION
OUDEM Residency – January

2024 FOUNDATIONS
CAREER SEARCH FOR POST RESIDENCY III
OUDEM Residency – November

EMS CASE STUDIES
OUDEM Residency – September

EMS INTERN ORIENTATION
OUDEM Residency – July

ACING THE EMERGENCY DEPARTMENT SHIFT
OUDEM Residency – July

HIGH FREQUENCY UTILIZERS OF EMS/EM CASE STUDIES
THE ROLE OF MOBILE INTEGRATED HEALTH
THE ROLE OF HOSPITAL-BASED CASE MGMT
THE ROLE OF COMMUNITY RESOURCE PARTNERS
OUDEM Residency - February

2023 FOUNDATIONS
CAREER SEARCH FOR POST RESIDENCY I
OUDEM Residency – December

FOUNDATIONS
PERSONAL FINANCE I
OUDEM Residency – September

IN-FLIGHT MEDICAL EMERGENCIES
OUDEM Residency - August

2023 EMS MEDICAL STUDENT LECTURE
OUDEM Residency – August

EMS INTERN ORIENTATION
OUDEM Residency – July

EMS CASE STUDIES
OUDEM Residency – May

FOUNDATIONS
ADVANCED RESUSCITATIVE INTERVENTIONS
OUDEM Residency – March

OPTIMAL CARDIAC ARREST RESUSCITATION II
OUDEM Residency – February

2022 OPTIMAL CARDIAC ARREST RESUSCITATION I
OUDEM Residency – December

FOUNDATIONS
PERSONAL FINANCE II
OUDEM Residency – December

EMS INTERN ORIENTATION
OUDEM Residency – July

FOUNDATIONS
PERSONAL FINANCE II
OUDEM Residency – May

EMS MEDICAL OVERSIGHT CLINICAL CASE STUDIES
OUDEM Residency – March

FOUNDATIONS
PERSONAL FINANCE
OUDEM Residency – March

2021 EMS MEDICAL OVERSIGHT CLINICAL CASE STUDIES
OUDEM Residency – December

FOUNDATIONS
PERSONAL DEVELOPMENT: JOBS/CONTRACTS
OUDEM Residency – December

EMS ORIENTATION
IHI Residency – November

2021 EMS ORIENTATION
IHI Residency – October

FOUNDATIONS
PERSONAL DEVELOPMENT: CONTRACTS
OUDEM Residency – September

EMS MEDICAL STUDENT LECTURE
OUDEM Residency – August

EMS INTERN ORIENTATION
OUDEM Residency – July

EMS MEDICAL OVERSIGHT CLINICAL CASE STUDIES
OUDEM Residency – March

FOUNDATIONS
CRITICAL CARE ADVANCED RESUSCITATIONS
OUDEM Residency – March

2020 REIMBURSEMENT UPDATES IN EM
OUDEM Residency – December

FOUNDATIONS
PERSONAL DEVELOPMENT: JOB HUNT II
OUDEM Residency – December
EMS MEDICINE UPDATES
STROKE; COVID; AIRWAY
OUDEM Residency – October

FOUNDATIONS
PERSONAL DEVELOPMENT: PERSONAL FINANCE I
OUDEM Residency – October

EMS INTERN ORIENTATION
OUDEM Residency – July

IMPLICATIONS OF SARS-CoV-2 & COVID-19
OUDEM Residency – March

2019 RUMINATIONS OF ACADEMIC REALITIES
TERMINATION OF RESUSCITATION
OPIOID USE DISORDER
THE EVIDENCE OF EBM
OUDEM Residency - September

2019 EMS INTERN ORIENTATION
OUDEM Residency – July

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2018 EMS INTERN ORIENTATION
OUDEM Residency – July

MASS CASUALTY INCIDENT/DISASTER PLANNING
TORNADO RELATED EMERGENCIES
OUDEM Residency – March

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2017 THE PRACTICE OF EMS MEDICINE
OUDEM Residency – Medical Student Lecture – August

DEFIBRILLATION STRATEGIES
RENAL EMERGENCIES
OUDEM Residency – August

EMS INTERN ORIENTATION
OUDEM Residency – July

2017 EFFICIENCY IN EMERGENCY DEPT DISCHARGE
OUDEM Residency – May

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2016 EMS CASE STUDIES & PROTOCOL REVIEW
OUDEM Residency – November

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2015 CARDIAC ARREST RESUSCITATION PRACTICUM
OUDEM Residency – November

CARDIAC ARREST JOURNAL CLUB
OUDEM Residency – November

EMS INTERN ORIENTATION
OUDEM Residency – July

2015 TRANEXAMIC ACID IN EMERGENCY MEDICINE
OUDEM Residency – April

CARDIAC ARREST ILCOR STANDARDS OF CARE
OUDEM Residency – April

THE PRACTICE OF EMS MEDICINE
OUDEM Residency – Medical Student Lecture – March

2014 EBOLA & EMS/ED CONSIDERATIONS
OUDEM Residency – October

THE PRACTICE OF EMS MEDICINE
OUDEM Residency – Medical Student Lecture – September

THE PRACTICE OF EMS MEDICINE
OUDEM Residency – Medical Student Lecture – August

EMS INTERN ORIENTATION
OUDEM Residency – July

2013 12-LEAD ECG ROUNDS
OUDEM Residency – August

12-LEAD ECG ANALYSIS INTERN ORIENTATION
OUDEM Residency – July
EMS INTERN ORIENTATION
OUDEM Residency – July

EMS RESEARCH UPDATES
OUDEM Residency – June

THE PRAXIS FOR ANAPHYLAXIS
OUDEM Residency – March

12-LEAD ECG ROUNDS
OUDEM Residency – February

2012 EMS & CARDIOVASCULAR EMERGENCIES
OUDEM Residency – December
Review for ABEM In-service Examination

12-LEAD ECG ANALYSIS INTERN ORIENTATION
OUDEM Residency – July

EMS INTERN ORIENTATION
OUDEM Residency – July

2012 JOURNAL CLUB
Clinical Application of Laboratory Diagnostics in ACS (highly sensitive Troponin assay) & Pediatric Fever Without Source
OUDEM Residency – February

ECG CONFERENCE
OUDEM Residency – February

EMS & CARDIOVASCULAR EMERGENCIES
OUDEM Residency - January
Review for ABEM In-service Examination

2011 ECG CONFERENCE
OUDEM Residency – December

BIOTERRORISM
Oklahoma Disaster Institute - November
Basic Disaster Life Support for Oklahoma Highway Patrol EMTs

PSYCHOLOGICAL ASPECTS OF DISASTERS
Oklahoma Disaster Institute - November
Basic Disaster Life Support for Oklahoma Highway Patrol EMTs

EMS TERMINATION OF RESUSCITATION
OSU EM Residency - Oklahoma City – August

EMS INTERN ORIENTATION
OUDEM Residency - July

THE ART AND SCIENCE OF CARDIOPULMONARY RESUSCITATION - ELEMENTAL OR DETRIMENTAL?
OUDEM Residency - July

ARRHYTHMIAS - ECG ANALYSIS
OU School of Medicine - Second Year Medical Students - April
Advanced Cardiac Life Support

TACTICAL COMBAT CASUALTY CARE
OUDEM SOMOS Program - April
Cadaver Lab for Oklahoma Highway Patrol EMTs

CARDIOVASCULAR EMERGENCIES
OUDEM Residency - January
Review for ABEM In-service Examination

2010 EMS BASE STATION
OUDEM Residency - December
OK State EMS Medical Director's Course & Practicum

ECG CONFERENCE
OUDEM Residency - September

ECG CONFERENCE
OUDEM Residency - August

EMS INTERN ORIENTATION
OUDEM Residency - July

ECG CONFERENCE
OUDEM Residency - July

EMS BASE STATION
OUDEM Residency - June
OK State EMS Medical Director's Course & Practicum

ECG CONFERENCE
OUDEM Residency - June

ECG CONFERENCE
OUDEM Residency – March

EMS & CARDIOVASCULAR EMERGENCIES
OUDEM Residency – February

2009 TRAUMA AIRWAY MANAGEMENT SKILLS PRACTICUM
OUDEM Residency – December

ECG CONFERENCE
OUDEM Residency – December

ECG CONFERENCE
OUDEM Residency – August

ECG CONFERENCE
OUDEM Residency - July

EMS INTERN ORIENTATION
OUDEM Residency – July

BIOTERRORISM
Oklahoma Disaster Institute - July
Basic Disaster Life Support

2009 EMS REFUSALS OF CARE CONSIDERATIONS
OUDEM Residency - June

EMS CASE STUDIES
OUDEM Residency - February

2008 CHILDREN WITH SPECIAL HEALTHCARE NEEDS
OUDEM Residency - November

CPAP/NON-INVASIVE VENTILATION
OUDEM Residency - October

12-LEAD ECG ANALYSIS PART III
OUDEM Residency - September

12-LEAD ECG ANALYSIS PART II
OUDEM Residency – August

EMS R2/EM INTERN ORIENTATION
OUDEM Residency - July

12-LEAD ECG ANALYSIS PART 1
OUDEM Residency - July

1999 UROGENITAL TRAUMA
UT Southwestern Emergency Medicine Residency

1998 ACUTE ABDOMINAL AORTIC ANEURYSM
UT Southwestern Emergency Medicine Residency
Morbidity & Mortality Conference

**b.** Emergency Medical Services Continuing Education Teaching

2021 COVID-19 Updates from Office of the Medical Director
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2020 COVID-19 Updates from Office of the Medical Director
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2018 PROTOCOL UPDATES 2018
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa
Featuring the OMD Team
Limiting epinephrine in ventricular fibrillation cardiac arrest

Limiting oxygen in acute coronary syndromes
Early utilization of double sequential external defibrillation
Early deployment of ResQCPR and efficiencies in resuscitation
Water submersion injuries

2017 CPR TEAM DYNAMICS
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa
Featuring Dr. Keith Lurie
Resuscitation team roles and dynamics
Continuity of chest compressions
Active Compression Decompression CPR
Passive oxygenation in limited rescuer situations
Supportive care strategies
Practical lab and video production

2016 DOUBLE SEQUENTIAL EXTERNAL DEFIBRILLATION
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

ACTIVE COMPRESSION DECOMPRESSION CPR
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2015 SPINAL MOTION RESTRICTION
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2013 TRANEXAMIC ACID
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Hemostasis options in traumatic hemorrhage
What is tranexamic acid (TXA)? Historical uses of TXA
Review of CRASH-2 and MATTERs research studies of TXA
Protocol changes and review & Operational handling of TXA
Interview with Dr. William Havron, OU Trauma Services

PRAXIS FOR ANAPHYLAXIS
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Defining anaphylaxis
Cardiovascular collapse form of anaphylaxis
World Allergy Organization treatment guidelines
Epinephrine treatment of anaphylaxis
Review of recent publications/abstracts regarding anaphylaxis
Protocol changes and review

2013 EMS CAPNOGRAPHY
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Basic of the capnography waveform
Uses of capnography in EMS
Advanced concepts of capnography and research review
Protocol review

2012 CPR TEAM DYNAMICS
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Resuscitation team roles and dynamics
Continuity of chest compressions
Timing of defibrillation
Passive oxygenation in limited rescuer situations
Supportive care strategies
Practical lab and video production

2011 CPR CHEST COMPRESSION TECHNIQUES
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Compression rate with metronome use
Compression techniques
Practical lab

2007 SIMPLE, COOL CHANGES IN PARAMEDIC AIRWAY CARE
Plano Fire Department Paramedic CE
Intubation techniques
Cricoid pressure vs. bimanual laryngoscopy
Airway bougie
Evaluation of a new alternative airway
When to abandon intubation attempts
Combitube vs. King LTS-D
Airway Management in Narcotic Overdoses
Titrating naloxone

EMS OCCUPATIONAL EXPOSURE:
IF IT HAPPENS TO YOU, WHAT WILL YOU DO?
Plano Fire Department EMT & Paramedic CE
Best practices & local experiences
Post-exposure management:
EMS needlestick injuries
EMS respiratory exposures
Infectious agents of concern
Hepatitis B & C; HIV; TB, Meningitis

2006 MASS CASUALTY FUNCTIONAL EXERCISES
Plano & Allen Fire Departments EMT & Paramedic CE
33 Full Scale Fire Rescue/EMS Exercises

CRITICAL THINKING IN PARAMEDIC PATIENT CARE
Plano & Allen Fire Departments Paramedic CE
Critical thinking concepts required to correctly deliver paramedic level care per EMS treatment protocols

PEDIATRIC CARDIAC CARE
Plano & Allen Fire Departments EMT & Paramedic CE
Pediatric CPR & PALS
Pediatric Vascular Access
Neonatal CPR & NALS
Pediatric Cardiac Arrest Scenario Exercises

TACHY/BRADYDYSRHYTHMIAS
Allen Fire Department Paramedic CE
AHA guidelines for bradydysrhythmias & tachydysrhythmias

ARTIFICIAL CIRCULATION: THE ROLE OF THE AUTOPULSE
Allen Fire Department EMT & Paramedic CE
Artificial circulations physiology
Suboptimal CPR effect
AutoPulse outcomes trials review & functional exercises

TACHY/BRADYDYSRHYTHMIAS
Plano Fire Department Paramedic CE
AHA guidelines for bradydysrhythmias & tachydysrhythmias
Diltiazem
Case studies

ARTIFICIAL CIRCULATION: THE ROLE OF THE AUTOPULSE
Plano Fire Department EMT & Paramedic CE
Artificial circulation physiology
Suboptimal CPR effect
AutoPulse outcomes trials review
Functional AutoPulse exercises

IMMEDIATE TRIAL: MODULE 2
Allen Fire Department Paramedic CE
Acute Coronary Syndromes
Glucose-Insulin-Potassium Infusion Physiology
Patient Care Enrollment & Logistics

IMMEDIATE TRIAL: MODULE 1
Plano Fire Department Paramedic CE
Acute Coronary Syndromes
12-Lead ECG Interpretation
Glucose-Insulin-Potassium Infusion Physiology

ADVANCED AIRWAY PLACEMENT CONFIRMATION
Allen Fire Department Paramedic CE
Confirmation Devices, Rationale, & Protocol

CHEMICAL RESTRAINT
Allen Fire Department EMT & Paramedic CE
Alternatives to physical and chemical restraint
Indications for physical and chemical restraint
Pharmacology of diazepam & haloperidol

ADULT RESUSCITATION 2006:
INCORPORATING NEW AHA GUIDELINES
Allen Fire Department EMT & Paramedic CE
2005 AHA Guideline Process
Adult CPR
Ventricular Fibrillation/Pulseless Ventricular Tachycardia
Pulseless Electrical Activity & Asystole

ADVANCED AIRWAY PLACEMENT CONFIRMATION
Plano Fire Department Paramedic CE
Confirmation Devices, Rationale, & Protocol

CHEMICAL RESTRAINT
Plano Fire Department Paramedic CE
Alternatives to physical and chemical restraint
Indications for physical and chemical restraint
Pharmacology of diazepam & haloperidol

ADULT RESUSCITATION 2006:
INCORPORATING NEW AHA GUIDELINES
Plano Fire Department EMT & Paramedic CE
2005 AHA Guideline Process
Adult CPR
Ventricular Fibrillation/Pulseless Ventricular Tachycardia
Pulseless Electrical Activity & Asystole

2005 AIRWAY & RESPIRATORY DISTRESS MANAGEMENT
Plano & Allen Fire Departments EMT & Paramedic CE
Airway management devices & techniques
Respiratory distress/arrest scenario exercises

COLD WEATHER EMS MEDICAL MANAGEMENT
Plano & Allen Fire Departments EMT & Paramedic CE
Heat loss mechanisms & body core temperature
EMS treatment of hypothermia
EMS treatment of cold-related tissue injuries
EMS treatment of cold-water immersion
HOLIDAY SEASON TOXICOLOGY
Plano & Allen Fire Departments Paramedic CE
NSAID, ASA, TCA, SSRI, GHB, PCP, LSD

VENOUS ACCESS IN EMS
Plano & Allen Fire Departments Paramedic CE
Goals & anatomy of venous access
Venous access techniques & complications
Difficult venous access tips & "When access fails" management

TOXICOLOGY I
Allen Fire Department Paramedic CE
Acetaminophen, Opiates/Narcotics, Benzodiazepines
Barbiturates, Toxicology Documentation

LAW ENFORCEMENT "LESS LETHAL" TACTICS:
MEDICAL CONCEPTS & CARE
Allen Fire Department EMT & Paramedic CE
Benefits & risks of pepper spray
Basic function of the Taser & removal of Taser probes
Medical consequences with "less lethal" tactics
Medical evaluation & transport priorities of "less lethal" patients
ADULT INTRAOSSEOUS ACCESS
Plano Fire Department Paramedic CE
Anatomy & physiology of intraosseous access
EZ-IO intraosseous access procedure & credentialing

TASERS: MEDICAL CONCEPTS & CARE
Plano Fire Department EMT & Paramedic CE
Basic function of the Taser
Medical events post-Taser use
Risks for post-Taser cardiac arrest & removal of Taser probes
Post-Taser medical evaluation and transport priorities

BURNS & LIGHTNING INJURIES
Allen Fire Department EMT & Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management
Lightning injuries & EMS lightning injury care

EXPLOSIVE EVENT INJURIES
Allen Fire Department EMT & Paramedic CE
Risks identification & complicating factors
Injury prediction based upon type of explosive and patients
Crush syndrome and its field treatment
Primary, secondary, and tertiary explosion injury paradigm

ASSISTED CHEST COMPRESSION: AUTOPULSE INTRODUCTION
Allen Fire Department EMT & Paramedic CE
AutoPulse Resuscitation System overview

BURNS & LIGHTNING INJURIES
Plano Fire Department EMT & Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management
Lightning injuries & EMS lightning injury care

EXPLOSIVE EVENT INJURIES
Plano Fire Department EMT & Paramedic CE
Risks identification & complicating factors
Injury prediction based upon type of explosive and patients
Crush syndrome and its field treatment
Primary, secondary, and tertiary explosion injury paradigm

ASSISTED CHEST COMPRESSION: AUTOPULSE DEPLOYMENT
Plano Fire Department EMT & Paramedic CE
AutoPulse Resuscitation System implementation system-wide

THE ABCDs of CPR: ELEMENTAL OR DETRIMENTAL?
City of Plano Public Safety Communications Annual EMD Training
Critical appraisal of EMS cardiac arrest care
Review of numerous research studies indicating need for changes:
- Pre-arrival instructions – emphasis during this presentation
- Ventilation
- Chest compression (including assistive devices)
- Defibrillation

MEDICATION FACILITATED INTUBATION: PERSPECTIVES, CHALLENGES, & DIRECTIONS
Allen Fire Department Paramedic CE
Span of intubation options
Evaluate intubation options using:
- Anecdotal experience of AFD

Reviews of relevant research
Future directions of MFI within AFD & protocol changes

2004 VASOPRESSIN UPDATE: NEW HOPE FOR ASYSTOLE PATIENTS?
Allen Fire Department Paramedic CE
Pathophysiology of asystole
Pharmacology of vasopressin
Research review and protocol changes

OPTIMAL EMS OPERATIONS & PATIENT CARE
Allen Fire Department EMT & Paramedic CE
Review of best practices in EMS operations & patient care

MEDICATION FACILITATED INTUBATION: PERSPECTIVES, CHALLENGES, & DIRECTIONS
Plano Fire Department Paramedic CE
Span of intubation options
Evaluate intubation options using:
Anecdotal experience of PFD
Reviews of relevant research
Future directions of MFI within PFD & protocol changes

OPTIMAL EMS OPERATIONS & PATIENT CARE
Plano Fire Department EMT & Paramedic CE
Review of best practices in EMS operations & patient care
START TRIAGE
Allen Fire Department EMT & Paramedic CE
Principles of triage in mass casualty incidents
START (simple triage and rapid treatment) triage procedure
Application of START triage to patient scenarios

MEDICAL NECESSITY DOCUMENTATION IN EMS
Allen Fire Department EMT & Paramedic CE
Concept of “medical necessity” documentation in EMS
Detail several specifics of required documentation by insurances
Patient care documentation as a component of customer service
Avoidance of fraudulent billing practices

SAM SLING: NEW STABILIZATION FOR PELVIC FRACTURES
Allen Fire Department EMT & Paramedic CE
SAM Sling indications and usage

MEDICAL NECESSITY DOCUMENTATION IN EMS
Plano Fire Department EMT & Paramedic CE
Concept of “medical necessity” documentation in EMS

Detail several specifics of required documentation by insurances
Patient care documentation as a component of customer service
Avoidance of fraudulent billing practices

SAM SLING: NEW STABILIZATION FOR PELVIC FRACTURES
Plano Fire Department EMT & Paramedic CE
SAM Sling indications and usage

NO TRANSPORT CASE REVIEWS
Plano Fire Department EMT & Paramedic CE
Review of no transport cases for protocol/operations compliance

CHILDREN WITH SPECIAL HEALTH CARE NEEDS
Allen Fire Department EMT & Paramedic CE
Illnesses of CSHCN
EMS assessments and interventions in CSHCN
Improve comfort level with CSHCN, related devices/meds, and parents of CSHCN

THE ABCDs of CPR: ELEMENTAL OR DETRIMENTAL?
Allen Fire Department EMT & Paramedic CE
Critical appraisal of EMS cardiac arrest care
Review of numerous research studies indicating need for changes:
Pre-arrival instructions & Ventilations
Chest Compressions & Defibrillation

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

THE ABCDs of CPR: ELEMENTAL OR DETRIMENTAL?
Plano Fire Department EMT & Paramedic CE
Critical appraisal of EMS cardiac arrest care
Review of numerous research studies indicating need for changes:
Pre-arrival instructions; Ventilations
Chest compression (including assist devices); Defibrillation

DEFIBRILLATION: SOONER IS NOT ALWAYS BETTER?
Allen Fire Department EMT & Paramedic CE
Review CPR First Defibrillation research
Pathophysiology benefits of CPR prior to defibrillation
Scenario-based review for protocol changes

SPINAL IMMOBILIZATION: NEW DIRECTIONS IN EMS
Allen Fire Department EMT & Paramedic CE
Perspectives on EMS spinal immobilization

Research on “selective” EMS spinal immobilization
Scenario-based review for protocol changes

CRICOTHYROTOMY
Plano Fire Department Paramedic CE
Anatomy & procedural review
Skill credentialing

TERRORISM RESPONSE & EMERGENCY CARE
Plano Fire Department EMT & Paramedic CE
Suicide bomber identification and incident reviews
Suicide bomber implications for EMS operations
Mass casualty operations in terrorism response

CPAP IN EMS
Allen Fire Department EMT & Paramedic CE
Physiology of CPAP & indications for use
CPAP regulator and mask functional exercises

12-LEAD ECG ANALYSIS
Allen Fire Department Paramedic CE
Functional exercises in 12-lead analysis

DEFIBRILLATION: SOONER IS NOT ALWAYS BETTER?
Plano Fire Department EMT & Paramedic CE
Review CPR First Defibrillation research
Pathophysiology benefits of CPR prior to defibrillation
SPINAL IMMOBILIZATION: NEW DIRECTIONS IN EMS
Plano Fire Department EMT & Paramedic CE
Perspectives on EMS spinal immobilization
Research on “selective” EMS spinal immobilization
Scenario-based review

2003 AIRWAY MANAGEMENT
Allen Fire Department EMT & Paramedic CE
Basic & advanced techniques in airway management
Endotracheal intubation & confirmation
Cricothyrotomy
Capnography in airway management
Airway management scenario exercises

VENOUS ACCESS IN EMS
Plano Fire Department Paramedic CE
Goals & anatomy of venous access
Venous access techniques & complications
Difficult venous access tips
“When access fails” management

NERVE AGENTS & ANTIDOTE TREATMENT
Plano Fire Department EMT & Paramedic CE
Nerve agent types & pathophysiology
Mark I autoinjector pharmacology & use

EMS OCCUPATIONAL EXPOSURE
Plano Fire Department EMT & Paramedic CE
Post-exposure management:
EMS needlestick injuries & EMS respiratory exposures

NEW EMS TREATMENT PROTOCOLS REVIEW
Allen Fire Department EMT & Paramedic CE
New Medical Director Introduction
New EMS protocols orientation & review

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

CHILDREN WITH SPECIAL HEALTH CARE NEEDS
Plano Fire Department Paramedic CE
Illnesses of CSHCN
EMS assessments and interventions in CSHCN
Improve comfort level with CSHCN, related devices/meds, and parents of CSHCN

BURNS & LIGHTNING INJURIES
Plano Fire Department Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management
Lightning injuries & EMS lightning injury care

EXPLOSIVE EVENT INJURIES
Plano Fire Department Paramedic CE
Risks identification & complicating factors
Injury prediction based upon type of explosive and patients
Crush syndrome and its field treatment
Primary, secondary, and tertiary explosion injury paradigm

NERVE AGENTS, ORGANOPHOSPATES, & CYANIDE
Plano Fire Department Paramedic CE
Pathophysiology and field treatments

CAPNOGRAPHY UPDATES IN EMS
Plano Fire Department Paramedic CE
Review of use in intubation confirmation

Use in non-intubated patients
COPD, Asthma, Undifferentiated dyspnea
Review of new capnograph within LP12 monitor

MEGACODE MANAGEMENT
Plano Fire Department Paramedic CE
Tachy/Bradydysrhythmia management using case studies
Megacode functional exercises with SimMan

2002 ORAL INTUBATION
Plano Fire Department Paramedic CE
Review of Intubation CQI Tracking
Oral intubation techniques

EMS MANAGEMENT OF MEDICAL EMERGENCIES
Plano Fire Department Paramedic CE
Case study reviews of PFD EMS incidents

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

TOXICOLOGY III
Plano Fire Department Paramedic CE
Beta-blockers, Calcium channel blockers, Antihistamines
Cocaine, Marijuana, Ecstasy

ARRHYTHMIA RECOGNITION
Plano Fire Department Paramedic CE
Functional exercises in basic ECG arrhythmia recognition

TOXICOLOGY II
Plano Fire Department Paramedic CE
NSAID, ASA, TCA, SSRI, GHB, PCP, LSD

TREATMENT SECTOR OPERATIONS IN MCIs
Plano Fire Department Paramedic CE
Tabletop exercises in designing, deploying, and operating an EMS treatment sector during multiple patient events

TOXICOLOGY I
Plano Fire Department Paramedic CE
Acetaminophen, Opiates/Narcotics, Benzodiazepines
Barbiturates, Toxicology Documentation

2001 WEAPONS OF MASS DESTRUCTION – BIO & CHEM
Plano Fire Department Paramedic CE
Biological classes of WMD and agents
Chemical classes of WMD and agents

SPORTS INJURIES
Plano Fire Department Paramedic CE
Identification & EMS treatment of multiple orthopedic injuries

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

RESUSCITATE: DO OR DO NOT?
Plano Fire Department Paramedic CE
Texas Law relating to: Advance Directives & OOH DNR
Medical Power of Attorney
Applying DNR Texas Law to EMS situations

EMS MANAGEMENT OF THERMAL BURNS
Plano Fire Department Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management

AIRWAY MANAGEMENT
Plano Fire Department Paramedic CE
Basic & advanced techniques in airway management
Airway management scenario exercises

12-LEAD ELECTROCARDIOGRAMS
Plano Fire Department Paramedic CE
ECG lead electrophysiology
Correlating ECG leads with anatomy
Systemic analyzing of the 12-lead ECG
Correlating abnormal ECGs with cardiac pathophysiology

PEDIATRIC CRITICAL CARE
Plano Fire Department Paramedic CE
PALS updates

2000 CARDIAC ARREST MANAGEMENT
Plano Fire Department Paramedic CE
ACLS updates

CPAP IN COPD & CHF MANAGEMENT
Plano Fire Department Paramedic CE

Physiology of CPAP & indications for use
CPAP regulator and mask functional exercises

CHEST PAIN MANAGEMENT
Plano Fire Department Paramedic CE
Differential causes of chest pain
EMS management of the acute chest pain patient

TRAUMA MANAGEMENT II
Plano Fire Department Paramedic CE
BTLS-derived curriculum
Abdominal & extremity trauma
Burns
Pediatric, Elderly, & Pregnancy patients
Effects of alcohol/drugs
Trauma CPR
Trauma scenarios

1999 TRAUMA MANAGEMENT I
Plano Fire Department Paramedic CE
BTLS-derived curriculum
Mechanisms of Injury
Scene Assessment & Initial Trauma Care
Airway Management in Trauma
Thoracic Trauma
Shock Evaluation & Management
Spinal & Head Trauma
Trauma Care in the Cold

12-LEAD ELECTROCARDIOGRAMS
Plano Fire Department Paramedic CE
ECG lead electrophysiology
Correlating ECG leads with anatomy
Systemic analyzing of the 12-lead ECG
Correlating abnormal ECGs with cardiac pathophysiology

AIRWAY MANAGEMENT
Plano Fire Department Paramedic CE
Basic & advanced techniques in airway management
Airway management scenario exercises
(co-taught with Brian Zachariah, MD, FACEP)

CRITICAL CARE PARAMEDIC PHARMACOLOGY I & II
AMR-Dallas Critical Care Paramedic School
Developed & taught 8-hour pharmacology curriculum
(co-taught with Robert Suter, DO, FACEP; Brian S. Zachariah, MD, FACEP; and John Myers, MD, FACEP)

**c.** Other Teaching

2020 THE ROLE OF EMS SYSTEMS & HOW EMS SYSTEMS CAN "FLATTEN THE CURVE"
COVID-19 Oklahoma Update ECHO (Friday, April 10)

2011 THE STATE OF TULSA TRAUMA CARE
Tulsa Metro Chamber Health Panel
(co-panelists Thomas SH, Yeary E, Sacra J, Williamson S, Dart B)

2000-2007 EMERGENCY MEDICAL SERVICES:
A NATIONAL & LOCAL HISTORY
Plano Fire Department Citizens Fire Academy
- EMS Historical Developments
- City of Plano EMS History
- Modern EMS Capabilities
- EMS Assessment & Treatment Equipment Display
- The Modern MICU Tour
- Citizen Question & Answer Sessions

(co-taught with Ken Klein, RN, EMTP)

1999 TRAUMA REGIONAL ADVISORY COUNCILS:
IMPACT UPON TRAUMA CARE IN TEXAS
University of Texas School of Public Health – Health Policy Presentation

1998 ALTERED MENTAL STATUS
Methodist Hospital of Indiana Emergency Medicine Residency Case Conference Presentation
Case review of treated otitis media progressing to meningitis with near-fatal outcome. Patient initially seen by me at time of diagnosis with meningitis.

EMS OCCUPATIONAL HAZARDS
Methodist Hospital of Indiana Emergency Medicine Residency Grand Rounds
Infectious disease risks assumed by EMS personnel
Post-exposure management of needlestick injuries, respiratory exposure, and contact exposure involving EMS personnel
Contributing factors and characteristics of EMS vehicle accidents
Risks of violence in the EMS environment

Occupational injuries sustained in EMS
EMS-related stressors
Importance of well-being practices in EMS

1997 MASS CASUALTY INCIDENTS
Methodist Hospital of Indiana Emergency Medicine Residency Grand Rounds
Classification of Mass Casualty Incidents & Notable MCIs
Emergency Physician role in MCIs
Treatment priorities & resource utilization in MCIs

1996 ACUTE ABDOMINAL AORTIC ANEURYSM
Methodist Hospital of Indiana Emergency Medicine Residency Morbidity & Mortality Conference Presentation
Case review of AAA initially presenting as renal colic.

CHOOSING AN EMERGENCY MEDICINE RESIDENCY
Tulane University School of Medicine
Residency application, evaluation, and interviewing strategies

## X. PROFESSIONAL SERVICE

### 1. Hospital clinical service

**a.** Hillcrest Medical Center Emergency Department - Tulsa (July 2011 - Present) Academic/clinical emergency medicine in regional referral hospital. Residency faculty and active medical staff responsibilities.
**b.** St. John Medical Center Emergency Department - Tulsa (August 2009 – September 2011). Clinical emergency medicine in Level II Trauma Center. Residency faculty and active medical staff responsibilities.
**c.** St. Francis Hospital Trauma Emergency Center - Tulsa (August 2007 - July 2009). Clinical emergency medicine in Level II Trauma Center. Residency faculty and active medical staff responsibilities.
**d.** For additional clinical activities, please see section on hospitals.

### 2. Leadership service to professional societies and organizations

**a.** Vice President – Communications, American College of Emergency Physicians (2024-Present)
**b.** Chair, Board of Directors, American College of Emergency Physicians (2023-2024)
**c.** Secretary/Treasurer, American College of Emergency Physicians (2021-2022)

**d.** Member, Board of Directors, American College of Emergency Physicians (2019-Present)

Liaison to:
- Communications Committee (2024-Present)
- ACEPNow Editorial Board (2024-Present)
- Bylaws Committee (2022-Present)
- Geriatric EM Section (2022-2024)
- Geriatric Accreditation BOG (2022-2024)
- Membership Committee (2022-2023)
- Sports Medicine Section (2022-2023)
- Awards Committee (2022-2023)
- Finance Committee (2021-2022)
- Audit Committee (2021-2022)
- American College of Surgeons Committee on Trauma (2020-Present)
- Excited Delirium Task Force (2020-2021 FDA CDER Testimony Jan 2021
- Nominating Committee (2020)
- Cruise Ship Medicine Section (2020-2021)
- Trauma & Injury Prevention Section (2020-2021)
- EMS Committee (2019-2022)
- Pediatric Emergency Medicine Committee (2019-Present)
- EMS Section (2019-2022)
- Tactical & Law Enforcement Medicine Section (2019-Present)
- Pediatric Emergency Medicine Section (2019-Present)
- Rural Emergency Medicine Task Force (2019-2020)
- American Academy of Emergency Nurse Practitioners (2021-Present)

**e.** Board of Trustees, Emergency Medicine Foundation
- Immediate Past Chair (2023)
- Chair (2022)
- Chair-Elect (2021)
- Secretary-Treasurer (2021)
- Member (2019-Present)

**f.** Candidate, President-Elect, American College of Emergency Physicians (2024, 2023)

**g.** Candidate, Board of Directors, American College of Emergency Physicians (2022, 2019, 2018)

**h.** EMS Subboard, American Board of Emergency Medicine
- LLSA Co-Editor (2021-2022)
- Member (2019-2022)

**i.** Member, Bylaws Committee, American College of Emergency Physicians (2018-2019)
**j.** Member, Advocacy Committee, National Association of EMS Physicians (2016-Present)
**k.** Member, Standards & Practice Committee, National Association of EMS Physicians (2016-2021)
**l.** President, Oklahoma College of Emergency Physicians (2016-2019).
**m.** Chair, EMS Committee, American College of Emergency Physicians (2016-2018)
**n.** President-Elect, Oklahoma College of Emergency Physicians (2015-2016).
**o.** Member, Advocacy, Clinical Standards and Practices, and Mobile Integrated Healthcare Committees, National Association of EMS Physicians (2015 – Present).
**p.** Vice President (2012-2016) Oklahoma Chapter, American College of Emergency Physicians.
**q.** Member, Council Steering Committee & Council Subcommittees for Annual Meeting and Non-Bylaws Resolutions. American College of Emergency Physicians (2011-2012). Active participant in developing 2012 Council Annual Meeting and promoting development and submission of non-bylaws resolutions. Selected as Reference Committee Chairman.
**r.** Member, EMS Committee, American College of Emergency Physicians (2011-present). Leading nationwide effort to improve EMS Medical Director understanding of Drug Enforcement Administration regulations regarding controlled substances. Working in multi-association taskforce to bring EMS Medical Director concerns to the DEA lead office in Washington, DC.
**s.** Member, Council Steering Committee & Council Standing Rules Subcommittee, American College of Emergency Physicians (2010-2011). Active participant in revising 2011-2012 Council Standing Rules. Presented the Council Standing Rule Subcommittee Report to the Council Steering Committee in May 2011. Served as Member of Reference Committee A for 2011 Annual Council Meeting, hearing testimony on bylaws-related resolutions and drafting summary recommendations to the Council.
**t.** Member, EMS Committee, American College of Emergency Physicians (2010-2011). Led the extensive revision of ACEP Policy: "Leadership in EMS", approved by ACEP Board of Directors without editing. Also, reviewed for subsequent revision of ACEP Policy "Interfacility transportation of the critical care patient and its medical direction."
**u.** Councillor, American College of Emergency Physicians
OCEP (2018-2019)
OCEP Alternate Councillor (2017)
Oklahoma Chapter Board of Directors (2008-2016)

Emergency Medicine Residents' Association (1996-1999)
Service as a councillor involves representing the physicians from the respective chapter/organization at the ACEP Council Annual Meeting. The ACEP Council considers and acts upon business matters and clinical positions of the College in a manner like a "House of Representatives" of a state/national government.

**v.** Site Reviewer, Commission on Accreditation of Ambulance Services (2001-2012). Perform on-site review of EMS organizations seeking to meet CAAS accreditation. Each review involves 2-3 days of extensive administrative and clinical operations review, with numerous interviews of leadership and front-line clinical personnel to evaluate compliance with over 200 standards.

**w.** Organization and Course Reviewer, Continuing Education Coordination Board for Emergency Medical Services (2000-2012). Review submissions for individual courses and organizations seeking CECBEMS accreditation and/or accreditation granting privileges. Multiple courses/organizations have been personally reviewed each year of service.

**x.** Member, Research Committee, National Association of EMS Physicians (1998-2000)

**y.** Member, Fellows Task Force, National Association of EMS Physicians (1998-1999)

**z.** Member, Mentoring Task Force, American College of Emergency Physicians (1998-1999)

**aa.** Member, Membership Committee, American College of Emergency Physicians (1997-1998)

**bb.** Board of Directors, Emergency Medicine Residents' Association
Immediate Past President (1997-1998)
President (1996-1997)
President-Elect/Treasurer (1995-1996)

**cc.** Vice President, Board of Directors, Indiana State Medical Association Resident Medical Society (1996-1998)

**dd.** Vice Chair and Delegate, Indiana Delegation, American Medical Association Resident Physician Section House of Delegates (1996-1998)

**ee.** Member, Commission on Legislation, Indiana State Medical Association (1996-1998)

**ff.** Member, Internal Communications Task Force, American College of Emergency Physicians (1996-1998)

**gg.** Member, Section Affairs Committee, American College of Emergency Physicians (1996-1997)

**hh.** Member, LifeLine/EMS Committee, Methodist Hospital of Indiana (1995-1998)

**ii.** Member, EMS Committee, Texas College of Emergency Physicians (1994-1995)

**jj.** Emergency Medicine Student Association, The University of Texas Medical School at San Antonio
President (1994-1995)
Vice President (1992-1993)
Secretary and Founding Officer (1991-1992)

**3. Editorial service**

**a.** Editorial Board, Prehospital Emergency Care (2015-Present)
**b.** Reviewer, International Journal of Chronic Obstructive Pulmonary Disease (2014-Present)
**c.** Reviewer, Risk Management and Healthcare Policy (2013-Present)
**d.** Reviewer, Journal of Bioanalysis & Biomedicine (2013-Present)
**e.** Reviewer, Canadian Journal of Emergency Medicine (2012-2018)
**f.** Guest Associate Editor, EM International (2011)
**g.** Editorial Board, Journal of Emergency Medical Services (2010-Present)
**h.** Reviewer, Internal and Emergency Medicine (2010-Present)
**i.** Reviewer, Access Emergency Medicine (2009-Present)
**j.** Reviewer, Critical Care (2009-Present)
**k.** Reviewer, Prehospital Emergency Care (2009-Present)

**4. Educational symposia development service**

**a.** Chairman & Course Coordinator, 5th Annual EMS Symposium – 2012 EMS Ways to Treat Trauma & Advance Trauma Care. EMS Section, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2012 in Tulsa, Oklahoma. Keynote Speaker – Paul Pepe, Chair of Emergency Medicine, University of Texas Southwestern Medical Center & Medical Director, Dallas Metropolitan Area BioTel (EMS) System.
**b.** Chairman & Course Coordinator, 4th Annual EMS Symposium - EMS Expanding Scopes of Practice & The Future of Oklahoma EMS, EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2011 in Tulsa, Oklahoma. Keynote Speaker - John Freese, Chief Medical Director, Fire Department New York.
**c.** Chairman & Course Coordinator, 3rd Annual EMS Symposium - EMS Cardiovascular Emergencies, EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2010 in Tulsa, Oklahoma. Keynote Speaker, Corey Slovis, Chair of Emergency Medicine, Vanderbilt University School of Medicine & Medical Director, Nashville Fire Department.
**d.** Course & Curriculum Developer - State of Oklahoma EMS Medical Director's Course & Practicum - Initial Course June 2010 in Oklahoma City, Oklahoma.
**e.** Chairman & Course Coordinator, 2nd Annual EMS Symposium - Therapeutic Hypothermia, EMS Division, Department of

Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2009 in Tulsa, Oklahoma. Keynote Speaker, Brent Myers, Director & Medical Director, Wake County, North Carolina EMS System.

**f.** Chairman & Course Coordinator, 1st Annual EMS Symposium - Airway Management, Oklahoma Institute for Disaster and Emergency Medicine, Department of Emergency Medicine, The University of Oklahoma College of Medicine - Tulsa, August 2008 in Oklahoma City, Oklahoma. Keynote Speakers, Allen Sims and Kelly Curry, Montgomery County, Texas Hospital District EMS System.

**5. Professional service**

**a.** Exam Writer, National Registry of Emergency Medical Technicians (2011)

**b.** Member, Oklahoma Emergency Medical Services for Children Advisory Committee (2011-Present).

**c.** Member, Oklahoma Emergency Response Systems Development Advisory Council (2009-2013). Direct appointment by Speaker of the House, State Oklahoma House of Representatives.

**d.** Member, Medical Audit Committee, Oklahoma State Department of Health, Trauma Division (2008-2013)

**e.** Interim Medical Advisor, Oklahoma State Department of Health, EMS Division (2008-2009)

**f.** Member, University of Oklahoma College of Medicine - Tulsa, Department of Emergency Medicine Chair search committee (2008)

**g.** Member, Medical Direction Subcommittee, Oklahoma Emergency Response Systems Development Advisory Council (2007-2013)

**6. Volunteer clinical service**

**a.** The University of Oklahoma School of Community Medicine Bedlam Clinic
Attending Physician (2011-2014)

**b.** Baylor University Volunteer EMS
Director of Communications (1990-1991)
Lieutenant/Paramedic (1990-1991)
EMT-Intermediate (1989-1990)
Emergency Medical Dispatcher (1988-1989)

**7. Grant review service**

**a.** Emergency Medicine Foundation COVID-19 (2020)

**b.** MedEvac International Foundation (2010)

**8. Research abstract review service**

**a.** Society for Academic Emergency Medicine - EMS (2010)
2011 Annual Meeting & Regional Meetings

**b**. National Association of EMS Physicians (2009)

2010 Scientific Assembly

## XI. ADMINISTRATION [College and University Service]

2007-Present Chief, EMS Section, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine

## XII. MEMBERSHIPS, HONORS, AWARDS and SPECIAL RECOGNITION

### 1. Memberships

- **a.** American College of Healthcare Executives (2019-Present)
- **b.** Texas Medical Association (2017-2019)
- **c.** Tarrant County Texas Medical Society (2017-2019)
- **d.** American College of Emergency Physicians (1991-Present)
  Oklahoma Chapter (2007-Present)
  Texas Chapter (1998-Present; 1991-1995)
  Indiana Chapter (1995-1998)
- **e.** American Medical Association (2018-Present; 2007-2013; 1995-1998)
- **f.** Oklahoma State Medical Association (2007-2013)
- **g.** Oklahoma County Medical Society (2009-2013)
- **h.** Tulsa County Medical Society (2007-2013)
- **i.** Indiana State Medical Association (1995-1998)
- **j.** Emergency Medicine Residents' Association (1991-Present/Life Member)
- **k.** Society for Academic Emergency Medicine (1994-1999; 2010 - 2014;2019-Preent)

### 2. Honors

- **a.** Fellow of the Academy of EMS (2017-present)
- **b.** US Metropolitan Municipalities EMS Medical Directors Consortium Corey M. Slovis Award recognizing excellence in EMS education (2014)
- **c.** Fellow of the American College of Emergency Physicians (2002-present)
- **d.** American Medical Association/Glaxo Wellcome Achievement Award recognizing leadership in organized medicine (1997)
- **e.** Texas College of Emergency Physicians Outstanding Senior Medical Student in Emergency Medicine (1995)

## XIII. PROFESSIONAL GROWTH AND DEVELOPMENT

### 1. Continuing Education

**a.** Virginia ACEP Annual Conference CME 2025
**b.** National Association of EMS Physicians Annual Meeting 2025
**c.** VAD CME HMC 2025
**d.** NIHSS Certification 2024
**e.** Florida College of Emergency Physicians Symposium by the Sea 2024
**f.** Michigan College of Emergency Physicians Summer Symposium 2024
**g.** VAD CME 2024
**h.** EMerald Coast Conference CME 2024
**i.** Maryland ACEP Annual Meeting 2024
**j.** Texas College of Emergency Physicians Annual Meeting 2024
**k.** Virginia ACEP Annual Conference CME 2024
**l.** NIHSS Certification 2023
**m.** Michigan College of Emergency Physicians Summer Symposium 2023
**n.** EMS State of the Science XXIV Meeting 2023
**o.** EMerald Coast Conference CME 2023
**p.** Maryland ACEP Annual Meeting 2023
**q.** Virginia ACEP Annual Conference CME 2023
**r.** ACEP E-QUAL Stroke CME 2021
**s.** LVAD CME 2023
**t.** Pain Mgmt Pearls: Opioids & Culture
**u.** Human Trafficking & Exploitation
**v.** NAEMSP PEC Manuscript Reviews (Editorial Board)
**w.** NIHSS Certification 2022
**x.** ACEP E-QUAL Stroke CME 2020
**y.** ABEM EMS Subboard Exam Meeting 2022
**z.** LVAD CME 2022
**aa.** EMS State of the Science XXIII Meeting 2022
**bb.** EMerald Coast Conference 2022
**cc.** NIHSS Certification 2021
**dd.** ABEM EMS Subboard Exam Meeting 2021
**ee.** EMS State of the Science XXII Meeting 2021
**ff.** Opioid Analgesics in the Mgmt of Acute and Chronic Pain 2021
**gg.** Clinician's Guide to Human Trafficking 2021
**hh.** Preventing Clinician Burnout 2021
**ii.** Suicide Assessment & Prevention 2021
**jj.** EMerald Coast Conference 2021
**kk.** EMS State of the Science Weekly Webinars 2020 – Present
**ll.** National Association of EMS Physicians Annual Meeting 2021
**mm.** ABEM EMS Subboard Exam Meeting 2020
**nn.** National Whole Blood in EMS Academy
**oo.** National Association of EMS Physicians Annual Meeting 2020
**pp.** EMS State of the Science XXI Meeting 2019
**qq.** National Association of EMS Physicians Annual Meeting 2019

**rr.** EMS State of the Science XX Meeting 2018
**ss.** National Association of EMS Physicians Annual Meeting 2018
**tt.** EMS State of the Science XIX Meeting 2017
**uu.** National Association of EMS Physicians Annual Meeting 2017
**vv.** EMS State of the Science XVIII Meeting 2016
**ww.** National Association of EMS Physician Annual Meeting 2016
**xx.** National EMS Board Review Certification Course 2015
**yy.** National EM Board Review Certification Course 2015
**zz.** EMS State of the Science XVII Meeting 2015
**aaa.** National Association of EMS Physicians Annual Meeting 2015
**bbb.** National Association of EMS Physicians Annual Meeting 2014
**ccc.** EMS State of the Science XVI Meeting 2014
**ddd.** National EMS Board Review Certification Course 2013
**eee.** RACI Conference on Resuscitation and Critical Care 2013
**fff.** EMS State of the Science XV Meeting 2013
**ggg.** National Association of EMS Physicians Annual Meeting 2013
**hhh.** Advanced Trauma Life Support Instructor Course 2012
**iii.** EMS State of the Science XIV Meeting 2012
**jjj.** National Association of EMS Physicians Annual Meeting 2012
**kkk.** Oklahoma ACEP Annual Meeting 2011
**lll.** ACEP Scientific Assembly 2011
**mmm.** National Association of EMS Physicians Annual Meeting 2011
**nnn.** TCEP EMS Med Director Seminar 2010
**ooo.** National Association of EMS Physicians Annual Meeting 2010
**ppp.** Oklahoma ACEP Annual Meeting 2009
**qqq.** TCEP EMS Med Director Seminar 2009
**rrr.** National Association of EMS Physicians Annual Meeting 2009
**sss.** Oklahoma ACEP Annual Meeting 2008
**ttt.** TCEP EMS Med Director Seminar 2008
**uuu.** National Association of EMS Physicians Annual Meeting 2008.
**vvv.** Oklahoma ACEP Annual Meeting 2007
**www.** TCEP EMS Med Dir Seminar 2007.
**xxx.** National Association of EMS Physicians Annual Meeting 2007.
**yyy.** ATLS Instructor
**zzz.** ACLS renewal
**aaaa.** BCLS renewal
**bbbb.** FEMA NIMS ICS course 100/200/300/400/700/800
**cccc.** BDLS
**dddd.** ADLS
**eeee.** NDLS Instructor
**ffff.** ABEM Lifelong Learning Self-Assessment Test 2021
**gggg.** ABEM Lifelong Learning Self-Assessment Test 2020
**hhhh.** ABEM EMS Lifelong Learning Self-Assessment Test 2018
**iiii.** ABEM Lifelong Learning Self-Assessment Test 2018
**jjjj.** ABEM Lifelong Learning Self-Assessment Test 2017
**kkkk.** ABEM Lifelong Learning Self-Assessment Test 2016
**llll.** ABEM EMS Lifelong Learning Self-Assessment Test 2016

**mmmm.** ABEM Lifelong Learning Self-Assessment Test 2015
**nnnn.** ABEM ConCert Board Recertification Test 2015
**oooo.** ABEM EMS Lifelong Learning Self-Assessment Test 2014
**pppp.** ABEM Lifelong Learning Self-Assessment Test 2014
**qqqq.** ABEM Lifelong Learning Self-Assessment Test Patient Safety
**rrrr.** ABEM Lifelong Learning Self-Assessment Test 2013
**ssss.** ABEM Lifelong Learning Self-Assessment Test 2012
**tttt.** ABEM Lifelong Learning Self-Assessment Test 2011
**uuuu.** ABEM Lifelong Learning Self-Assessment Test 2010
**vvvv.** ABEM ConCert Board Recertification Test 2009
**wwww.** ABEM Lifelong Learning Self-Assessment Test 2008
**xxxx.** ABEM Lifelong Learning Self-Assessment Test 2007
**yyyy.** ABEM Lifelong Learning Self-Assessment Test 2006
**zzzz.** ABEM Lifelong Learning Self-Assessment Test 2005
**aaaaa.** ABEM Lifelong Learning Self-Assessment Test 2004

### 2. Coursework

**a.** Ultrasonography in the emergency department
**b.** 19th Annual High-Risk Emergency Medicine
**c.** 13th Annual National Emergency Medicine Board Review

## XIV. COMMUNITY SERVICE

### 1. Civic Organizations

**a.** Halfway Home Greyhound Adoption Service - Tulsa, Oklahoma (2007-2012)
**b.** Habitat for Humanity - Waco, Texas (1990-91)
Service Project of Alpha Epsilon Delta, Texas Beta Chapter

**CV updated 03/01/25**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

## Gabe D. Kelen, MD, FRCP(C), FACEP

***Question #1:*** **How will you best support members, especially trainees, navigate the upcoming changes in emergency medicine training and certification?**

***Do What You Love, and the Money Will Follow***

First, we must acknowledge that this is a time of considerable uncertainty. Our members—and especially our trainees—are navigating a shifting landscape of training standards, emerging technologies, workforce insecurity, and evolving professional employment structures. They are entering a field where burnout has been endemic for over well over two decades. Value as measured by reimbursement has not kept pace with inflation or other specialties and is further under threat. And yet, uncertainty can often be the impetus for creating new, stabilizing—and even uplifting—set of possibilities. (See response to Question 3.)

As President, I will ensure ACEP provides clear, proactive guidance, programs and opportunities. Robust mentorship and meaningful professional development at all stages of career is key. We need to work closely with EMRA, and in concert with other trainee-centered organizations—CDEM, CORD, SAEM—to create a cohesive, responsive approach that not only addresses current issues, but more so anticipates the challenges ahead.

I've learned as much from trainees and new attendings as from any set of individuals. Most bring a fresh unvarnished, clear-eyed view of the world. Each generation arrives with its own vision of personal life, purpose, and career. We must listen—truly listen—and support trainees not just as participants, but as co-authors of emergency medicine's future, which they will inherit.

Trainees already have a strong voice through EMRA, but we must do more to create meaningful pathways for influence. While EMRA and ACEP leaders meet regularly, we rarely engage in structured discussions about how to jointly shape the future of our specialty. As President, I will establish a **standing forum for collaborative dialogue**, bringing together not only organizational leaders, but also early-career voices to design what comes next.

Finally, the greatest role a President can play is to create opportunities for every emergency physician at all stages of their careers to thrive—by **building a culture of belonging** and ability to influence, where contributing to the College through participation is not only welcomed, but expected and valued.

***Question #2:*** **Describe your leadership style and how do you think that distinguishes you from the other president-elect candidate?**

***Walk the Talk***

**Visionary Leadership** I believe I inspire others to believe in themselves—beyond what they thought possible—and to imagine the specialty several tiers beyond conventional thinking.

**Strategic Thinking.** Alongside vision, I have the experience and skill set to map practical paths forward that garner broad buy-in. I've guided over 20 "moon shots" that initially seemed implausible (ask me about these). I believe that every problem has a solution. One needs diligence and creativity to find the answers.

**Embodied Leadership (Walk the Talk).** I lead by example. I ask nothing of others that I wouldn't do myself. I work clinically in the same demanding environment as my colleagues. I teach and mentor actively. I engage in the kind of roll-up-your-sleeves administration that keeps systems running. I understand and administrate my near $200 million budget as much as our director of finance. I try to model the fulfillment that comes from service—to our patients, our institutions, and to the College. I directly experience and hold myself to the consequences of decisions—because leadership without proximity lacks accountability.

**Commitment to Mentorship and Professional Development.** I have a long track record of effective mentorship across multiple spheres. I believe everyone—regardless of role or seniority—deserves meaningful opportunities to grow. That includes trainees, senior physicians, academicians, nurses, and administrators alike. I bring the same commitment to development and support into every part of my life—including raising children and coaching Little League for 15 years across four different sports. Mentorship remains a defining source of meaning and fulfillment.

**Emphasis on Unity.** I'm committed to giving all stakeholders a voice and to bringing disparate views to consensus to achieve a shared vision.

**Communication Mastery.** I believe I convey ideas and reasoning clearly, with transparency--very important asset to build trust. It's equally important that people feel heard and that you have considered their perspective and provide rationale if a decision is not the one favored.

**Humility with Humor.** I'm actually a pretty funny person. I don't take myself too seriously; I know I have blind spots. Still, I am serious and laser-focused on the mission.

**Fearless Conviction.** At this stage in my career, I fear no one. I am guided by my principles. I don't shape my views based on expediency or to win approval—but on what I believe is right for the specialty, ACEP and those we serve.

**Credibility Across Domains**—in Policy, Advocacy, Academia, and Specialty Medical Societies. I am fluent in these spaces and understand how they intersect. I believe effective, durable representation requires a trusted presence across these arenas—and the mean to align toward a shared goal.

***Question #3:*** **In one sentence, describe what you would like your legacy to be at the conclusion of your term as president and then explain why.**

***"He advocated for me and my patients, fiercely championed the dignity and heroism of emergency medicine, and forged an essential new direction for the specialty."***

Standing on the shoulders of giants who founded the field, and following their example, I *aspire* to *inspire* the emergency medicine community to usher in a new era of emergency medicine—one that elevates the standing of emergency medicine to its rightful and respected place in the house of medicine by advancing a unifying and transformative vision of the specialty.

We will work together to envision this new paradigm that empowers emergency physicians to shape the specialty's future and unite an ever-fracturing discipline around a renewed sense of high common calling. This will promote professional dignity for individual emergency physicians, and fulfillment across expansive career pathways within a reimagined landscape of emergency medicine.

The fundamental nature of emergency medicine must evolve to overcome current malaise and pervasive disaffection. Our current model has led to extensive and persistent burnout, early retirement, and disillusionment with the field--sufficient to give medical students and their advisors pause. Incremental advances, as important as they have been, have been matched with equal setbacks, and cannot by themselves overcome the fundamental structural difficulties that hinder the specialty and impede realizing fulfilling long-term careers.

**Just as the original visionaries of emergency medicine foresaw the creation of a new specialty, it is now time for another major paradigm shift**. We need a visionary concept of emergency medicine that not only anticipates the rapidly changing landscape of healthcare but actively shapes the future and provides new opportunities on our terms. The viability of the specialty and ability to serve our patients appropriately depends on no less.

Lofty idea. Perhaps. But the original notion that emergency medicine should be an independent, autonomous specialty was also initially viewed as unrealistic and met with considerable skepticism. Many of you may doubt that a new transformation can occur. However, if we are to address the multiplicity of issues facing the emergency medicine community and our patients, and elevate our standing, we must think and act boldly. Only by doing so can we advance the field for the benefit of emergency physicians and the patients we serve and gain the deserved recognition for the heroic and noble profession that defines who we are.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Gabe D. Kelen, MD, FRCP(C), FACEP

***Contact Information***

***Phone:410-404-8640 (C); 410-955-8191 (O)***
***E-Mail:*** gkelen@jhmi.edu

***Current and Past Professional Position(s)***

***Current***

Chair, Department of Emergency Medicine, Johns Hopkins Medicine and University
Emergency Physician-in-Chief, Johns Hopkins Health System
Director, Office of Critical Event Preparedness and Response (CEPAR), Johns Hopkins Institutions
Professor, Emergency Medicine, Johns Hopkins University
Professor of Anesthesiology and Critical Care Medicine, Johns Hopkins University
Professor, Health Policy and Management, Johns Hopkins Bloomberg School of Public Health
Senior Principal Staff, Johns Hopkins Applied Physics Laboratory
Elected, National Academies of Science
Chair, Unified Command, (Johns Hopkins Institutions
Board of Directors, (Founding), Society for Disaster Medicine and Public Health Preparedness

***Past***

Chair, Medical Board, Johns Hopkins Hospital (2005-8)
President STEM/SAEM (1988-2000)
President Association of Academic Chairs of Emergency Medicine (2005-6)
Chair, Board of Directors, Johns Hopkins Emergency Medical Services, LLC (2001-2022)
Residency Program Director, Emergency Medicine, Johns Hopkins Hospital (1984-2010)
Board of Trustees, Johns Hopkins Hospital (2005-2008)
Director, National Center for Preparedness and Critical Event Response (2005-2015)
Research Director, Department of Emergency Medicine, Johns Hopkins University SOM (1984-2005)
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)
Editorial Boards (N=6)

***Education (include internships and residency information)***

EM Residency, Johns Hopkins Hospital (1984)
MD: University of Toronto, Ontario Canada (1979)

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

American Board of Emergency Medicine (1985)
Royal College of Physicians and Surgeons of Canada (1985-)

***Professional Societies***

ACEP (Chair, Board of Directors)
EMRA Alumni
AACEM (Past President)
SAEM (past president; Leadership Award)
DMPHP (Founding member)

***National ACEP Activities – List your most significant accomplishments***

National Research Award
Academic Affairs Task Force (1987-1988)
EMF Board of Directors (1988-1994)
AIDS Task Force (1987-1992), Chair (1991-1992)
Chair, Infectious Disease Committee (1992-1993)
Chair, Public Health Committee (1993-1995)
Designated Spokesperson (1991-)
Councilor (AACEM), (2010-2019)
Council Steering Committee (2017-2019)
Workforce Task Force (2018-2020)
ED Boarding Summit Task Force (2022-23)
Board of Directors (2019-present)
Chair, ACEP Board of Directors (2024-25)
Executive Director Search Committee (2024-25)

***ACEP Chapter Activities – List your most significant accomplishments***

AACEM (Secretary Trea, Vice Pres, President, Life Time Achievement Award)
Maryland Chapter

***Practice Profile***

***Total hours devoted to emergency medicine practice per year: 0*** **~4,000+** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **25** % Research **15** % Teaching **10** % Administration **50** %

Other: **ACEP BOD, SAEM, DMPHP activities** ____ %

***Describe current emergency medicine practice.***

Academic, not for profit, employed by university, Chair 4 hospitals (2 community, 1 teaching affiliate, 1 AMC)

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

**See "Current Positions" Above**

***Expert Witness Experience***

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

| | | | | |
|---|---|---|---|---|
| **Defense Expert** | **1 (2015)** | **Cases** | **Plaintiff Expert** | **0 Cases** |

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Gabe D. Kelen, MD, 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: University School of Medicine

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: ACEP

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Medical Specialty Society

Leadership Position: Chair, Board of Directors

Oct 2024 – present (Chair)

Term of Service: Board of Directors 2019-present

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE

☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE

☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Gabe Kelen, MD** Date June 11, 2025

Maryland Chapter
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

**MARYLAND ACEP CHAPTER**
**Direct:** 214-769-4564
info@mdacep.org
Adriana.alvarez@mdacep.org
www.mdacep.org

**BOARD OF DIRECTORS**
Michael C. Bond, MD, FAAEM, FACEP
President
Councillor
Kerry Forrestal, MD, FACEP
President-Elect
Suzanna Martin, MD, PhD, FACEP
Secretary
Jonathan L. Hansen, MD, FACEP
Treasurer
Councillor
Michael A. Silverman, MD, FACEP
Immediate Past President
Dov Frankel, MD, FACEP
Director
Timothy P. Chizmar, MD, FACEP
Director
Alternate Councillor
Reginald M. Brown, MD
Director
Mustapha Saheed, MD, FACEP
Director
Amitabh Chandra, MD
Director
Edana D. Mann, MD, FACEP
Director
Councillor
Christian Wood, MD
Resident Director - JHU
Satyarnarayan Vedula, MD
Resident Director - UMD

**COUNCILLORS**
Kathleen D. Keeffe, MD, FACEP
Councillor
R. Gentry Wilkerson, MD, FACEP
Councillor
Gregory Corcoran, MD, FACEP
Councillor
Patrick McCarville, MD, FACEP
Councillor
Kyle Fischer, MD, MPH
Alternate Councillor
Carolina Mendoza, MD
Alternate Councillor
Arjun Chanmugam, MD, FACEP
Alternate Councillor
Daniel B. Gingold, MD, FACEP
Alternate Councillor
Debra M. Ravert, MD, MPH, FACEP
Alternate Councillor
Nicholas Rizer, MD
Alternate Councillor
Angela Wu, MD
Alternate Cuncillor

Thursday, July 10, 2025

Melissa W. Costello, MD, FACEP
Chair
ACEP Nominating Committee
PO Box 619911
Dallas, TX 75261-9911

RE: G. D. Kelen, MD, FRCP(C), FACEP - Endorsement Letter

Dear Dr. Costello,

On behalf of the ***Maryland Chapter of the American College of Emergency Physicians (MDACEP)*** it gives me great pleasure to endorse ***G. D. Kelen, MD, FRCP(C), FACEP*** as a candidate for President-Elect at the upcoming elections during the ACEP Council Meeting that will be held in Utah.

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 and is currently serving as Chair of the Board of Directors. In addition, he has served the specialty of EM by being a leader of SAEM, 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 30 years.

MDACEP is proud to endorse Dr. Kelen for President-Elect and feel his vast experience as department Chair, ACEP Board Member, current ACEP Chair of the Board and his work with SAEM and multiple other organizations have more than prepared him for the rigors of this role. He will bring a seasoned perspective and balance to the board and would be an effective spokesperson for ACEP while representing the best interests of emergency physicians and the specialty.

Sincerely,



Michael C. Bond, MD, FACEP, FAAEM
President
Maryland ACEP Chapter

# Gabe D. Kelen, MD, FRCP(C), FACEP

Standing on the shoulders of giants who founded the field, and following their example, I *aspire* to *inspire* the emergency medicine community to usher in a new era of ascendant emergency medicine. One that elevates the standing of emergency medicine and emergency practitioners to its rightful and respected place in the house of medicine by advancing a unifying and transformative vision of the specialty.

We will work together to envision this new paradigm that empowers emergency physicians to shape the specialty's future and unite an ever-fracturing discipline around a renewed sense of high common calling. This will promote professional dignity for individual emergency physicians, provide much-needed sustenance for community physicians, and fulfillment across newly expansive career pathways within a reimagined landscape of emergency medicine.

The fundamental nature of emergency medicine must evolve to overcome current malaise and pervasive disaffection. Our current model has led to extensive and persistent burnout, early retirement, and disillusionment with EM—sufficient to give medical students and their advisors pause. Incremental advances, as important as they have been, have been matched with equal setbacks, and cannot by themselves overcome the fundamental structural difficulties that hinder the specialty and impede the realization of fulfilling long-term careers.

**Just as the original visionaries of emergency medicine foresaw the creation of a new specialty, it is now time for another major paradigm shift**. We need an inspired concept of emergency medicine that not only anticipates the rapidly changing landscape of healthcare but actively shapes the future and provides new opportunities, particularly for the practicing community physician. The viability of the specialty and ability to serve our patients appropriately depend on no less.

This will require some heavy lifting and stimulation of new thought. Each major transformation in our history required considerable time from concept to fruition—Alexandria Plan to the formation of ACEP, then to the first certifying exam, then achievement of an autonomous ABEM, and subsequently the proliferation and ascendancy of training programs and creation of academic departments.

I believe I have the background, experience and expertise in practice, business, advocacy, and **established history of effectuating visionary change** to initiate a new direction for the College. If elected, I will work with emergency physicians in all corners of our field from rural practice to AMCs, to develop the vision, define the tenets, and create a durable template to follow. The input of young physicians would be particularly important as they will inherit this future. We must re-image and redefine our field if we are to enjoy healthy careers and practice.

While this develops, we must unabatedly continue to support the community emergency physician and fight hard for fair reimbursement, overcome the financial unfairness of EMTALA, hold corporate medicine accountable, and work to relieve boarding. We must redouble our efforts to address burnout and sense of isolation, resist scope-of-practice threats, reverse the thousand paper cuts related to the demands of endless *metrication* and documentation requirements. But incrementalism is not likely to suddenly pay dividends when almost all these *soul-sucking* issues have not advanced and many even regressed the last 25 years.

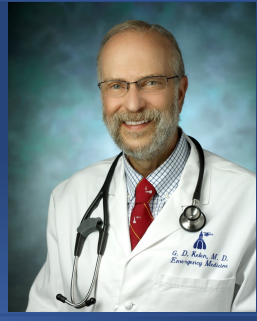
Lofty idea. Perhaps. The original notion that EM should be an independent, autonomous specialty was also viewed as unrealistic and met with considerable skepticism. You may doubt that a new transformation can occur. However, if we are to address the multiplicity of issues facing the emergency medicine community, **we must think and act boldly**. Only by doing so can we advance the field for the benefit of all emergency physicians, the patients we serve, and gain the deserved recognition for the heroic and noble profession that defines us.

# Gabe Kelen, MD, FRCP(C), FACEP, PGY 41

Chair ACEP BOD

Chair, Department of Emergency Medicine, Johns Hopkins University

***Leadership, Experience,* Expertise**



## ACEP Leadership

- Board of Directors (Chair)
- Executive Director Search
- Councilor (10 years)
- Steering Committee
- PA/NP Task Force
- Academic Affairs Task Force
- Chair, AIDS Task Force
- Chair, Public Health Committee
- National ACEP Speaker
- ED AHRQ Boarding Summit
- Congressional Testimony X 4 ACEP
- Designated Spokesperson EMF
- BOD EMF Center of Excellence
- Panel EMF External Reviewer
- White House Representative (GWB)
- Editor, Tintinalli
- Annals Reviewer
- Designated Spokesperson

## Clinical Leadership

- Full-Time Clinician
- Emergency Physician-in-Chief, JHM
- Best Physicians in Region (Baltimore Mag)
- Board of Trustees; Johns Hopkins Hospital
- Emergency Physician-in-Chief, JHM
- Best Physicians in Region (Baltimore Mag)

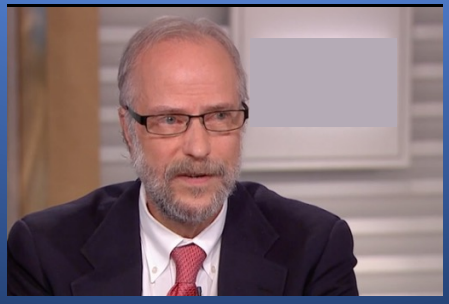
## Administrative Leadership

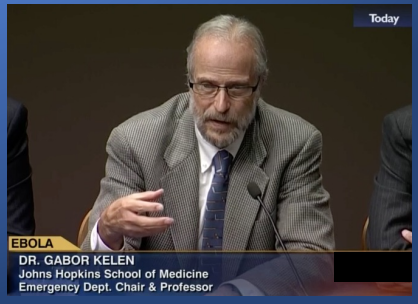
- Department Chair--Johns Hopkins University
- Unified Commander (JHM Disaster)
- Residency Director
- Research Director
- Center Director (CEPAR and PACER)
- President, STEM/SAEM President, AACEM
- Board of Directors, SAEM
- Chair, Medical Board JHH

## Recognition

- National Academies of Science (elected)
- ACEP Research Award
- MD ACEP EM Award
- MD ACEP Chair of the Year
- Hal Jayne Academic Excellence (SAEM)
- Leadership Award (SAEM)
- Distinguished Service Award (AACEM)
- Chair of the Year (MD ACEP) X 2
- Teacher of the Year (JHM Residency)






*Endorsed by AACEM and Maryland ACEP

# Gabe Kelen, MD, FRCP(C), FACEP

Chair ACEP BOD

Chair, Department of Emergency Medicine, Johns Hopkins University

***Leadership, Experience, Expertise***



## Management Proficiency

***Responsible for 4 EDs***

2 Community
1 Teaching Affiliate
1 Academic Medical Center (JHH)

***Personnel Reporting***

1500 individuals
Nursing Reports to Chair (Hire/Fire)

***Budget Managed***

$200,000,000

***JHU/SOM Clinical Practice Assoc***

***JHU Finance Committee***

***Unified Command Lead (JHM)***

62K personnel; 6M patients

## Media Releases (recent)

| | |
|---|---|
| **NYT** | **Forbes** |
| **WaPo** | **CNBC** |
| **Bloomberg** | **NPR** |
| **ABC** | **The Hill** |
| **NBC** | **Fox** |
| **MSN** | **Yahoo** |
| **Marketwatch** | **Baltimore Sun** |
| **WYPR** | **Maryland Daily Rec** |

## Advocacy

NEJMCatalyst

Gabor D. Kelen, MD, Richard Wolfe, MD, Gail D'Onofrio, MD, MS, Angela M. Mills, MD, Deborah Diercks, MD, Susan A. Stern, MD, Michael C. Wadman, MD, and Peter E. Sokolove, MD

September 28, 2021

COMMENTARY

**Emergency Department Crowding: The Canary in the Health Care System**

Annals of Emergency Medicine

Volume 67, Issue 6, June 2016, Pages 737-740



The practice of emergency medicine/editorial

Kelen GD, et al. In the Name of Patient Safety, Lets Burden the Emergency Department More. https://doi.org/10.1016/j.annemergmed.2015.11.031

Home | JAMA | Vol. 304, No. 22

**Commentary**

**Violence in the Health Care Setting**

Gabor D. Kelen, MD; Christina L. Catlett, MD

INSIGHTS REPORT

**Emergency Department Boarding Reflects Ongoing Strains**



With **Gabor Kelen, MD, FRCP(C), FACEP**
Professor and Chair, Department of Emergency Medicine, Johns Hopkins University School of Medicine; Department of Emergency Medicine, Johns Hopkins Medicine, Baltimore, Maryland, USA

Vol. 6 No. 3 | March 2025

NEJM Catalyst Innovations in Care Delivery 2025; 03

*Endorsed by AACEM and Maryland ACEP

# CURRICULUM VITAE

## GABOR DAVID KELEN, M.D., FRCP(C), FACEP

**Home Address**
1307 Malvern Ave.
Baltimore, Maryland 21204
(410-339-7262)

**Office Address**
Department of Emergency Medicine
Suite 6-100, 1830 E. Monument Street
Baltimore, Maryland, 21287
Phone: (410-955-8191)
E-mail: gkelen@jhmi.edu

## EDUCATION

| | |
|---|---|
| · B.Sc.<br>(Honors with distinction) | Carleton University, Ottawa (1974)<br>(Experimental Physiological Psychology) |
| · M.D. | University of Toronto (1975-79) |
| · Internship | University of Toronto<br>St. Michael's Hospital (07/79-06/80) |
| · Residency<br>Internal Medicine | University of Toronto<br>St. Michael's Hospital (07/81-06/82)<br>Women's College Hospital (11/80-01/81) |
| · Fellowship/Residency<br>Emergency Medicine | Johns Hopkins University, Baltimore<br>Johns Hopkins Hospital (07/82-06/84) |

## AWARDS AND HONORS

· Ontario Scholar (1970)
· Dr. H. Katznelson Award; First in Class (Carleton University) (1972)
· James A. Gibson Award; First in Biology (Carleton University) (1972)
· Fellowship and Research Grant, Carleton University (1974)
· Graduate Scholarship, Carleton University (1974)
· Career Development Award, Emergency Medicine Foundation (1988-89)
· (W.M. Keck) **Clinician Scientist Award**, Johns Hopkins University (1988-90)
· **Hal Jayne Academic Excellence Award**, Society for Academic Emergency Medicine (1992)
· **Outstanding Contribution to Research Award**, American College of Emergency Physicians (1993)
· Emergency Medicine Award, Maryland Chapter of ACEP (1994)
· The **Best Physicians in the Region**, Baltimore Magazine (2000)
· Elected, **National Academy of Medicine** (formerly IOM), National Academies of Sciences (2005)
· **Leadership Award**, Society for Academic Emergency Medicine (2007)
· Elected, ***Alpha Omega Alpha*** Society (2008)
· Appointed, Senior Principal Staff, Johns Hopkins Applied Physics Laboratory (2008)

· Johns Hopkins **Institute for Excellence in Education Award** (2015)
· **Distinguished Service Award**, Association of Academic Chairs of Emergency Medicine (2018)
· **Teacher of the Year Award,** Johns Hopkins Emergency Medicine (2018)
· **Physician of the Year Award,** Health Care Heroes, The Daily Record, (2021)
· **Best Doctors, Baltimore**, Baltimore Magazine, November (2021)
· **Chairman of the Year Award,** American College of Emergency Physicians (Maryland Chpt) (2023)
· **GEMA Global Health Endeavors Department Award**, Global Emergency Medicine Acad. (2023)
· **Health Services Award,** Boy Scouts of America (Maryland), (2023)

## SPECIALTY QUALIFICATIONS

| | |
|---|---|
| · Board Certification | The Royal College of Physicians and Surgeons of Canada (Emergency Medicine) (1985-) |
| · Board Certification | American Board of Emergency Medicine (1985, 1995, 2005, 2014) (#840848) |
| · Fellow (FRCPC) | The Royal College of Physicians and Surgeons of Canada (1986) (#300714) |
| · Fellow (FACEP) | The American College of Emergency Physicians (1987) |
| · Fellow (FAAEM) | The American Academy of Emergency Medicine Founding Member (1994) |

## LICENSURE

| | |
|---|---|
| · Diplomat | The Medical Council of Canada (1979) |
| · Diplomat (License) | College of Physicians and Surgeons of Ontario (#31901) (1980-) |
| · Diplomat (License) | The Maryland Board of Medical Examiners (#D30854) (1984-) |

## ACADEMIC APPOINTMENTS

| | |
|---|---|
| · Professor | Department of Emergency Medicine, Johns Hopkins University School of Medicine (1993-) |

| | |
|---|---|
| · Professor | Anesthesiology Critical Care Medicine, Johns Hopkins University School of Medicine (2018-) |
| · Joint Appointment | Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health (1996-) |
| · Senior Scientist | Center for Emergency Care and Disaster Preparedness, University of Alabama at Birmingham (2004-) |
| · Principal Staff | Applied Physics Laboratory, Johns Hopkins University (2008-) |

**CURRENT POSITIONS**

| | |
|---|---|
| · Chair Board of Directors | American College of Emergency Physicians (2024-2025) |
| · Chair | Department of Emergency Medicine, Johns Hopkins University School of Medicine (1993-) |
| · Director | Johns Hopkins Office of Critical Event Preparedness and Response (CEPAR) (2002-) |
| · Member | Advisory Council, Johns Hopkins Center for Health Policy and Health care Transformation (2011-) |
| · Emergency Physician-in-Chief | Department of Emergency Medicine, Johns Hopkins Hospital (1993-) |
| · Presidential Advisory Council | Carleton University, Ottawa (1996-) |
| · Active Staff | The Johns Hopkins Hospital (1984-) |

**PREVIOUS POSITIONS**

| | |
|---|---|
| · Chair, Board of Directors | Johns Hopkins Emergency Medical Services, LLC (2001-2022) |
| · Chair, Board of Directors | Johns Hopkins Emergency Medical Services, LLC (2001-2022) |
| · Program Director | Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1986-2010) |
| · 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 (2005-8) |
| · Director (PI) | National Center for the Study of Preparedness and Catastrophic Event Response (2005-2015) |
| · Research Director | Department of Emergency Medicine, Johns Hopkins University School of Medicine (1984-2005) |
| · President | Association of Academic Chairs of Emergency Medicine (2005-6) |
| · President Elect | Association of Academic Chairs of Emergency Medicine (2004-05) |
| · Secretary/Treasurer | Association of Academic Chairs of Emergency Medicine (2003-04) |
| · Chair, Board of Directors | Cedar Emergency Services (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) |
| · Active Staff | Johns Hopkins Bayview Medical Center (1996-2000) |
| · Board of Directors | Emergency Medicine Foundation (1993-95) |
| · Chair | American College of Emergency Physicians Public Health Committee (1993-95) |
| · Director | Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1984-86) |
| · Acting Director | Department of Emergency Medicine, Johns Hopkins Hospital (1992-93) |
| · Acting Director | (Autonomous) Division of Emergency Medicine, Johns Hopkins University (1992-93) |
| · Associate Professor | Division of Emergency Medicine, Johns Hopkins University (1989-93) |

| | |
|---|---|
| · Assistant Professor | Division of Emergency Medicine, Johns Hopkins University (1985-89) |
| · Editor | Society of Teachers of Emergency Medicine Letter (1985-88) |
| · Instructor | Division of Emergency Medicine, Johns Hopkins University (1984-85) |
| · Associate Editor | Society of Teachers of Emergency Medicine Letter (1984-85) |
| · Chief Resident | Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1983-84) |
| · Research Scholar | Non-Medical Use of Drugs Dir. (Grant: National Health & Welfare, Canada). Carleton University, Ottawa (05/73-09/74; 05/74-09/75) |
| · Consultant | Bureau of Epidemiology, National Health & Welfare, Ottawa (01/75-03/75) |
| · Research Assistant | Bureau of Biologics, Drugs Directorate, Health Protection Branch; National Health & Welfare, Ottawa (05/77-09/77) |

## ELECTED POSITIONS

| | |
|---|---|
| · Chair Board of Directors | American College of Emergency Physicians (2024-2025) |
| · Board of Directors | American College of Emergency Physicians (2019-22; 2022-) |
| · Councilor (AACEM) | American College of Emergency Physicians (2010-19) |
| · Member | *Alpha Omega Alpha*, Johns Hopkins University (2008-) |
| · Member | National Academy of Medicine (Institute of Medicine), National Academies of Sciences (2005-) |
| · Chair | Medical Board, Johns Hopkins Hospital (2005-08) |
| · President | Association of Academic Chairs of Emergency Medicine (2005-06) |
| · Secretary/Treasurer | Association of Academic Chairs of Emergency Medicine (2003-04) |

| | |
|---|---|
| · Agenda Committee | Johns Hopkins University School of Medicine Advisory Board of the Medical Faculty (1996-99; 2003-06; 2021-) |
| · Vice Chair | Johns Hopkins Hospital Medical Board (2002-05) |
| · Board of Advisors | Johns Hopkins University Clinical Practice Association (1997-2000) |
| · Board of Directors | Society for Academic Emergency Medicine (1988-90) |
| · President | Society of Teachers of Emergency Medicine (1988-90) |

## EDITORIAL BOARD

*Society of Teachers of Emergency Medicine Letter* (1984-88) (Editor-in-Chief, 1985-88)
*American Journal of Emergency Medicine* (1986-)
*Academic Emergency Medicine* (1998-2009)
*Academic Emergency Medicine* (Special Editor: November 2003, November 2004*)*
*Bioterrorism and Biosecurity* (2003-2009)
*Journal of Disaster Medicine and Public Health Preparedness* (2006-)
*Health Security (2020-)*

## MANUSCRIPT CONSULTANT (Peer Review)

*Annals of Internal Medicine*
*American Journal of Medicine*
*Academic Emergency Medicine*
*Journal of General Internal Medicine*
*European Journal of Medicine*
*Archives of Ophthalmology*
*Annals of Emergency Medicine*
*American Journal of Emergency Medicine*
*Journal of the American Medical Association*
*Journal Acquired Immunodeficiency Syndrome*
*Journal Urban Health*
*NEJM Catalyst*

## PEER REVIEW CONSULTANT

| | |
|---|---|
| Peer Review | ADAMHA/NIH (1993-97) |
| External Reviewer | EMRA Scientific Paper Competition, Ohio Chapter (1988) |
| Consulting Protocol Reviewer | Centers for Disease Control (1988) |
| External Reviewer | Society for Academic Emergency Medicine Abstracts (1995-) |
| External Reviewer | Emergency Medicine Foundation Center of Excellence Grant (1994, 1995) |
| Study Section | Bioterrorism Review Committee/AHRQ (2004) |
| Study Section | Healthcare Safety and Quality Improvement Research Study Section (2011-2025) |

## CONSULTANCIES FOR THE DEVELOPMENT OF EMERGENCY MEDICINE

McGill University - Royal Victoria Hospital (1991)
Barnes Hospital - University of Washington (1992)
Booth Hospital - Cornell University (1993)
New York Hospital - Cornell University (1994)
University of Puerto Rico (1997)
Medical College of Virginia (1998)
University of Maryland (2001)
Rhode Island University (2001)
Milton S. Hershey Medical Center - Pennsylvania State University (2002)
Ohio State University (2002)
University of Utah (2002)
Beth Israel Medical Center (2003)
University of Medicine and Dentistry of New Jersey (Robert Wood Johnson) (2006)
University of Alabama (2006)
University of Illinois, Chicago (2006)
Coney Island Hospital, NYC, (2008)
University of Massachusetts, Worcester, MA, (2012)
Harvard University, Beth Israel Deaconess, Boston, MA, (2015)
University of Michigan, Anne Arbor, MI, (2021)

## FORMAL MEDICAL SCHOOL TEACHING ACTIVITIES

· JHU Medical Student Research Prefect (1986-), 87 students
· Sponsor: NIH Medical Student Research Training Grant (9T35HL07606; 1989)
· Sponsor: EMF Medical Student Research Training Grant (1989)
· Research Fellow Preceptor (1986-99), 9 fellows
· Medical Student Advisor (1992-)
· Introduction to Clinical Skills Course (1999-2002)
· Introduction to Clinical Medicine Course (2002-6)
· First Year Preceptor (2002-)
· Lectures at JHU School of Medicine
  Cardiopulmonary Resuscitation (1985,86)
  Approach to Trauma (1985-88, 90-91, 95-)
  Nosocomial Risk of AIDS (1989)
  Differential of Consequence (2004-05)
· Transition to the Wards (2024)

## DOCTORAL THESIS ADVISEES

Matthew H-M. Ma - Ph.D., Health Policy and Management. System Performance and Appropriateness of Care for Elderly Trauma Patients. Johns Hopkins University Bloomberg School of Public Health, 1996

Keith A. Holterman - Dr.P.H., Health Policy and Management. Triaging and Alternative Actions for Non-Urgent 911 Requests for Ambulance Service. Johns Hopkins University Bloomberg School of Public Health, 1997

Jo M. Walrath - Ph.D., Policy Sciences Graduate School. Healthchoice: 2001. The Impact of Mandated Managed Care of Emergency Department Utilization in the State of Maryland.@ University of Maryland, Baltimore County, 2002

Deborah E. Trautman - Ph.D., Policy Sciences Graduate School. Intimate Partner Violence and Emergency Department Screening. University of Maryland, Baltimore County, 2004

Julius Pham - Ph.D. State of Healthcare Quality in Emergency Medicine. Department of Emergency Medicine, Johns Hopkins University School of Medicine, 2008

Gai Cole, Dr.Ph. Capturing Nursing Effort in the Emergency Department to Improve Socioeconomic Effectiveness. Johns Hopkins University, Bloomberg School of Public Health, 2014

Michelle Patch, MSN, APRN-CNS, ACNS-BC, DNP. Prevalence and Associated Characteristics of Emergency Department Visits by Women after Non-Fatal Intimate Partner Strangulation and Subsequent Diagnostic and Treatment Experiences: A Mixed Methods Study. Johns Hopkins University School of Nursing. 2019

## OTHER UNIVERSITY TEACHING ACTIVITIES

- HIV Testing. AIDS and Public Policy, JHU School of Hygiene and Public Health (1992)
- Ethical Issues in HIV Testing. AIDS and Public Policy, Johns Hopkins Bloomberg School of Public Health (1993-95, 1997)
- First Responder Communications Challenges. Public Health Emergency Preparedness, Johns Hopkins Bloomberg School of Public Health (Feb 2008, Feb 3rd, 2010)

## COMMITTEES

**NATIONAL**

AGENCY FOR HEALTHCARE POLICY AND RESEARCH (AHRQ)

- Office of the Forum Quality and Effectiveness in Health Care, Technical Advisor (1991)
- AHRQ Mass Casualty Planning Summit (Washington, D.C., May 2006)

CENTERS FOR DISEASE CONTROL (CDC)
- Representative, CDC/HMA Partnership Council

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)
- Member, Office of Preparedness & Emergency Operations Healthcare and Public Health Sector; Joint Advisory Working Group for Research and Development (2007-2014)
- Chair, Medical Surge Work Group, Joint Advisory Working Group (2008-2014)

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS ()
- Academic Affairs Task Force (1987-1988)
- AIDS Task Force (1987-1992), Chair (1991-1992)
- Chair, Infectious Disease Committee (1992-1993)
- Chair, Public Health Committee (1993-1995)
- Designated Spokesperson (1991-)
- Council Steering Committee (2017-2019)
- Workforce Task Force (2018-2020)
- ED Boarding Summit Task Force (2022-23)
- Board of Directors (2019-)
- Chair, ACEP Board of Directors (2024-5)
- Executive Director Search (2024-5)

SOCIETY OF TEACHERS OF EMERGENCY MEDICINE (STEM)
- STEM Letter Editor-in-Chief (1984-1988)
- Faculty Development Committee (1985-1988)
- STEM/UAEM Amalgamation Task Force (1987-1988)
- Board of Directors (1987-1989)
- Chair, Nominations Committee (1987-1988)
- President (1988-1990)
- Consultant. Residency Program Site Consultant, Society for Academic Emergency Medicine (1991-)

ASSOCIATION OF ACADEMIC CHAIRS OF EMERGENCY MEDICINE (AACEM)
- Representative, Council of Academic Societies of the AAMC (2000-10)
- Secretary/Treasurer of the Executive Committee (2003-2004)
- Membership Task Force (2003-2004)
- President (2005-2006)
- ACEP Council Representative (2010-2019)

SOCIETY FOR ACADEMIC EMERGENCY MEDICINE (SAEM)
- Board of Directors (1988-1990)
- Representative to Emergency Medicine Foundation (1989-1994)
- Chair, Infectious Diseases Committee (1991-1994)
- Program Committee (1999)
- Chair, Research Committee (2000-2001)
- Chair, Investment Subcommittee (2005-2006)
- Research Fund Senior Council (2006-)
- Consultation Services Committee (2007-)
- Awards Committee (2008-)

· Finance Committee (2011-2)
· Program Committee (2011-)
· Abstract Subcommittee (2014-8)
· Faculty Development Committee (2018-)
· Consultant. Residency Program Site Consultant, Society for Academic Emergency Medicine (1991-)

EMERGENCY MEDICINE FOUNDATION (EMF)
· Board of Directors (1988-1990)
· Board of Directors (1993-1995)
· Centers of Excellence Grant Panel (1994-1995)

COUNCIL OF TEACHING HOSPITALS (Section of Emergency Medicine) (COTH)
· Executive Council (1992-8)

INSTITUTE OF MEDICINE, NATIONAL ACADEMIES OF SCIENCES (IOM)
· Forum of Surge Capacity (Washington, D.C., June 2006)

SOCIETY FOR DISASTER MEDICINE AND PUBLIC HEALTH EMERGENCIES
· Founding Board of Directors (2011-2025)

DAVID LYNCH FOUNDATION
· National Medical Advisory Board (2022)

**JOHNS HOPKINS MEDICINE**
· Unified Command (2020-2023)
· JHM Joint Council (2014-)
· JHM Unified Command Lead—COVID-19 (2020--2023)

**JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE**
· Advisory Board of the Medical Faculty (1992-)
· Committee of the Whole (1992-)
· Clinical Practice Association Board of Governors (1993-)
· Hospital Affiliations Task Force (1994)
· Faculty and Student Assistance Program Advisory Committee (1994-96)
· Pediatric Chair Search Committee (1995-1996)
· Medical Student Promotions Committee; third and fourth year (1995-1999)
· Chair, Johns Hopkins Bayview Director of Emergency Medicine Search Committee (1996)
· Professorial Promotions Committee (1996-2001);
Ad Hoc Acting Chair (1998-2001)
· Agenda Committee of the Advisory Board of the Medical School (1996-1999; 2003-2006, 2022-5)
· Board of Advisors, Clinical Practice Association (1997-2000)
· Chair, Clinical Practice Association Board of Governors Operations Oversight Committee (1997-98)
· Ad Hoc Committee to Revise Guidelines for the Promotions of Clinical Educators and Scholars (1997)
· Chair, Johns Hopkins Medicine United Way Campaign (1997, 1998)
· Clinician Scientist Award Selection Committee (1997-2005, 2010-)
· Faculty Budget Advisory Committee (1997-2004)
· Associate Professor Reappointment Committee (1997-2002)

- President's Council on Urban Health (1998-2000)
- Chair, Dermatology Chair Search Committee (1998-99)
- Chair, Howard County General Hospital Director of Emergency Medicine Search Committee (1999)
- Research Advisory Council (2000-01)
- Medicine Chair Search Committee (2000-01)
- Surgery Chair Search Committee (2002)
- School of Medicine *Human Resources Newsletter* Advisory Group (2002-03)
- *Change* Newsletter Advisory Board (2002-05)
- Chair, Critical Event Preparedness and Response Executive Council (2002-)
- Education Policy Committee (2002-04)
- Education Policy Committee, Clerkship Directors Subcommittee (2002-04)
- Johns Hopkins Medicine Center for Information Services Advisory Board (2002-04)
- Public Health Preparedness and Leadership Chair Search Committee (2003-04)
- Johns Hopkins Medicine Board of Trustees Committee on Professional Liability (2006-8)
- Howard County General Hospital Director of Emergency Medicine Search Committee (2008)
- Johns Hopkins Medicine Leadership Council (2012-)
- Medicine Chair Search Committee (2013)
- Compensation Task Force (2014-5)
- Anesthesiology Critical Care Medicine Chair Search Committee (2014)
- Pediatric Chair Search Committee (2015-2016)
- Faculty Compensation Committee (2015-2020)
- Chair, Department of Obstetrics Department Review Committee (2018)
- Otolaryngology H&NS Search Committee (2024)

**JOHNS HOPKINS HOSPITAL (JHH)**

- Medical Board (1992-),
- Adult Trauma QA Committee (1992-97)
- Pediatric Morbidity & Mortality Committee (1992)
- Pediatric EMSC Council (1992-93)
- Services Task Force (1994)
- Medical Advisory Council (1994-95)
- Re-engineering Steering Committee (1994-97)
- Clinical Quality Committee (1994)
- Contingency Planning Committee (1995-96)
- Chair, Urgent Care Planning Committee (1995-96)
- East Baltimore Primary Care Planning Committee (1995)
- East Baltimore Primary Healthcare Delivery System (1996-99)
- Management Services Reorganization Task Force (1996-98)
- Clinical Directors Communications (1996-)
- Medicaid Managed Care Executive Oversight Committee (1996-99)
- Urban Health Institute Council (1999)
- Johns Hopkins Medicine Operations SWAT Committee (2000-)
- Administrative Committee of the Medical Board (2000-08), Chair (2002-05)
- Agenda Committee for the Administrative Committee of the Medical Board (2002-08)
- Chair Administrative Committee of the Medical Board (2002-05)
- Performance Improvement Council (2002-08)
- Innovations in Quality Patient Care Steering Committee (2002-08)

· Capacity/Access Oversight Group (2004-)
· Vice Chair, Medical Board (2002-05)
· Johns Hopkins Medicine Executive Quality Improvement Council (2006-08)
· Chair, Medical Board (2005-2008)

**JOHNS HOPKINS BAYVIEW PHYSICIANS ASSOCIATION**
· Board of Directors (1996-2001)

**EMERGENCY DEPARTMENT**
· Chair, Research Committee (1985-98)
· Chair, Executive Committee (1992-)
· Chair, Programs Committee (1992-96)

## SOCIETIES AND MEMBERSHIPS

· American College of Emergency Physicians (ACEP)
· Maryland Chapter of the American College of Emergency Physicians (MD ACEP)
· Society for Academic Emergency Medicine (SAEM)
· College of Physicians and Surgeons of Ontario (CPSO)
· Royal College of Physicians and Surgeons of Canada (RCPSC)
· Council of Teaching Hospitals (COTH): Emergency Medicine Section
· Association of Academic Chairs of Emergency Medicine (AACEM)
· American Academy of Emergency Medicine (Charter Member) (AAEM)
· Society for Disaster Medicine and Public Health Emergencies (DMPHP)

## AWARDS AND GRANTS

| | | |
|---|---|---|
| 1. | 1974 | Research Scholar: "Behavior control of brain serotonin in the rat". Department of Health and Welfare, Canada: Non-Medical Use of Drugs Directorate - RODA Grant: $1,200 (Advisor: B. Pappas, Ph.D., Carleton University) |
| 2. | 1975 | Research Scholar: "5-Hydroxy-dopamine conditioning in mice". Department of Health and Welfare, Canada: Non-Medical Use of Drugs Directorate - RODA Grant: $1,400 (Advisor: B. Pappas, Ph.D., Carleton University) |
| 3. | 1986-1987 | Co-Principal Investigator: "ADSOL flow characteristics in volume resuscitation: An in-vitro comparison of new infusion techniques". Arrow; Micro Medex; Baxter Travenol: $6,300 |
| 4. | 1987-1988 | Principal Investigator (Sponsor): "Risk of unsuspected exposure of emergency department personnel to HTLV-III antibody positive patients". American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000 |
| 5. | 1988 | Co-Principal Investigator: "Hepatitis B surface antigen among emergency department patients". Merck, Sharp & Dohme: $23,000 |
| 6. | 1988-1989 | Principal Investigator (Sponsor): "A survey of knowledge and practices for risk reduction of HIV exposure in emergency health care providers". American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000 |
| 7. | 1988-1990 | Principal Investigator: Co-variation of hepatitis B virus (HBV) and the human immunodeficiency virus in emergency patients. W.M. Keck Clinician Scientist Award: $60,000 |
| 8. | 1988-90 | Principal Investigator: Unrecognized HTLV-1 infection in emergency patients. American College of Emergency Physicians/Emergency Medicine Foundation Career Development Grant: $25,000 |
| 9. | 1989 | Preceptor: NIH Medical Student Research Training Grant (9T35HL07606): $1,600 |
| 10. | 1989 | Co-Principal Investigator: "Assessment of a rapid HIV-1 screen for emergency department patients". Genetic Systems: $10,000 |
| 11. | 1989 | Principal Investigator (Sponsor): "Assessment of emergency presentations of patients with symptomatic infection with HIV". Emergency Medicine Foundation Medical Student Training Grant: $2,400 |
| 12. | 1988-1989 | Principal Investigator: "Human immunodeficiency virus infection in hospital emergency department patients". Centers for Disease Control (200-88-0701(P)): $321,000 |

| | | |
|---|---|---|
| 13. | 1989-1990 | Principal Investigator (Sponsor): "HIV infection in emergency department patients and risk of acquisition of HIV infection by emergency care providers". American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000 |
| 14. | 1989-1991 | Principal Investigator: "Assessment of emergency care needs of AIDS patients". American Foundation for AIDS Research (000879): $119,820 |
| 15. | 1990-1991 | Principal Investigator (Sponsor): "Doubly hidden HIV infection among intravenous drug users in the emergency department". American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000 |
| 16. | 1990-1995 | Co-Investigator: "Trials to promote behavior change to prevent HIV spread". National Institute of Mental Health (1 UO 1 MH48019-01): $1,800,000 |
| 17. | 1991-1992 | Principal Investigator (Sponsor): "Hepatitis C virus among emergency department staff". American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000 |
| 18. | 1991-1994 | Co-Investigator: "Compliance with HIV prevention measures among high-risk workers. National Institute of Occupational Safety and Health: Funding for 1st year: $248,828 |
| 19. | 1992-1993 | Co-Investigator (Site Principal Investigator): "Frequency and natural history of symptomatic primary HIV-1 infection". Abbott Laboratories: $131,250 ($37,500 to JHU) |
| 20. | 1992-1993 | Principle Investigator (Sponsor): "Detection of hepatitis C virus in seronegative emergency department patients by polymerase chain reaction". American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000 |
| 21. | 1992-1994 | Co-Investigator: An Assessment of anti-needlestick IV devices. ERC Inc. National Institute of Occupational Safety and Health: $248,980 |
| 22. | 1992-1993 | Co-Investigator (Site Principal Investigator): Evaluating Medicaid patient access to care. Robert Wood Johnson Foundation Small Grants Program: $50,000 ($5,000 to JHU) (PI: Arthur Kellerman, MD, MPH) |
| 23. | 1993-1996 | Principal Investigator: Early detection and treatment of HIV infection. NIAID (N01-AI-15123 (DATRI 002)): $344,408 |
| 24. | 1994 | Principal Investigator: Evaluation of the changes in HIV-1 burden in peripheral blood and lymphoid tissue following ZDV treatment in HIV-1 infected patients with CD4+cells between 100 and 400/$mm^3$". NIAID (N01-AI-15123 (DATRI 012)): $75,000 (Award Declined by PI) |
| 25. | 1995-1998 | Co-Investigator: Implications of strategies for the prevention of occupational transmission of bloodborne pathogens. NIOSH (U60/CC312197-0): $275,433 |

| | | |
|---|---|---|
| 26. | 1996-1997 | Preceptor: Career Development Grant (Gary Green, M.D., M.P.H.): Emergency Medicine Foundation: $25,000 |
| 27. | 1996 | Co-Investigator: Center for Injury Research and Policy. Johns Hopkins University Bloomberg School of Public Health: 10% |
| 28. | 1997-1999 | Co-Investigator: The role of alcohol in asthma. Alcoholic Beverage Medical Research Foundation: $80,000 |
| 29. | 1998-2000 | Preceptor: JHU Clinician Scientist Award (Richard Rothman, M.D., PhD): $130,000 |
| 30. | 1998-2001 | Principal Investigator: Center for the study of emergency and acute care health services and policy. Emergency Medicine Foundation: $250,000 |
| 31. | 1998-1999 | Co-Principal Investigator: Appropriate emergency department evaluation of fever in injecting drug users. AHCPR: $50,000 |
| 32. | 2000-2002 | Preceptor: JHU Clinician Scientist Award (Gary Green, M.D.): $130,000 |
| 33. | 2000-2005 | Co-Investigator: Cost effective algorithm to evaluate febrile IDU at risk for infective endocarditis. NCRR: $300,000 (PI: Richard Rothman, MD, PhD). |
| 34. | 2001-2004 | Co-Investigator: Coronary thrombosis and risk in emergency department patients. NHLBI (R-01): $1,2500,000 PI (Gary Green, MD, MPH) |
| 35. | 2003-2005 | Principal Investigator: Discharge Criteria for Creation of Hospital Surge Capacity. AHRQ (RO-1/U01 HS14353-01): $873,802 |
| 36. | 2003-2005 | Co-Investigator: Evaluation of Bioterrorism Training for Clinicians. AHRQ (R-O1/U01 HS014337-01): $991,843 |
| 37. | 2004-2006 | Preceptor: JHU Clinician Scientist Award (Samuel Yang, M.D.): $130,000 |
| 38. | 2006-2009 | Principal Investigator: National Center for the Study of Preparedness and Catastrophic Event Response (PACER). United States Department of Homeland Security (N00014-06-1-0991): $15,000,000 |
| 39. | 2006-10 | Principal Investigator. Balancing Risk with Readiness. DHS-PACER (N00014-06-1-0991); $702,613 |
| 40. | 2007-11 | PI. FY08 Homeland Security Preparedness Technical Assistance Program. FEMA (#104549), $550,000 |
| 41. | 2008-2009 | Principal Investigator: "Johns Hopkins GO Team." HRSA/ HHS (1D1DHP10619-0): $236,367 |
| 42. | 2010-2012 | Co-Investigator: Kentucky critical Infrastructure Protection Institute Program Management Support DHS (#108291) (PI Ed Hsu) |

| | | |
|---|---|---|
| 43. | 2010-2013 | Principal Investigator: National Center for the Study of Preparedness and Catastrophic Event Response@ (PACER). United States Department of Homeland Security (N00014-06-1-0991): $6,500,000 |
| 44. | 2010-2013 | PI. Principal Investigator. Surge Capacity Metrics, DHS-PACER (N00014-06-1-0991): $489,295 |
| 45. | 2011-2013 | Preceptor: JHU/SOM Clinician Scientist Award (JL Jenkins, MD, MSc): $130,000 |
| 46. | 2014-2021 | Co-PI: Johns Hopkins Center of Excellence for Influenza Research and Surveillance. NIAID--HHSN272201400007C $28,000,000 (Rothman/Pekosz) |
| 47. | 2014-2021 | PI: Pandemic Public Health Research Response Plan and Risk Assessment. Johns Hopkins Center of Excellence for Influenza Research and Surveillance. NIAID--HHSN272201400007C (Rothman/Pekosz): $2,260,910. |
| 48. | 2017 | PI (dual): Vitamin C, Thiamin, Steroid, (VICTAS), Clinical Trail Planning Group. Marcus Foundation Grant ($168,000) |
| 49. | 2017-2019 | CO-PI: Vitamin C, Thiamin, Steroid, (VICTAS), Controlled Clinical Trial. Marcus Foundation Grant ~$10,000,000) |
| 50. | 2017-2019 | PI (dual): Clinical Coordinating Center. Vitamin C, Thiamin, Steroid, (VICTAS), Controlled Clinical Trial. Marcus Foundation Grant (~$3,000,000) |
| 51. | 2018- | Inv; (S. Levin PI): R18 HS026640 |
| 52. | 2019- | Inv; (A. Gurses PI): ED Diagnostic Safety AHRQ R01-027198-01 |
| 53. | 2021-24 | PI. Racism and Repair. Johns Hopkins University |
| 54. | 2022-2027 | (PI: Kelen), SIREN (Strategies to Innovate EmeRgENcy Care Clinical Trials) NIH (NINDS & NHLBI) 1U24NS129499 ($2,000,000) |
| 55. | 2023- | Co-PI: Region 3 Public Health Emergency and Preparedness Response (75D30123C17988) |

Patents and Inventions

1. Novel Assay for Contamination-Free PCR System for Detection of Bacteremia (DM-3669) Completed 2002 (in market)

2. A Real-Time PCR Assay Using the 16S rRNA: A Multiprobe System which Permits Quantitation and Speciation of Bacterial Pathogens (DM-3772). Completed 2002 (in market)

3. HopScore: An Electronic Emergency Triage System 2014 (JHU #C12888)

4. PACER Application Suite (EMCAPS 2.0, Surge App, FluCast) 2014 (JHU C13027)

5. Levin SR, Kirsch T, Toerper M, GD Kelen, Dugas A. E-triage: an electronic emergency triage system. US16/544,016; **US20200005188A1**

**6.** Levin S, Kelen G, Dugas, A, Toerper M, Kirsch T. E-Triage: An Electronic Emergency Triage System; US Patent #**12,148,529** on 11/19/2024

## PUBLICATIONS

### Texts

1. Noji EK and **Kelen GD** (Eds). Toxicology Manual for Emergency Medicine (850 pp). Yearbook Medical Publications, Chicago, 1989

2. **Kelen GD** (Ed). HIV and Emergency Medicine. Emergency Medicine Clinics of North America 13(1) (234 pp). Saunders, Philadelphia, 1995

3. Nordenlhotz K, Rubin M, **Kelen GD** (Eds). Emergency Medicine Ultrasound. Emergency Medicine Clinics of North America 15(4) (269 pp). Saunders, Philadelphia, 1997

4. Tintinalli JE, **Kelen GD**, Stapczynski JS (Eds). Emergency Medicine: A Comprehensive Study Guide (5th ed) (2127 pp). Korean and Spanish versions also printed. McGraw-Hill, New York, 1999

5. Cline DM, Ma OJ, Tintinalli JE, **Kelen GD**, Stapczynski JS (Eds). Just the Facts in Emergency Medicine (596 pp). McGraw-Hill, New York, 2001

6. Tintinalli JE, **Kelen GD**, Stapczynski JS (Eds.) Emergency Medicine: A Comprehensive Study Guide ($6^{th}$ ed) (2043 pp). Romanian and Spanish versions also printed. McGraw-Hill, New York, 2004

7. Ma OJ, Cline DM, Tintinalli JE, **Kelen GD**, Stapczynski JS (Eds). Emergency Medicine Manual. (897pp). McGraw-Hill, New York, 2004

8. Chanmugam A, Triplett P, **Kelen GD** (Eds). Psychiatric Emergencies. Cambridge University Press. New York. 2013

9. Chanmugam A, Triplett P, **Kelen GD** (Eds). Psychiatric Emergencies ($2^{nd}$ Editions). Cambridge University Press. New York. (In Press)

### Peer-Review Manuscripts

10. **Kelen GD**. Lesch-Nyhan Syndrome. Med J Univ Toronto LIV(2):40-42, 1977

11. **Kelen GD**, Brown CG, Moser M, Ashton J, Rund DA. Reporting methodology in three acute care journals. Ann Emerg Med 14(9):880-84, 1985

12. Brown CG, **Kelen GD**, Moser M, Moeschberger ML, Rund DA. Methodology reporting in three acute care journals: Replication and reliability. Ann Emerg Med 14(10):986-91, 1985

13. Brown CG, Moser M, Moeschberger M, **Kelen GD**. Controlled clinical trials in emergency medicine. Am J Emerg Med 3(1):67-73, 1985

14. **Kelen GD**, Noji E, Doris P. Guidelines for use of lumbar spine radiography. Ann Emerg Med 15(3):245-51, 1986

15. Gong V, **Kelen GD**, Sivertson KT. AIDS update. Maryland Med J 35(5):361-371, 1986

16. Brown CG, **Kelen GD**, Ashton JJ, Werman HA. The beta error and sample size determination in clinical trials in emergency medicine. Ann Emerg Med 6(2):183-87, 1987

17. Fritz S, **Kelen GD**, Sivertson KT. Foreign bodies of the external auditory canal. In Emerg Med Clin N Amer 5(2):183-92, 1987

18. Baker J, **Kelen GD**, Sivertson KT, Quinn TC. Unsuspected human immunodeficiency virus (HIV) in critically ill emergency patients. JAMA 257(19):2609-11, 1987

19. **Kelen GD**, Brown CG, Ashton J. Statistical reasoning in clinical trials: Hypothesis testing. Am J Emerg Med 6(1):52-61, 1988

20. **Kelen GD**, Baker JL. AIDS: Implications for emergency medicine. Am J Emerg Med 6(2):180-84, 1988

21. **Kelen GD**, Fritz S, Qaqish B, Brookmeyer R, Baker JL, Kline RL, Cuddy RM, Goessel TK, Floccare D, Williams KA, Sivertson KT, Altman S, Quinn TC. Unrecognized human immunodeficiency virus infection in emergency department patients. N Engl J Med 318(25):1645-50, 1988

22. **Kelen GD**. Reanalysis of surveillance data regarding health care worker risk of nosocomial acquisition of HIV. (Editorial) Ann Emerg Med 17(10):1101-02, 1988

23. **Kelen GD**, Fritz S, Qaqish B, Floccare D, DiGiovanna T, Baker JL, Sivertson KT, Quinn TC. Substantial increase in human immunodeficiency virus (HIV-1) infection in critically ill emergency patients: 1986 and 1987 compared. Ann Emerg Med 18(4):378-82, 1989

24. **Kelen GD**, DiGiovanna T, Bisson L, Kalainov D, Sivertson KT, Quinn TC. Human immunodeficiency virus infection in emergency department patients. Epidemiology, clinical presentations, and risk to health care workers: The Johns Hopkins experience.
    JAMA 262(4):516-22, 1989
    Edizione Italiana (JAMA) 6:496-505, 1989
    Southeast Asia (JAMA) 5:19-25, 1989
    Japan (JAMA) 262:36-45, 1990

25. Floccare D, **Kelen GD**, Altman RS, Hassett JM, Qaqish B, Ness PM, Sivertson KT. Rapid infusion of additive red blood cells: Alternative techniques for massive hemorrhage. Ann Emerg Med

19(2):129-33, 1990

26. **Kelen GD**, Fleetwood D. HIV infection and intravenous drug users. Implications for emergency services. Emerg Med Clin N Amer 8(3):653-64, 1990

27. Marco C, **Kelen GD**. Acute intoxication. In Emerg Med Clin N Amer 8(4):731-48, 1990

28. **Kelen GD**. Human immunodeficiency virus and the emergency department: Risks and risk protection for health care providers. Ann Emerg Med 19(3):242-48, 1990

29. Noji EK, **Kelen GD**, Armenian HK, Oganessian A, Jones NP, Sivertson KT. The 1988 earthquake in Soviet Armenia: A case study. Ann Emerg Med 19(8):891-97, 1990

30. **Kelen GD**, DiGiovanna TA, Lofy L, Junkins E, Stein A, Sivertson KT, Lairmore M, Quinn TC. Human T-lymphotropic virus (HTLV I-II) infection among patients in an inner-city emergency department. Ann Internal Med 113(5):368-72, 1990

31. **Kelen GD**, DiGiovanna TA, Celentano DD, Kalainov D, Bisson L, Junkins E, Stein A, Lofy L, Scott CR, Sivertson KT, Quinn TC. Adherence to universal (barrier) precautions during interventions on critically ill and injured emergency department patients. J Acquir Immuno Defic Syndr 3(10):987-94, 1990

32. **Kelen GD**, Johnson G, DiGiovanna TA, Loring K, Sivertson KT. Profile of patients with human immunodeficiency virus infection presenting to an inner-city emergency department: Preliminary report. (Lead Article) Ann Emerg Med 19(9):963-69, 1990

33. Brown CG, **Kelen GD**. High-dose epinephrine in pediatric cardiac arrest. (Editorial) Ann Emerg Med 20(1):104-05, 1991

34. Green GB, Chan DW, Chandra NC, **Kelen GD**. Role of the laboratory in the diagnosis of myocardial injury. Crit Care Report 2(3):318-30, 1991

35. Green GB, Hansen KN, Chan DW, Guerci AD, Fleetwood DH, Sivertson KT, **Kelen GD**. The potential utility of a rapid CK-MB assay in evaluating emergency department patients with possible myocardial infarction. (Lead Article) Ann Emerg Med 20(9):954-60, 1991

36. **Kelen GD**, Bennecoff TA, Kline R, Green GB, Quinn TC. Evaluation of two rapid screening assays for the detection of human immunodeficiency virus-1 infection in emergency department patients. Am J Emerg Med 9(5):416-20, 1991

37. **Kelen GD**, Green GB, Hexter DA, Fortenberry DC, Taylor E, Fleetwood DH, Sivertson KT. Substantial improvement in compliance with universal precautions in an emergency department following institution of policy. Arch Intern Med 151(10):2051-56, 1991

38. Viscidi RP, Hill P, Li S, Cerny E, Vlahov D, Farzadegan H, Halsey N, **Kelen GD**, Quinn TC. Diagnosis and differentiation of HTLV-1 and HTLV-II infection by enzyme immunoassays using synthetic peptides. J Acquir Immuno Defic Syndr 4(12):1190-98, 1991

39. **Kelen GD,** Green GB, Purcell RH, Chan DW, Qaqish BF, Sivertson KT, Quinn TC. Hepatitis B and hepatitis C in emergency department patients.
N Engl J Med 326(20):1399-404, 1992
J Internat Med 224:27-33, 1992 (translation)

40. DiGiovanna T, Rosen T, Forsett R, Sivertson K, **Kelen GD**. Shipboard medicine: A new niche for emergency medicine. Ann Emerg Med 21(12):1476-79, 1992

41. Loring K, Crandall CS, **Kelen GD**. The influence of perceived risk of exposure to human immunodeficiency virus on medical students' planned specialty choices. Am J Emerg Med 11(2):143-48, 1993

42. Marcus R, Culver DH, Bell DM, Srivastava PU, Mendelson MM, Zalenski RJ, Farber B, Fligner D, Hassett J, Quinn TC, Schable CA, Sloan EP, Tsui P, **Kelen GD**. Risk of human immunodeficiency virus infection among emergency department workers. Am J Med 94(4):363-70, 1993

43. Glass GE, Watson AJ, LeDuc JW, **Kelen GD**, Quinn TC, Childs JE. Infection with a ratborne hantavirus in US residents is consistently associated with hypertensive renal disease. J Infect Dis 167(3):614-20, 1993

44. **Kelen GD**, Chanmugam A, Meyer WA, Farzadegan H, Stone D, Quinn TC. Detection of HIV-1 by polymerase chain reaction and culture in seronegative intravenous drug users in an inner-city emergency department. (Lead Article) Ann Emerg Med 22(5):769-75, 1993

45. Thomas DL, Factor SH, **Kelen GD**, Washington AS, Taylor E, Quinn TC. Viral hepatitis in health care personnel at The Johns Hopkins Hospital. The seroprevalence of and risk factors for hepatitis B virus and hepatitis C virus infection. Arch Intern Med 153(14):1705-12, 1993

46. Gershon RRM, Curbow B, **Kelen GD**, Celentano D, Lears K, Vlahov D. Correlates of attitudes concerning human immunodeficiency virus and acquired immunodeficiency syndrome among hospital workers. Am J Infect Control 22(5):293-99, 1994

47. Restifo KM, **Kelen GD**. Sternal fracture from a seatbelt. (Case Report) J Emerg Med 12(3):321-23, 1994

48. Medicaid Access Study Group. Access of Medicaid recipients to outpatient care. N Engl J Med 330(20):1426-30, 1994

49. Clark SJ, **Kelen GD**, Henrard DR, Daar ES, Craig S, Shaw GM, Quinn TC. Unsuspected primary human immunodeficiency virus type 1 infection in seronegative emergency department patients. J Infect Dis 170(1):194-97, 1994

50. Tom PA, Morrow CT, **Kelen GD**. Delayed hypotension after overdose of sustained release verapamil. (Case Report) J Emerg Med 12(5):621-25, 1994

51. Gershon RRM, Vlahov D, **Kelen GD**, Conrad B, Murphy L. Review of accidents/injuries among emergency medical services workers in Baltimore, Maryland. Prehospital Disaster Med 10(1):14-18, 1995

52. Scott WW, Bluemke DA, Mysko W, Weller GE, **Kelen GD**, Reichle RL, Weller JC, Gitlin JN. Interpretation of emergency department radiographs by radiologists and emergency medicine physicians: Teleradiology workstation versus radiograph readings. Radiology 195(1):223-29, 1995

53. Marcus R, Srivastava PU, Bell DM, McKibben PS, Culver DH, Mendelson MH, Zalenski RJ, **Kelen GD.** Occupational blood contact among prehospital providers. Ann Emerg Med 25(6):776-79, 1995

54. **Kelen GD**, Hansen KN, Green GB, Tang N, Ganguli C. Determinants of emergency department procedure- and condition-specific universal (barrier) precautions requirements for optimal provider protection. Ann Emerg Med 25(6):743-50, 1995

55. Marco CA, Schoenfeld C, Hansen KN, Hexter DA, Stearns DA, **Kelen GD**. Fever in geriatric emergency patients: Clinical features associated with serious illness. Ann Emerg Med 26(1):18-24, 1995

56. Levy F, Mysko WK, **Kelen GD**. Spontaneous esophageal perforation presenting with right-sided pleural effusion. J Emerg Med 13(3):321-25, 1995

57. **Kelen GD**, Hexter DA, Hansen KN, Tang N, Pretorius S, Quinn TC. Trends in human immunodeficiency virus (HIV) infection among a patient population of an inner-city emergency department: Implications for emergency department-based screening programs for HIV infection. Clin Infect Dis 21(4):867-75, 1995

58. Bozeman W, Hexter DA, Liang H, **Kelen GD**. Esophageal detector device versus detection of end-tidal $CO_2$ level in emergency intubation. Ann Emerg Med 27(5):595-99, 1996

59. **Kelen GD**, Hexter DA, Hansen KN, Humes R, Vigilance PND, Baskerville M, Quinn TC. Feasibility of an emergency department-based, risk-targeted voluntary HIV screening program. (Lead Article) Ann Emerg Med 27(6):687-92, 1996

60. Aghababian RV, Barsan WG, Bickell WH, Biros MH, Brown CG, Cairns CB, Callaham ML, Carden DL, Cordell WH, Dart RC, Dronen SH, Garrison HG, Goldfrank LR, Hedges JR, **Kelen GD**, Kellermann AL, Lewis LM, Lewis RG, Ling LJ, Marx JA, McCabe JB, Sanders AB, Schriger DL, Sklar DP. Research directions in emergency medicine. Am J Emerg Med 14(7):681-83, 1996

61. Pagane J, Chanmugan AS, Kirsch TD, **Kelen GD**. New York City police officers incidence of transcutaneous exposures. Occup Med 46(4):285-88, 1996

62. Li G, Baker SP, DiScala C, Fowler C, Ling J, **Kelen GD**. Factors associated with the intent of firearm-related injuries in pediatric trauma patients. Arch Peds & Adolesc Med 150(11):1160-65, 1996

63. Hirshon JM, Kirsch T, Mysko W, **Kelen GD**. Effect of rotational patient assignment on emergency department length of stay. J Emerg Med 14(6):763-68, 1996

64. Michalsen A, Delclos G, Felknor S, Davidson AL, Johnson PC, Vesley D, Murphy LR, **Kelen GD**, Gershon RRM. Compliance with universal precautions among physicians. J Occup Environ Med 39(2):130-37, 1997

65. Morton T, **Kelen GD**. Hepatitis C. Ann Emerg Med 31(3):381-90, 1998

66. Marco CA, Bessman ES, Schoenfeld CN, **Kelen GD**. Ethical issues of cardiopulmonary resuscitation: Current practice among emergency physicians. Acad Emerg Med 4(9):898-904, 1997

67. Green GB, Li DJ, Bessman ES, Cox JL, **Kelen GD**, Chan DW. The prognostic significance of troponin I and troponin T. Acad Emerg Med 5(8):758-67, 1998

68. Hansen KN, Korniewicz DM, Hexter DA, Kornilow JR, **Kelen GD**. Loss of glove integrity during emergency department procedures. Ann Emerg Med 31(1):65-72, 1998

69. Green GB, Beaudreau R, Chan DW, DeLong D, Kelley CA, **Kelen GD**. Use of troponin T and creatine kinase-MB subunit levels for risk stratification of emergency department patients with possible myocardial ischemia. Ann Emerg Med 31(1):19-29, 1998

70. Li G, Keyl PM, Rothman RE, Chanmugam AS, **Kelen GD**. Epidemiology of alcohol-related emergency department visits. Acad Emerg Med 5(8):788-95, 1998

71. Li G, Baker SP, Langlois JA, **Kelen GD**. Are female drivers safer? An application of the decomposition method. Epidemiology 9(4):379-84, 1998. Recipient of the 1999 Roche Epidemiology Prize

72. Li G, Chanmugam AS, Rothman RE, DiScala C, Paidas CN, **Kelen GD**. Alcohol and other psychoactive drugs in trauma patients aged 10 to 14 years. Injury Prev 5(2):94-97, 1999

73. Ma MH, MacKenzie EJ, Alcorta R, **Kelen GD**. Compliance with prehospital triage protocols for major trauma patients. J Trauma Injury, Infect & Crit Care 46(1):168-75, 1999

74. **Kelen GD,** Shahan JB, Quinn TC, Project Educate Workgroup. Emergency department-based HIV screening and counseling: Experience with rapid and standard serologic testing. Ann Emerg Med 33(2):147-55, 1999

75. Kirsch T, Chanmugam A, Keyl P, Regan L, Shahan JB, Hexter DA, **Kelen GD**. Feasibility of an emergency department-based tuberculosis counseling and screening program. Acad Emerg Med 6(3):224-31, 1999

76. Li G, Tang N, DiScala C, Meisel Z, Levick N, **Kelen GD**. Cardiopulmonary resuscitation in pediatric trauma patients: Survival and functional outcome. (Lead Article) J Trauma 47(1):1-7, 1999

77. Rothman RE, Keyl PM, McArthur JC, Beauchamp NJ, Danyluk T, **Kelen GD**. A decision guideline for emergency department utilization of noncontrast head computed tomography in HIV-infected patients. Acad Emerg Med 6(10):1010-19, 1999

78. Hill MN, Bond LR, Hilton SC, Roary MC, **Kelen GD**, Levine DM. A clinical trial to improve high blood pressure care in young urban black men: Recruitment, follow-up, and outcomes. Am J Hyperten 12(6):548-54, 1999

79. Green GB, Skarbek-Borowski GW, Chan DW, **Kelen GD**. Myogloblin for early risk stratification of emergency department patients with possible myocardial ischemia. Acad Emerg Med 7(6):625-36, 2000

80. Eng J, Mysko W, Weller G, Renard R, Gitlin JN, Bluemke DA, Magid D, **Kelen GD**, Scott WW. Interpretation of emergency department radiographs: A Comparison of emergency medicine physicians with radiologists, residents with faculty, and film with digital display. Am J Roentgenol 175(5):1233-38, 2000

81. Green GB, Dehlinger E, McGrievey TS, Li DJ, Jones KA, **Kelen GD**, Chan DW. CK-MB isoforms for early risk stratification of emergency department patients. Clin Chim Acta 300(1-2):57-73, 2000

82. Mehta SD, Rothman RE, **Kelen GD**, Quinn TC, Zenilman JM. Unsuspected gonorrhea and chlamydia in patients of an urban adult emergency department: A critical population for STD control intervention. Sex Transm Dis 28(1):33-39, 2001

83. Mehta SD, Rothman RE, **Kelen GD**, Quinn TC, Zenilman JM. Clinical aspects of diagnosis of gonorrhea and chlamydia infection in an acute care setting. Clin Infect Disease 32(4):655-59, 2001

84. Scheulen JJ, Li G, **Kelen GD**. Impact of ambulance diversion policies in urban, suburban and rural areas of Central Maryland. Acad Emerg Med 8(1):36-40, 2001

85. **Kelen GD**, Scheulen JJ, Hill PM. Effect of an emergency department (ED) managed acute care unit on ED overcrowding and emergency medical services diversion. Acad Emerg Med 8(11):1095-100, 2001

86. Yang S, Lin S, **Kelen GD**, Quinn TC, Dick JD, Gaydos CA, Rothman RE. Quantitative multiprobe PCR assay for simultaneous detection and identification to species level of bacterial pathogens. J Clin Microbiol 40(9):3449-54, 2002

87. Rothman RE, Majmudar M, **Kelen GD**, Madico G, Gaydos CA, Walker T, Quinn TC. Detection of bacteremia in emergency department patients at risk for infective endocarditis using universal 16S rRNA primers in a decontaminated polymerase chain reaction assay. J Infect Dis 186(11):1677-81, 2002

88. Rothman RE, Ketlogetswe KS, Dolan T, Wyer PC, **Kelen GD**. Preventive care in the emergency department: Should emergency departments conduct routine HIV screening? A systematic review. Acad Emerg Med 10(3):278-85, 2003

89. Li G, Grabowski JG, McCarthy ML, **Kelen GD**. Neighborhood characteristics and emergency department utilization. Acad Emerg Med 10(8):853-59, 2003

90. Levy F, **Kelen GD**. Resuscitation attempts in asystolic patients: The legal tail wagging the dog? J Emerg Med 30(2):223-226, 2006

91. Hsu EB, Thomas TL, Bass EB, Whyne D, **Kelen GD**, Green GB. Healthcare worker competencies for disaster training. BMC Medical Education 6(19), 2006

92. Hsu EB, Casani JA, Romanosky A, Millin MG, Singleton CM, Donohue J, Feroli ER, Rubin M, Subbarao I, Whyne DM, Snodgrass TD, **Kelen GD**. Are regional hospital pharmacies prepared for public health emergencies? Biosecurity and Bioterrorism 4(3):237-43, 2006

93. Rothman RE, Quianzon CCL, **Kelen GD**. Narrowing in on JCAHO recommendations for community-acquired pneumonia. (Editorial) Acad Emerg Med 13(9):983-85, 2006

94. **Kelen GD**, Rothman R. Community pneumonia practice standard mandates: Can't see the forest for the trees. (Editorial) Acad Emerg Med 13(9):986-88, 2006

95. Koenig K, **Kelen GD**. Executive summary: The science of surge conference. Acad Emerg Med 13(11):1087-88, 2006

96. **Kelen GD**, McCarthy ML. The science of surge. (Lead Article) Acad Emerg Med 13(11):1089-94, 2006

97. McCarthy ML, Aronsky D, **Kelen GD**. The measurement of daily surge and its relevance to disaster preparedness. Acad Emerg Med 13(11):1138-41, 2006

98. Rothman RE, Hsu EB, Kahn CA, **Kelen GD**. Research priorities for surge capacity. Acad Emerg Med 13(11):1160-68, 2006

99. **Kelen GD**, Kraus CK, McCarthy ML, Bass E, Hsu EB, Li G, Scheulen JJ, Shahan JB, Brill JD, Green GB. Inpatient disposition classification for the creation of hospital surge capacity: A multiphase study. Lancet 368:1984-90, 2006

100. Ding R, McCarthy ML, Li G, Kirsch TD, Jung JJ, **Kelen GD**. Patients who leave without being seen: Their characteristics and history of emergency department use. Ann Emerg Med 48(6):686-93, 2006

101. Shahan JB, **Kelen GD**. Research ethics. Emerg Med Clin N Amer 24(3):657-69, 2006

102. Rothman RE, **Kelen GD**. Narrowing in on JCAHO recommendations for community-acquired pneumonia. (Editorial) Acad Emerg Med 10:983-5, 2006

103. Trautman D, McCarthy ML, Miller N, Campbell JC, **Kelen GD**. Intimate partner violence and emergency department screening: Computerized screening versus usual care. Ann Emerg Med 49(4):526-34, 2007

104. Ritsema TS, **Kelen GD**, Pronovost PJ, Pham JC. The national trend in quality of emergency department pain management for long bone fractures. Acad Emerg Med 14(2):163-69, 2007

105. Khalil A, **Kelen GD**, Rothman RE. A simple screening tool for identification of community-acquired pneumonia in an inner city emergency department. Emerg Med J 24(5):336-38, 2007

106. Li G, Lau JT, McCarthy ML, Schull MJ, Vermeulen M, **Kelen GD**. Emergency department utilization in the United States and Ontario, Canada. Acad Emerg Med 14(6):582-84, 2007

107. Kraus CK, Levy FL, **Kelen GD**. Lifeboat ethics: Considerations in the discharge of inpatients for the creation of hospital surge capacity. Disaster Med Publ Health Prep 1(1):51-56, 2007

108. **Kelen GD**, Scheulen JJ. Emergency Department Crowding as an Ethical Issue. (Editorial). Acad Emerg Med 14(8):751-754, 2007

109. Tang N, **Kelen GD**. Role of tactical EMS in support of the public safety and public health response to a hostile mass casualty incident. (Invited Commentary). Disaster Med Publ Health Prep 1(suppl 1):S55-56, 2007

110. McCarthy ML, Shore AD, Li G, New J, Scheulen JJ, Tang N, Colella R, **Kelen GD**. Likelihood of reroute during ambulance diversion periods in central Maryland. Prehosp Emerg Care 11(4):408-15, 2007

111. Hsu EB, Casani JA, Romanosky A, Millin MG, Singleton CM, Donohue J, Feroli ER, Rubin M, Subbarao I, Whyne DM, Snodgrass TD, **Kelen GD**. Critical assessment of statewide hospital pharmaceutical surge capabilities for chemical, biological, radiological, nuclear and explosive incidents. J Prehosp Disaster Med 22(3):214-18, 2007

112. Pham JC, **Kelen GD**, Pronovost P. National study on the quality of emergency department care in the treatment of acute myocardial infarction and pneumonia. Acad Emerg Med 14(10):856-63, 2007

113. **Kelen GD**. Public health initiatives in the emergency department. Not so good for the public health? Acad Emerg Med 15(2):194-97, 2008

114. Laeyendecker O, Rothman RE, Henson C, Horne BJ, Ketlogetswe KS, Kraus C, Shahan JB, **Kelen GD**, Quinn TC. The effect of viral suppression on cross sectional incidence testing in the Johns Hopkins Hospital Emergency Department. JAIDS 48(2):211-15, 2008

115. McCarthy ML, Zeger SL, Ding R, Aronsky D, Hoot NR, **Kelen GD**. The challenge of predicting demand for emergency department service. Acad Emerg Med 15(4):337-46, 2008

116. Hsieh YH, Rothman RE, Bartlett JG, Yang S, **Kelen GD**. HIV seropositivity predicts longer duration of stay and rehospitalization among nonbacteremic febrile injection drug users (IDUs) with skin/soft tissue infections (SSTIs). JAIDS 49(4):398-405, 2008

117. Hsieh YH, Rothman RE, Newman-Toker DE, **Kelen GD**. National estimation of rates of HIV serology testing in US emergency departments 1993-2005: Baseline prior to the 2006 Centers of Disease Control and Prevention recommendations. AIDS 22(16):2127-34, 2008

118. Pham JC, Story JL, Hicks RW, Shore AD, Morlock LL, Cheung DS, **Kelen GD**, Pronovost PJ. National study on the frequency, types, causes, and consequences of voluntarily reported emergency department medication errors. J Emerg Med doi10.1016/j.jemermed.2008.02.059

119. Scheulen JJ, Thanner MH, Hsu EB, Latimer CK, Brown J, **Kelen GD**. Electronic Mass Casualty Assessment and Planning Scenarios (EMCAPS): Development and application of computer

modeling to selected national planning scenarios for high consequence events. Ann Emerg Med 53(2):226-232, 2009

120. **Kelen GD**, Sauer LM. Trend analysis of disaster health articles in peer-review publications pre- and post- 9/11. Amer J Disast Med 3(6):369-76, 2008

121. Jenkins JL, McCarthy ML, **Kelen GD**, Sauer LM, Kirsch TD. Changes needed in the care for sheltered persons: A multi-state analysis from Hurricane Katrina. Amer J Disast Med 4(2):101-06, 2009

122. Lyons MS, Lindsell CJ, Haukoos JS, et al. Nomenclature and definitions for emergency department human immunodeficiency virus (HIV) testing: Report from the 2007 Conference of the National Emergency Department HIV Testing Consortium. Acad Emerg Med 16(2):168-77, 2009

123. Marco CA, Bessman ES, **Kelen GD**. Ethical issues of cardiopulmonary resuscitation: Comparison of emergency physician practices from 1995 to 2007. Acad Emerg Med 16(3):270-73, 2009

124. McCarthy ML, Brewster P, Hsu EB, MacIntyre AG, **Kelen GD**. Consensus and tools needed to measure health care emergency management capabilities. Disaster Med Publ Health Prep(Suppl1):S45-S51, 2009

125. Hick JL, Barbera JA, **Kelen GD**. Refining surge capacity: Conventional, contingency and crises capacity. Disaster Med Publ Health Prep 3(Suppl1):S59-S67, 2009

126. Jenkins, JL, **Kelen GD**, Sauer LM, Fredericksen KA, McCarthy ML. Review of hospital preparedness instruments for NIMS Compliance. Disaster Med Publ Health Prep 3(Suppl 1):S83-S89, 2009

127. **Kelen GD**, McCarthy ML, Kraus CK, Ding R, Hsu EB, Li G, Shahan JB, Green GB. Creation of surge capacity by early discharge of hospitalized patients at row risk for untoward events. (Lead Article) Dis Med Publ Health Prep 3(Suppl 1):S10-S16, 2009

128. **Kelen GD**, McCarthy ML. Developing the science of health care emergency preparedness and response. (Editorial) Dis Med Publ Health Prep 3(Suppl 1):S2-S3, 2009

129. **Kelen GD**, Rothman RE. ED-based HIV testing: Too little, but not too late. Ann Emerg Med 54:64-71, 2009 (doi:10.1016/j.annemergmed.2009.03.027)

130. Hoffman B, Um P, Bessman ES, Ding R, **Kelen GD**, McCarthy ML. Routine screening for asymptomatic abdominal aortic aneurysm in high risk patients is not recommended in emergency departments that are frequently overcrowded. Acad Emerg Med 16:1242-1250, 2009

131. Morton MJ, Kirsch TD, Rothman RE, Byerly MM, Hsieh YH, McManus JG, **Kelen GD**. Pandemic influenza and major disease outbreak preparedness in US emergency departments: a survey of medical directors and department chairs. Am J Disaster Med. 4(4):199-206, 2009

132. Hsieh YH, Jung JJ, Shahan JB, Moring-Parris D, **Kelen GD**, Rothman RE. Emergency medicine resident attitudes and perceptions before and after an educational program and testing implementation. Acad Emerg Med 16:1165-1173, 2009

133. Hsieh YH, Chen K-F, Gaydos CA, Rothman RE, **Kelen GD**. Antiviral prescriptions to U.S. ambulatory care visits with a diagnosis of influenza before and after high level of adamantine resistance 2005-06 season. PLOS ONE 5(1): 38945, 2010 (doi:10.1371/journal.pone.0008945)

134. Brown TW, McCarthy ML, **Kelen GD**, Levy F. An epidemiologic study of closed emergency department malpractice claims in a national database of physician malpractice insurers. Acad Emerg Med 17:553-650, 2010

135. James JJ, Benjamin GC, Burkle FM, Gebbie KM, **Kelen GD**. Disaster medicine and public health preparedness. A discipline for all health professionals. Dis Med Publ Health Prep 4:1-6, 2010.

136. Mathews SC, **Kelen GD**, Pronovost PJ, Pham JC. A national study examining emergency medicine specialty training and quality measures in the emergency department. Am J Med Qual DOI: 10.1177/1062860610369171, Aug 17, 2010

137. Hill PM, Mareiniss DM, Murphy P, Gardner H, Hsieh Y-H, Levy F, **Kelen GD**. Significant reduction of laboratory specimen labeling errors by implementation of an electronic ordering system paired with a bar-code specimen labeling process. Ann Emerge Med 56:630-636, 2010 http://dx.doi.org/10.1016/j.annemergmed.2010.05.028

138. Hodge JG, Anderson E, Kirsch TD, **Kelen G**. Facilitating hospital emergency preparedness through model memoranda of understanding. Dis Med Publ Health Prep 5:54-61, 2010 (doi:10.1001/10-v4n2-hsf10003, July 19, 2010)

139. **Kelen GD**, Catlett CL. Violence in the Health Care Setting. JAMA 304;(22):2530-1, 2010

140. Thanner M, Links J, Meltzer M, Scheulen J, **Kelen G**. Understanding estimated worker absenteeism rates during an influenza pandemic. Amer J Disast Med, 6:89-106, 2011

141. **Kelen GD**. Emergency Department HIV Testing. Reflections forward. Ann Emerg Med 58:S168-S172, 2011

142. Hsieh, Y-H, Jung JJ, Shahan JB, Pollack HA, Hairston HS, Moring-Paris D, **Kelen GD**, Rothman RE. Outcomes and cost analysis of 3 operational models for rapid HIV testing services in an academic inner-city emergency department. Ann Emerg Med 58:S133-S139, 2011

143. Hill PM, Rothman R, Saheed M, DeRuggiero K, Hsieh Yu-H, **Kelen GD**. A comprehensive approach to achieving near 100% compliance with the joint commission core measures for pneumonia antibiotic timing. Amer J Emerg Med 29:989-998, 2011

144. McCarthy ML, Ding R, Zeger SL, Agada N, Bessman S, Chiang W, **Kelen GD**, Scheulen JJ, Bessman ES. A Randomized Controlled Trial of the Impact of Service Delivery Information on Patient Satisfaction in an ED Fast Track. Ann Emerg Med 18:674-685, 2011

145. Cousins MM, Laeyendecker O, Beauchamp G, Brookmeyer R, Towler WI, Hudelson SE, Khaki L, Koblin B, Chesney M, Moore RD, **Kelen GD**, Coates T, Celum C, Buchbinder SP, Seage GR III, Quinn TC, Donnell D, Eshleman SH. Use of a High Resolution Melting (HRM) Assay to Compare

Gag, Pol, and Env Diversity in Adults with Different Stages of HIV Infection. PLoS One. 6(11):e27211. Epub 2011 Nov 2.

146. Catlett CL, Kirsch, TD, Scheulen JJ, Cole G, **Kelen GD**. Maximizing utility of a deployable medical team from an academic medical center to a disaster. World Medical & Health Policy 3(4):1-11, 2011

147. Rothman RE, **Kelen GD**, Harvey L, Shahan J, Hairston H, Burah A, Moring-Parris D, Hsieh Y-U. Factors associated with no or delayed linkage to care in newly diagnosed human immunodeficiency virus (HIV)-1-infected patients identified by emergency department-based rapid HIV screening programs in two urban EDs. Acad Emerg Med, 19:497-503, 2012

148. Levin S, Sauer L, **Kelen G**, Kirsch T, Pham J, Desai S, France D. Situational awareness in emergency medicine. IIE Transactions on Healthcare Systems Engineering. 2:2,172-180, 2012

149. Soong TR, Jun JJ, **Kelen GD**, Rothman RE, Burah A, Shahan J, Hsieh, Yu-H. Is inadequate human immunodeficiency virus care associated with increased ED and hospital utilization? a prospective study in human immunodeficiency virus-positive ED patients. Amer J Emerg Med, 30(8):1466-1473, 2012

150. **Kelen GD**, Catlett CL, Kubit JG Hsieh Yu-H. Hospital-based shootings in the United States: 2000 to 2011. Ann of Emerg Med 60: (6): 790-798, 2012. http://dx.doi.org/10.1016/j.annemergmed.2012.08.012 (featured article)

151. James MM, Laeyendecker O, Sun J, Hoover DR, Mullis CE, Cousins MM, Coates T, Moore RD, **Kelen GD**, Fowler MG, Kumwenda JJ, Mofenson LM, Kumwenda NI, Taha TE, and Eshleman SH. Antibody maturation and viral diversification in HIV-infected women. PLoS One. 2013. PLoS One. 2013; 8(2): e57350, Published online 2013 February 27. doi: 10.1371/journal.pone.0057350

152. Hsieh Y-H, **Kelen GD**, Dugas AF, Chen K-F, Rothman RE. Emergency Physician's adherence to Center for Disease Control and Prevention guidance during the 2009 influenza A H1N1 pandemic. Western J Emerg Med; 14(2):191,-199, 2013

153. Dugas AF, Morton M, Beard R, Pines JM, Bayram J, Hsieh YU-H, **Kelen GD**, Usher-Pines L, Jeng K, Cole G, Rothman RE. Interventions to mitigate the impact of emergency department and hospital crowding during an infectious respiratory disease outbreak: results from an expert panel. PLOS Currents Disaster 17(5): 2013ecurrents.dis.1f277e0d2bf80f4b2bb1dd5f63a13993. doi: 10.1371/currents.dis.1f277e0d2bf80f4b2bb1dd5f63a13993

154. Pham JC, Alblaihed L, Cheung DS, Levy F, Hill PM, **Kelen GD**, Pronovost PJ, Kirsch TD. Measuring patient safety in the emergency department. Amer J Med Quality Amer J Med Qual. XX(X):1-6, 2013.

155. McCarthy ML, Ding R, Rodere N, Seinwachs DM, Ortmann MJ, Pham JC, Bessman ES, **Kelen GD**, Atha W, Retezar R, Bessman S, Zeger SL. Does providing prescription information or services improve medication adherence among patients discharged from the emergency department? A randomized controlled trial. Ann Emerg Med, 62(13);213-223, 2013

156. Bayram JD, Sauer LM, Catlett C, Levin S, Cole G, Kirsch TD Toerper M, **Kelen G**. Critical Resources for hospital surge capacity: an expert consensus panel. PLOS Currents Disasters Oct 7, 2013. ecurrents.dis.67c1afe8d78ac2ab0ea52319eb119688 http://currents.plos.org/disasters/wp-admin/post.php?post=9423&action=edit

157. Tang N, **Kelen GD**. Tactical Medicine in Response to Acts of Terrorism. J Spec Ops Med 13(4): 109-110, 2013

158. Patel EU, Frank MA, Hsieh Y-H, Rothman RE, Baker AEO, Kraus CK, Shahan J, Gaydos CA, **Kelen GD**, Quinn TC, and Laeyendecker O. Prevalence and Factors Associated with Herpes Simplex Virus Type 2 Infection in Patients Attending a Baltimore City Emergency Department. PLoS One. 2014:9(7): e102422. doi:10.1371/journal.pone.0102422

159. Bayram JD, Zuabi S, McCord CM, Sherak RA, Hsu EB, **Kelen GD**. Disaster Metrics: Evaluation of de Boer's Disaster Severity Scale (DSS) Applied to Earthquakes. Prehosp Disaster Med. 2015; 30(1):1-6

160. Hsieh,Y-H, **Kelen GD**, Laeyendecker O, Kraus CK, Quinn TC, Rothmann RE. HIV Care Continuum for HIV-Infected Emergency Department Patients in an Inner-City Academic Emergency Department Ann Emerg Med 66:69-78;2015 http://dx.doi.org/10.1016/j.annemergmed.2015.01.001

161. Hsieh Y-H, **Kelen GD**, Beck K, Kraus C, Shahan J, Laeyendecker O, Quinn TC, Rothman RE. Evaluation of hidden HIV infections in an urban emergency department with a rapid HIV Screen Program. Amer J Emerg Med In Press 2016 doi: 10.1016/j.ajem.2015.10.002. [Epub ahead of print]

162. **Kelen GD**, Sauer L, Clattenburg E, Lewis-Newby M, Fackler J. Pediatric disposition classification (reverse triage) system to create surge capacity. Dis Med Publ Health Prep. 9:283-290, 2015 http://dx.doi.org/10.1017/dmp.2015.27

163. Morton MJ, DeAugustinis, ML, Velasquez CA, Singh S, **Kelen GD**. Developments in Surge Research Priorities: A systematic review of the literature following the academic Emergency Medicine Consensus Conference 2007-2012. Acad Emerg Medicine,22(11):1235-52, 2015 doi: 10.1111/acem.12815, 2015

164. Korley FK, **Kelen GD**, Jones CM, Diaz-Arrastia R. Emergency department evaluation of traumatic brain injury in the United States, 2009-2010. J Head Trauma Rehabil, 2016 31(6): 379-387. doi: **10.1097/HTR.0000000000000187**

165. **Kelen G**, Peterson S, Pronovost P. In the name of patient safety, let's burden the emergency department more. Ann Emerg Med 2015. http://dx.doi.org/10.1016/j.annemergm**ed.2015.11.031**

166. **Kelen GD**, Hsieh Y-H, Rothman RE, Patel EU, Laeyendecker OB, Marzinke MA, Clarke W, Parsons T, Manucci JL, Quinn TC. Improvements in the HIV continuum in Care in an inner-city emergency department. AIDS 30(1):113-20; 2016; doi: 10.1097/QAD.0000000000000896.

167. Patal EU, Laeyendecker O, Hsieh Y-H, Rothman RE, **Kelen GD**, Quinn TC. Parallel declines in HIV and hepatitis C virus prevalence, but not herpes simplex virus type 2 infection: a 10-year

serial, cross-sectional study in an inner-city emergency department. J Clin Virol. 2016;80:93-97. http://doi.org/10.1016/j.jcv.2016.05.003

168. Hsieh Y-H, Rothman RE, Laeyendecker OB, **Kelen GD**, Avornu A, Patel EU, Kim J, Irwin R, Thomas DL, Quinn TC. Evaluation of the CDC recommendations for HCV testing in an urban emergency department. Clin Infect Dis 62; 1059-65, 2016

169. Regan L, Jung J, **Kelen GD**. Education Value Units. A mission-based approach to assigning and monitoring faculty teaching activities in an academic medical department. Acad Med 2016 91(12); 1642–1646. DOI: 10.1097/ACM.0000000000001110. ISSN: 1040-2446

170. Garibaldi BT, **Kelen GD**, Brower GT, Bova G, Ernst N, Reimers M, Langlotz R, Ginsburg A, Iati M, Smith C, MacConnell S, James H, Lewin JL, Trexler P, Black MA, Lynch C, Clarke W, Marzinke MA, Sokoll LJ, Carroll KC, Parish NM, Dionne K, Biddison ELD, Gwon HS, Sauer L, Hill P, Newton SM, Garrett MR, Miller RG, Perl TM, Maragakis LM. The creation of a biocontainment unit at a tertiary care hospital: The Johns Hopkins Medicine Experience Annals of American Thoracic Society 2016 DOI: 10.1513/AnnalsATS.201509-58PS

171. Patel EU, Laeyendecker O, Hsieh YH, Rothman RE, **Kelen GD**, Quinn TC. Parallel declines in HIV and hepatitis C virus prevalence, but not in herpes simplex virus type 2 infection: A 10-year, serial cross-sectional study in an inner-city emergency department. Journal of Clinical Virology. 2016 Jul 31;80:93-7.

172. Balhara KS, Hsieh Y-H, Hamade B, Circh R, **Kelen GD**, Bayram JD. Clinical metrics in emergency medicine: the shock index and the probability of hospital admission and inpatient mortality. 10.1136/emermed-2015-205532

173. Morton (Hamer) MJ, Reed PL, Greulich JD, **Kelen GD**, Bradstreet NA, Beadling CW. The West Africa disaster preparedness initiative: strengthening national capacities for all-hazards disaster preparedness. Disaster Med Publ Hea Prep 2017 24:1-8. Doi.org/10.1017dmp.2016.155

174. Hansoti B, Jenson A, Keefe D, Stewart De Ramerez S, Anest T, Twomey M, Lobner K, **Kelen G**, Wallis L. Reliability and Validity of Pediatric Triage Tools Evaluated in Low Resource Settings: A Systematic Review. BMC Pediatrics 2017 17(1); 37. doi: 10.1186/s12887-017-0796-x.

175. **Kelen GD**, Troncoso R, Trebach, Levin S, Cole G, Delaney CM, Jenkins JL, Fackler J, Sauer L. Effect of reverse triage for creation of pediatric hospital surge capacity. JAMA Pediatrics 2917;171(4)e164829. doi:10.1001/jamapediatrics.2016.4829

176. Lentz BA, Jenson A, Hinson JS, Levin S, Cabral S, George K, Hsu EB, **Kelen G**. Validity of emergency department triage tools: addressing heterogeneous definitions of over-triage and under-triage. Am J Emerg Med 2017; http://doi.org/10.1016/j.ajem.2017.02.012

177. Klein EY, Levin S, Toerper M, Makowsky M, Xu T, Cole G, **Kelen G**. The effect of Medicaid expansion on utilization in Maryland emergency departments. Ann Emerg Med 2017 70:607-614 doi: 10.1016/j.annemergmed.2017.06.021

178. Toerper MF, **Kelen GD**, Sauer LM, Bayram JD, Catlett C, Levin S. Hospital surge capacity: a web-based simulation tool for emergency planners. 2017 Disaster Med Publ Hea Prep https://doi.org/10.1017/dmp.2017.93

179. Hansoti B, Jenson A, Kironji A, **Kelen G**, Katz J, Levis S, Rothman R, Wallis L. SCREEN: a simple layperson administered screening algorithm in low resource international settings significantly reduces waiting time for critically ill children in primary healthcare clinics. PLOS One 2017, https://doi.org/10.1371/journal.pone.0183520

180. Messing JT, Patch M, Wilson JS, **Kelen GD**, Campbell JC. Differentiating among attempted, completed and multiple nonfatal strangulation in women experiencing intimate partner violence. Women's Health Issues. 2018;28:104-111. 10.1016/j.whi.2017.10.002

181. Hansoti B, **Kelen GD**, Quinn TC, Whalen MW, DesRosier TT, Reynolds SJ, Redd A, Rothman RE. A systematic Review of Emergency Department Based HIV testing and linkage to care initiatives in Low Resource Settings. PLOS ONE: https://doi.org/10.1371/journal.pone.0187443

182. Mistry B, Steward de Ramierez S, **Kelen GD**, Schmitz PSK, Balhara K, Levin S, Marinez D, Psoter K, Anton X, Hinson JS. Accuracy and reliability of emergency department triage using the emergency severity index: An international multicenter assessment. Annals Emerg Med 2017; http://dx.doi.org/10.1016/j.annemergmed.2017.09.036.

183. Reznek MA, Scheulen JJ, Harbertson CA, Kotkowski KA, Kelen GD, Volturo GA. Contributions of academic emergency medicine programs to US health care: Summary of the AAAEM-AACEM benchmarking data. Acad Emerg Medicine. Oct 2017 DOI: 10.1111/acem.13337

184. Levin S, Toerper M, Hamrock, Hinson, Barnes S, Gardner H, Dugas A, Linton B, Kirsch, **Kelen G**. Machine-learning-based electronic triage more accurately differentiates patients with respect to clinical outcomes compared with the emergency severity index. Annals Emerge Med 2018;71(5):565.e2

185. Peterson SM, Harbertson CA, Scheulen JJ, **Kelen GD**. Trends and Characterization of Academic Emergency Department Patient Visits: A Five Year Review. Acad Emerg Med Aug 2018; DOI: 10.1111/acem.13550

186. Bai G, **Kelen GD**, Frick KD, Anderson GF. Nurse practitioner and physician assistants in emergency medicine services who billed independently. 2012-2016. Amer J Emerg Med; 2019; doi: 10.1016/j.ajem.2019.01.052. [Epub ahead of print]

187. Al Jalbout N, Balhara KS, Hamade B, Hsieh YH, **Kelen GD**, Bayram JD. Shock index as a predictor of hospital admission and inpatient mortality in a US national database of emergency departments. Emerg Med J. Published Online First: 25 March 2019. doi: 10.1136/emermed-2018-208002

188. Hager DN, Hooper MH, Bernard GR….**Kelen GD**….et al. The Vitamin C, Thiamine and Steroids in Sepsis (VICTAS) Protocol: A prospective, multi-center, double-blind, adaptive sample size, randomized, placebo-controlled, clinical trial. 2019; Trials 20(197): DOI: 10.1186/s13063-019-3254-2

189. Rademacher NJ, Cole G, Psoter KJ, **Kelen G**, Fan JWZ, Gordon D, Razzak J. Use of Telemedicine to Screen Patients in the Emergency Department: Matched Cohort Study Evaluating Efficiency and Patient Safety of Telemedicine. JMIR Med Inform 2019;7(2):e11233. DOI: 10.2196/11233; PMID: 31066698; PMCID: 6530260

190. Lindsell C, McGlothlin A, Nwosu S, Rice TW, Hall A, Bernard GR, Busse LW, Ely EW, Fowler AA, Aieski DF, Hinson JS, Hooper M, Jackson JC, Kelen GD, Levine M, Martin GS, Rothman RE Sevransky JE, Viele K, Write DW, Hager DN. Update to the Vitamin C, Thiamine and Steroids in Sepsis (VICTAS) Protocol: statistical analysis plan for a prospective, multi-center, double-blind, adaptive sample size, randomized, placebo-controlled, clinical trial. Trials 2019, Dec 4;20(1):670 doi: 10.1186/s13063-019-3775-8.PMID: 31801567

191. Wilson CL, Rose D, **Kelen GD**, Billioux VG, Bright L. Comparison of ultrasound guided vs traditional arterial cannulation by emergency medicine residents. West JEM. Feb 26, 2020, DOI: 10.5811/westjem.2019.12.44583

192. Ehmann MR, Klein EY, **Kelen GD**, Regan LR. Emergency medicine career outcomes and scholarly pursuits: the impact of transitioning for a three-year to a four-year niche-based residency curriculum. AEM Education and Training. Jan 13, 2020; https://doi.org/10.1002/aet2.10435

193. Morton JH, Kirsch TD, Rothman RE, Byerly MM, Hsieh YH, McManus JG, **Kelen GD**. Pandemic influenza and major disease outbreak preparedness in US emergency departments: a survey of medical directors and department chairs. Am J Disaster Med. 2020 14(4):279-286. doi: 10.5055/ajdm.2019.0341.PMID: 32803747

194. Severansky JE, Rothman RE, Hager DN, Bernard GR, Bron M, Buchman TG, Busee L, Coopersmith M, DeWilde C, Wesley E, Eyzaguirre LM, Flowler AA, Gaieski DF, Gong MN, Hall A, Hinson JS, Hooper MH, **Kelen GD**, Khan A, Levin MA, Lewis RJ, Lindsell CJ, Marlin JS, McGlothilin A, Moore BL, Nugent KL, Nwosu S, Polito CC, Rice TW, Ricketts EP, Rudolph CC, Sanfilippo F, Viele K, Martin GS, Wright DW. Effect of Vitamin C, Thiamine, and hydrocortisone on ventilator- and vasopressor-free days in patients with sepsis. The VICTAS Randomized Clinical Trials. JAMA. 2021: 325(8):742-750. doi:10.1001/jama.2020.24505

195. **Kelen GD**. Swedien D, Hansen J, Saheed M, Scheulen J, Mann E. Characterization and impact of COVID-19-tested and infected patients: experience of The Johns Hopkins Health System Regional Emergency Departments. JACEP. 08, Dec 2020. https://doi.org/10.1002/emp2.12321

196. Mohareb A, Patel A, Laeyendecker OB, Toerper M, Signer D, Clarke W, **Kelen G**, Quin T, Haukoos, JS, Rothma RE, Hsieh Yu-H. The HIV screening cascade. Current emergency department-based screening strategies leave many patients with HIV undiagnosed. JAIDS. Dec 28, 2020. doi: 10.1097/QAI.0000000000002609

197. Patch M, Farag YMK, Anderson JC, Perrin N, **Kelen G**, Campbell J. United States ED visits by adult women for nonfatal intimate partner strangulation, 2006 to 2014: Prevalence and Associated characteristics. J EM Nursing. 2021. https://doi.org/10.1016/j.jen.2021.01.008

198. Laeyendecker O, Hsieh Yu-H, Rothman RE, Dashler G, Kickler T, Fernandez RE, Clarke W, Patel EU, Tobian AAR, **Kelen GD**, Quinn TC. Demographic and clinical correlates of acute and

convalescent SARS-CoV-2 infection among patients of a U.S. emergency department. AJEM 2021; 261-268. https://doi.org/10.1016/j.ajem.2021.04.081.

199. Mann E, Swedien D, Hansen J, Peterson S, Saheed, M, Klein E, Ajit M, Scheulen J, **Kelen GD**. Reduction in emergency department presentations in a regional health system during the COVID-19 pandemic. (In press). Available on line https://escholarship.org/uc/item/2n4320cz.

200. Spencer SEF, Laeyendecker O, Dyson L, Hsieh, Yu-H, Patel EU, Rothman RE, **Kelen GD**. Quinn TC, Hollingsworth TD. Estimating HIV, HCV, HSV2 incidence from emergency department serosurvey. Gates Open Research 2021, 5:116. https://doi.org/10.12688/gatesopenres.13261.1

201. Ehmann, MR, Klien EY, **Kelen GD**, Regan L. Emergency Medicine Career Outcomes and Scholarly Pursuits: The impact of transitioning from a three-year to a four-year niche-based residency curriculum. AEM Educ Train 2020; 5(1):43-51. doi: 10.1002/aet2.10435

202. **Kelen GD**, Wolfe R, D'Onofrio G, Mills AM, Dierck D, Stern SA, Wadman M, Sokolove PE. Emergency department crowding. The canary in the health care system. **NEJM**Catalyst, Sept 29, 2021. DOI: 10.1056/CAT.21.0217

203. Bright L, Zink K, Klein E, Wright R, **Kelen G**. A missed opportunity in the ED: Palliative care consult delays during inpatient admission. Amer J Emerg Med. On line Nov 8, 2021, print 2002; 51:326-30. https://doi.org/10.1016/j.ajem.2021.11.002;

204. Hsieh Yu-H, Rothman Re, Solomon SS, Anderson M, Stec M, Laeyendecker O, Lake IV, Fernandez RE, Dashler G, Mehta R, Kickler T, **Kelen GD**, Mehta SH, Cloherty GA, Quinn TC. A Tale of 3 pandemics: Sever Acute respiratory syndrome coronavirus 2, hepatitis C virus, and human immunodeficiency virus in an urban emergency department in Baltimore, Maryland. Open Forum Infectious Diseases. 2022; 5(9): ofac130 https://doi.org/10.1093/ofid/ofac130

205. Hinson JS, Klein E, Smith A, Toerper M, Dungarani T, Hager D, Hill P, **Kelen G**, Niforatos JD, Stephens RS, Strauss AT, Levin S. Multisite implementation of a workflow-integrated machine learning system to optimize COVID-19 hospital admission decision. Nature, npj Digit. Med. 5, 94 (2022). https://doi.org/10.1038/s41746-022-00646-1

206. Patch M, Anderson J C, Alexander KA, Somoano FA, **Kelen G**, Holbrook DS, Campbell JC. Didn't put a label on it: Examining intimate partner strangulation within a diagnostic framework. JAN. July 21, 2022. https://doi.org/10.1111/jan.15380

207. Wang R, Rothman RE, Mohareb AM, Laeyendecker O, Anderson M, Solomon SS, Fernandez RE, Dashler G, Meht R, Stec M, Kickler T, **Kelen GD**, Mehta SH, Cloherty GA, Quinn TC, Hsieh Yu-H. The high burden of undiagnosed hepatitis B and associated transaminitis in an urban emergency department—an identity unliked seroprevalence study in Baltimore 2020. Clinical Gastroenterology and Hepatology. 2022. https://doi.org/10.1016/j.cgh.2022.10.033

208. **Kelen GD**, Marcozzi D, Marx JJ, Kachalia A. Criteria for declaring crisis standards of care: A single, uniform model. NEJM Catalyst. 2023. https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0269

209. **Kelen GD**, Kaji AH, and the Consortium of Societies of Emergency Medicine. The AHRQ report on diagnostic errors in the emergency department: the wrong answer to the wrong question. First on-line June 10, 2023.https://doi.org/10.1016/j.annemergmed.2023.03.031

210. Klein E, Saheed M, Irvin N, Balhara KS, Badaki-Makun O, Poleon S, **Kelen G**, Cosgrove SE, Hinson J. Racial and socioeconomic disparities evident in appropriate antibiotic prescribing in the emergency department. Ann of Emerge Med 2024: 84(2);101-110. https://doi.org/10.1016/j.annemergmed.2023.12.003

211. Garg N, Johnson J, Garg S, Chang B Zabbo C, Pridha K, Becker L, Levy P, Kelen GD, Davis JJ, Shah M. National needs assessment of emergency medicine faculty regarding scholarly activity practices and support. JACEP Open. 2024;5:e13292. Sept 25, 2004. **https://doi.org/10.1002/emp2.13292**

212. Maher PJ, Rothman R, Neumar, R, Brown J, Sharp W, Cairns C, Kelen GD, Kaji A, Richardson LD. T32 programs in emergency medicine: A report from the ACEP-SAEM Federal Research Funding Workgroup. Acad Emerg Med. 2024;00:1-8. Aug 16, 2024. **https://doi.org/10.1111/acem.15002**

*213.* Patch M., Jacobi-Dorbeck A, Rodney T, Kelen G, Campbell J., Rubin L, Wagner C, Perrin N, Gill J. Examining acquired brain injury-associated symptoms and fluid-based biomarkers in females surviving intimate partner violence: An observational pilot study protocol. *Women's Health.* 2025; Vol 21. https://doi.org/10.1177/17455057251320717

214. Bradshaw JC, Kelen GD. Advancing emergency medicine. Embracing new horizons. *Can J Emerg Med*, 2025. https://doi.org/10.1007/s43678-024-00856-4

215. (with) Kelen G. Emergency department boarding reflects ongoing strains. *NEJM Catalyst*, 2025;6(3). https://catalyst.nejm.org/doi/pdf/10.1056/CAT.25.0048

**Chapters**

216. Kelen GD and Noji EK. Advanced toxicology poisoning and life support. In Noji EK and Kelen GD (Eds): Toxicology Manual for Emergency Medicine. Yearbook Medical Publications, Chicago, 1989

217. Werman H and Kelen GD. Acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) infections. In Schillinger D, Harwood A (Eds): Infectious Diseases of Emergency Medicine (vol 1). Churchill Livingston, New York, 1989

218. Kelen GD. Infectious disease risk to health care workers. In Callaham M (Ed): Current Therapy in Emergency Medicine. B.C. Decker, Philadelphia, 1991

219. Kelen GD and Werman H. AIDS. In Harwood A, Linden C, Luten RC, Sternbach G, Wolfson AB (Eds): The Clinical Practice of Emergency Medicine. J.B. Lippincott, Philadelphia, 1991

220. Kelen GD. Safety precautions for the health care worker: Special considerations for emergency personnel. In DeVita VT, Hellman S, Rosenberg SA (Eds): AIDS: Etiology, Diagnosis, Treatment, and Prevention. Lippincott, Philadelphia, 1992

221. Kelen GD, Marco C. HIV-1 in the emergency department. In Rosen P, et al (Eds): Emergency Medicine. Mosby, St. Louis, 1992

222. Fritz S, Kelen GD. Foreign bodies in the ear. In Schwarz GR, et al (Eds): Principles and Practice of Emergency Medicine. Saunders, Philadelphia, 1992

223. Kelen GD, Hansen KN. Evaluating the random needlestick: Hepatitis and AIDS. In Flomenbaum N, Goldfrank L, Jacobson S (Eds): Emergency Diagnostic Testing (2nd ed). Mosby-Year Book, Chicago, 1995

224. Marco CA, Kelen GD. HIV infection and related disorders. In Harwood A, et al. (Eds): The Clinical Practice of Emergency Medicine (2nd ed). Lippincott-Raven, Philadelphia, 1996

225. Kelen GD, Brown CG. The future of emergency medicine research. In: The Role of Emergency Medicine in the Future of American Medical Care. Proceeding a Conference. Josiah Macy, Jr., Foundation, 1995

226. Marco C, Kelen GD. HIV-1 in the emergency department. In Rosen P, et al. (Eds): Emergency Medicine (4th ed). Mosby, St. Louis, 1997

227. Kelen GD. Safety precautions for the health care worker: Special considerations for emergency personnel. In DeVita VT, Hellman S, Rosenberg SA (Eds): AIDS: Etiology, Diagnosis, Treatment, and Prevention (2nd ed). Lippincott-Raven, Philadelphia, 1997

228. Nicolaou DD, Kelen GD. Airway management for the trauma patient. In Cameron J, et al (Eds): Current Surgical Therapy (6th ed). Mosby, Philadelphia, 1998

229. Nicolaou DD, Kelen GD. Acid-base disorders. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (5th ed). McGraw-Hill, New York, 1999

230. Londner MS, Carr CM, Kelen GD. Fluid and electrolyte problems. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (5th ed). McGraw-Hill, New York, 1999

231. Rothman RE, Kelen GD. HIV infection and AIDS. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (5th ed). McGraw-Hill, New York, 1999

232. Bowling WM, Wilson RF, Kelen GD, Buchman TG. Thoracic trauma. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (5th ed). McGraw-Hill, New York, 1999

233. Kelen GD. Genitourinary trauma. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (5th ed). McGraw-Hill, New York, 1999

234. Rothman RE, Kelen GD. HIV infection and related disorders. In Harwood-Nuss A (Ed): Clinical Practice of Emergency Medicine. Lippincott Raven, Philadelphia, 2000

235. Rothman RE, Marco CA, Kelen GD. AIDS and HIV infection. In Rosen P (Ed): Emergency Medicine: Concepts and Clinical Practice (5th ed). Mosby, St. Louis, 2002

236. Marco CA, Rothman RE, Kelen GD. HIV and AIDS in emergency medicine (Part I). ***www.EMedHome.com/news/cfm*** July 5, 2002

237. Noji EK, Kelen GD. Disaster medical services. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (6th ed). McGraw-Hill, New York, 2004

238. Nicolaou DD, Kelen GD. Acid base disorders. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (6th ed). McGraw-Hill, New York, 2004

239. Londner MS, Hammer D, Kelen GD. Fluid and electrolyte problems. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (6th ed). McGraw-Hill, New York, 2004

240. Rothman RE, Marco CA, Kelen GD. HIV infection and AIDS. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (6th ed). McGraw-Hill, New York, 2004

241. Buchman TG, Hall BL, Bowling WM, Kelen GD. Thoracic trauma. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (6th ed). McGraw-Hill, New York, 2004

242. Levy F, Kelen GD. Genitourinary trauma. In Tintinalli JE, Kelen GD, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (6th ed). McGraw-Hill, New York, 2004

243. Kelen GD, Hsu EB. Fluid and electrolyte problems. In Tintinalli JE, Cydulka R, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (7th ed). McGraw-Hill, New York, 2011

244. Nicolaou DD , Kelen GD. Acid base disorders. In Tintinalli JE, Cydulka R, Stapczynski JS (Eds): Emergency Medicine: A Comprehensive Study Guide (7th ed). McGraw-Hill, New York 2011

245. Sauer LM, Rothman RE, Kelen GD. Emergency Medicine Research Ethics. In: Ethical Dilemmas in Emergency Medicine: A Multimedia Resource. Eds. Catherine Marco MD, Raquel Shears, MD. Cambridge University Press. 2015

246. Kelen GD, Nicolaou DD, Cline DM. Acid-Base Disorders. In Tintinalli JE, Stapczynski JS, Ma J, Cline DM, Cydulka RK, Meckler GD (Eds): Emergency Medicine: A Comprehensive Study Guide (8th ed). McGraw-Hill, New York, 2016

247. Kelen GD, Cline DM. Acid-Base Disorders. In Tintinalli JE, Stapczynski JS, Ma J, Cline DM, Cydulka RK, Meckler GD (Eds): Emergency Medicine: A Comprehensive Study Guide (9th ed). McGraw-Hill, New York, 2019

248. Scheulen JJ, Kelen GD. Financial Success in Academic Emergency Medicine. In: Strauss RW and Mayer TA (Eds). Emergency Department Management (2nd Ed), American College of Emergency Physicians, Dallas, Texas, 2021.

249. Kelen AM, Kelen GD. Financial Planning for Individuals. In: Strauss RW and Mayer TA (Eds). Emergency Department Management (2nd Ed), American College of Emergency Physicians, Dallas, Texas, 2021.

**Letters**

250. Kelen GD, Brown CG. Dog bites in children: Epidemiology, microbiology, and penicillin prophylactic therapy. (Letter) Am J Emerg Med 2(1):111-12, 1984

251. Kelen GD. Out-of-hospital pulmonary edema: Diagnosis and treatment. (Letter) Ann Emerg Med 13(7):575-76, 1984

252. Kelen GD, Riggs B. Management of protocols for nonpenetrating gunshot wounds. (Letter) J Trauma 24(9): 862-64, 1984

253. Baker JL, Kelen GD, Sivertson KT, Quinn TC. Research on humans published in JAMA. (Letter) JAMA 258:1605-06, 1987

254. Popper C, Kelen GD, Cunningham G. Naloxone hazard in a drug abuser. (Letter) Lancet 334(8660):446, 1989

255. Kelen GD, Quinn TC. Hepatitis B in the emergency department. (Letter) N Engl J Med 327:1032, 1992

256. Chanmugam AS, Kirsch TD, de Obeso EA, Li G, Shahan JB, Kelen GD. Tuberculosis screening of residents and staff in long-term care facilities. (Letter) Acad Emerg Med 5(6):652-53, 1998

257. Li G, Kelen GD, Baker SP, Langlois JA. Gender and driving safety. (Letter) Epidemiology 10(1):99, 1999

258. Li G, Keyl PM, Rothman RE, Chanmugam A, Kelen GD. Quality of national ED-based information system questioned. (Letter) Acad Emerg Med 6(6):666-68, 1999

259. Rothman RE, Bloomfield PJ, Kelen GD. Emergency department HIV testing: Sounds good, but...? (Letter) Acad Emerg Med 10(12):1416-17, 2003

260. Busta F, Clarke N, Goldman LR, Haas C, Kelen G, Lafree G, Rose J, von Winterfeldt D. Cuts in Homeland Security research. Science 313(5793):1571, 2006

261. Kelen GD. Age proofing hospital surge capacity. Author's reply. Lancet 369:823, 2007

262. Pham JC, Kelen GD, Pronovost PJ. National study on the quality of emergency department care in the treatment of acute myocardial infarction and pneumonia – Author's reply. Acad Emerg Med 15(3), 2008

263. Lindsell CJ, McGlothlin A, Nwosu S. Rice TW, Hall A, Bernanrd GR, Busse LW, Ely EW, Fowler DF, Hinson JS, Hooper MH, Jackson JC, Kelen GD, Levine M, Martin GS, Rothman RE, Sevransky JE, Viele K, Wright DW, Hager DN. Trials 21:351, 2020. In response: letter on update to the vitamin C, thiamine and steroids in sepsis (VICTAS) protocol

**Software**

1. Electronic Mass Casualty Assessment and Planning Scenarios (EMCAPS). http://www.hopkins-cepar.org/.

**Other Non-Peer Review**

1. Kelen GD. A journal club curriculum to teach research techniques to residents. (7 part series) STEM Letter 5(5):7-9 through 6(6):9-12. Society of Teachers of Emergency Medicine, Lansing, Michigan, 1984-1985

2. Kohri K, Latimer CK, Catlett CL, Scheulen JJ, Kelen GD. The Johns Hopkins Office of Critical Event Preparedness and Response. Johns Hopkins Applied Physics Laboratory Technical Digest 24(4):321-25, 2003

3. Tang N, Li G, Kelen GD. Clinical outcome of pulmonary resuscitation in pediatric trauma. Business Briefing: Emergency Medicine Review 2005. Touch Briefings 94-96, 2005

**Thesis** (Honors)

1. Kelen, GD. Neurohormonal conditioning in the rat. Experimental Physiological Psychology Honors Thesis. Carleton University, September 1974. Advisor: B. Pappas, Ph.D., Department of Psychology.

**Published Abstracts**

1. Pappas BA, Peters DAV, Saari M, Blouin A. Kelen G. Pavlovian conditioning of brain serotonin levels? Presented at the annual meeting of the annual meeting of the Eastern Psychological Association, New York, 1975

2. Kelen GD, Brown CG, Moser M, Ashton J, Rund DA. Methodology reporting in three acute care journals: Validity. Ann Emerg Med 13(5):381, 1984

3. Brown CG, Kelen GD, Ashton J and Werman H. The beta error and sample size determination in clinical trials in emergency medicine. Ann Emerg Med 14(5):494, 1985

4. Kelen GD, Brown CG, Ashton J, Moser MJ, Rund DA. Methodology reporting: Comparison of weighted and unweighted analysis. Clin Invest Med 8(3):A73, 1985

5. Kelen GD, Brown CG, Ashton J, Moser MJ, Rund DA. Methodology reporting: Comparison of weighted and unweighted analysis. Arch Emerg Med 3(1):91-2, 1986

6. Kelen GD, Brown CG, Hess P, Moser M. Referencing errors in emergency medicine literature. Ann Emerg Med 15(5):622, 1986

7. Kelen GD, Baker JL, Sivertson KT, Quinn TC. Prevalence of unsuspected human immunodeficiency virus (HIV) in critically ill emergency patients. Ann Emerg Med 16(4):477, 1987

8 Kelen GD, Floccare D, Altman S, Qaqish B, Ness P, Sivertson KT. Rapid volume resuscitation with new ADSOL-PRBCs: Effect of new trauma tubing and other infusion techniques on transfusion times. Clin Invest Med 10(4 suppl):B70, 1987

9. Kelen GD, Fritz S, Qaqish B, Brookmeyer R, Baker JL, Cuddy RM, Goessel TK, Floccare DJ, Sivertson KT, Altman S, Quinn TC. Unrecognized HIV infection in emergency patients: Failure of risk factor assessment practices to indicate need for barrier precautions. Ann Emerg Med 17(4):408, 1988

10. Fritz S, Kelen GD, Qaqish B, Floccare D, DiGiovanna T, Baker JL, Sivertson KT, Quinn TC. Substantial increase in unsuspected HIV infection in critically ill emergency patients. Ann Emerg Med 17(4):408, 1988

11. Kelen GD. Reanalysis of surveillance data regarding health care worker risk of nosocomial acquisition of the human immunodeficiency virus (HIV). Ann Emerg Med 17(4):420, 1988

12. Kelen GD, Fritz B, Qaqish B, Floccare B, Quinn TC. Extent of prehospital care (EMS) provider exposure to emergency patients with undiagnosed HIV infection. Clin Invest Med 11(4 suppl):C29, 1988

13. Sivertson KT, DiGiovanna T, Kelen GD. Emergency department division of non-urgent patients to an off-site walk-in facility. Ann Emerg Med 18(4):465, 1989

14. Sivertson KT, Kelen GD, DiGiovanna T, Brothers T, Quinn TC. Hepatitis B infection and human immunodeficiency virus infection in emergency department patients. Ann Emerg Med 18(4):472, 1989

15. Kelen GD, Johnson G, DiGiovanna T, Loring K, Sivertson KT. Impact of the HIV epidemic: Emergency department resource utilization by patients with known human immunodeficiency virus (HIV-1) infection. Ann Emerg Med 18(4):442, 1989

16. Kelen GD, DiGiovanna T, Kalainov D, Bisson L, Junkins E, Stein A, Scott C, Sivertson K. Adherence to universal precautions by health care providers performing emergency interventions in an inner-city emergency department. Ann Emerg Med 18(4):442-43, 1989

17. Kelen GD, DiGiovanna T, Lofy L, Bisson L, Kalainov D, Sivertson KT, Quinn TC. HTLV-1 infection in an emergency department population: The next retrovirus epidemic? Ann Emerg Med 18(4):471-72, 1989

18. Kelen GD, DiGiovanna T, Kalianov D, Bisson L, Junkins E, Stein A, Scott C, Sivertson KT. Adherence to universal precautions by health care providers performing emergency interventions in an inner-city emergency department. Vth International Conference on AIDS Abstracts (#WAO4) 5:63, 1989

19. Kline R, Kelen GD, Brothers TA, Quinn TC. Utility of a rapid antibody assay for detection of HIV-1 infection in patients attending an emergency department. Vth International Conference on AIDS Abstracts: (#TBP126) 5:307, 1989

20. Kline R, Kelen GD, Hook EW, Brothers TA, O'Sullivan SM, Quinn TC. Evaluation of a recombinant HIV-1 enzyme immuno-assay (EIA) in patients attending an emergency room and sexually transmitted disease clinic. Vth International Conference on AIDS Abstracts (#TBP127) 5:308, 1989

21. Johnson G, Kelen GD, DiGiovanna T, Loring K, Sivertson KT. Clinical features of HIV-1 infected patients presenting to an inner-city emergency department. Ann Emerg Med 18(9):918-19, 1989

22. Marcus R, Bell DM, Culver DH, Cooperative Emergency Department Study Group. Frequency of emergency care providers' contact with blood of patients infected with human immunodeficiency virus. Ann Emerg Med 19(4):454, 1990

23. Kelen GD, Green GB, Fortenberry C, Taylor E, Hexter DA, Fleetwood D, DiGiovanna T, Sivertson KT. Substantial improvement in adherence to universal precautions in an emergency department following administrative changes. Ann Emerg Med 19(4):481, 1990

24. Loring K, Kelen GD. Influence of the AIDS epidemic on medical students' career choices. VIth International Conference on AIDS Abstracts (#SD873) Book 6:308, 1990

25. Fleetwood D, Johnson G, Kelen GD. Acute presentations of patients with HIV infection to an emergency department. VIth International Conference on AIDS. Abstracts Book 2: 185, 1990

26. Kelen GD, Brothers T, Kline R, Quinn TC. Evaluation of two rapid screening assays in the detection of HIV-1 infection in emergency department patients. J Emerg Med 8(3):383, 1990

27. Brothers T, Kline R, Kelen GD, Quinn TC. Evaluation of a rapid screening test (Abbott Testpack) for antibody to HIV-1 in diverse population groups. VIth International Conference on AIDS Abstracts (#SC595) Book 6:237, 1990

28. Quinn TC, Kelen GD, Meyers W, Fleetwood D, Brothers T, Kline R. Detection of HIV-1 infection by polymerase chain reaction (PCR) and culture in HIV-1 seronegative patients attending an emergency department. VIth International Conference on AIDS Abstracts (#Th.C.557) Book 6:264, 1990

29. Kelen GD, Fleetwood D, DiGiovanna T, Hexter DA, Green GB, Stone D, Sivertson KT, Quinn TC. Doubly hidden HIV infection in emergency department patients: Failure to detect HIV-1 infection by antibody testing. Ann Emerg Med 19(10):1223, 1990

30. Green GB, Hansen KN, Fleetwood D, Chan DW, Guerci AD, Kelen GD. The usefulness of a rapid creatine phosphokinase (CPK)-MB assay in the evaluation of emergency department patients with possible myocardial infarction. Ann Emerg Med 19(10):1227, 1990

31. Pronovost P, Kelen GD, Green GB, Tom P, Scheulen JJ, Sivertson KT. Emergency Department resource consumption by HIV-symptomatic patients: A matched-controlled time-and-motion cost study. VIIth International Conference on AIDS Abstracts (#WD4076) Book 7:407, 1991

32. Kelen GD, Green GB, Pronovost P, White JR, Vernacchio L, Chan C, Guislain Y. Effect of HIV-infected patients on human resource utilization in the ED: A time and motion study. Ann Emerg Med 20(4):467, 1991

33. DiGiovanna T, Green GB, Sivertson KT, Kelen GD. A comparison of three antiemetics used in the treatment of motion sickness. Ann Emerg Med 20(4):456, 1991

34. Kelen GD, Green GB, Sivertson KT, Quinn TC. Seroprevalence of HIV, HTLV, HCV and HBV among emergency department patients and potential risk to health care workers. Clin Invest Med 14(4 suppl):A31, 1991

35. Hansen KN, Korniewicz D, Larson E, Green GB, Kelen GD. Loss of glove integrity during common ED procedures. VIIIth International Conference on AIDS Poster Abstracts (#PoC 4547) 8:C336, 1992

36. Korniewicz D, Hansen KN, Kelen GD, Larson E. A comparative analysis of glove use in the emergency department. VIIIth International Conference on AIDS, Poster Abstracts (#PoC 4820) 8:C379, 1992

37. Kelen GD, Hansen KN, Green GB. Procedure and condition specific universal precautions requirements during emergency department procedures. VIIIth International Conference on AIDS, Poster Abstracts (#PoD 5760) 8:D515, 1992

38. Kelen GD, Hexter DA, Hansen KN, Pretorius ES, Vigilance PND, Quinn TC. Feasibility of an emergency department-based, risk-targeted HIV screening program. Ann Emerg Med 22(5):939, 1993

39. Marco CA, Schoenfeld CN, Hansen KN, Sterns D, Kelen GD. Geriatric patients with fever: Clinical significance. Ann Emerg Med 22(5):954, 1993

40. Clark SJ, Henrard DR, Daar ES, Kelen GD, Shaw GM, Quinn TC. Detection of p24 antigenemia in HIV seronegative patients attending an urban hospital emergency department (ED). IXth International Conference on AIDS, Poster Abstract (#WS-A245) 9:40, 1993

41. Kelen GD, Hexter DA, Kline R, Carella A, Moss M, Quinn TC. Dynamics of the HIV epidemic in an inner-city emergency department (ED): Implications for ED-based targeted screening. IXth International Conference of AIDS, Poster Abstract (#PO-C29-3257) 9:760, 1993

42. Sue D, Shahan JB, Kelen GD. Primary care access for Medicaid versus privately insured patients. Acad Emerg Med 1(2):A1, 1994

43. Green GB, Beaudreau RW, Chan D, Baskerville D, Grausz H, Kelen GD. The potential clinical utility of troponin T for risk stratification of emergency department patients with possible myocardial ischemia. Acad Emerg Med 1(2):A4, 1994

44. Hirshon JM, Kirsch TD, Mysko WK, Dipre M, Kelen GD. The rotational assignment of patients to physicians improves ED patient flow. Acad Emerg Med 1(2):A10,1994

45. Casani JA, Scheulen JJ, Kelen GD. Development and operation of an ED-based advanced life support transportation system. Acad Emerg Med 1(2):A28, 1994

46. Hexter DA, Kirsch TD, Chanmugam AS, Rock MP, Shahan JB, Kelen GD. Screening for tuberculosis in the emergency department. Acad Emerg Med 1(2):A29, 1994

47. Hexter DA, Zavell PJ, Grausz H, Vigilance PND, Rock MP, Shahan JB, Quinn TC, Kelen GD. Feasibility of an ED-based HIV screening program. Acad Emerg Med 1(2):A75, 1994

48. Bozeman WP, Hexter DA, Liang HK, Kelen GD. The esophageal detector device versus end tidal $CO_2$ detection in emergency intubations. Acad Emerg Med 1(2):A77, 1994

49. Beaudreau RW, Green GB, Chan D, Baskerville M, Grausz H, Kelen GD. Comparison of CK-MB, troponin T, and simultaneous CK-MB/troponin T testing in evaluating emergency department patients with possible myocardial ischemia. Acad Emerg Med 1(2):A77-78, 1994

50. Epting CL, Moore MJ, Chen CL, Whitfield MN, Jones-Perry MS, Shahan JB, Charache P, Quinn TC, Kelen GD. Feasibility of ED-based HIV screening program utilizing on-site rapid testing. Acad Emerg Med 2(5):388-89, 1995

51. Li G, Bajer SP, Kelen GD, DiScala C, Fowler C, Ling J. Factors associated with the intent of firearm-related injury in pediatric trauma patients. Acad Emerg Med 3(5):516, 1996

52. Rothman RE, Kelen GD, McArthur J, Chanmugam AS, Lee R, Shahan JB, Beauchamp N. ED utilization of head CT in HIV-positive patients. Acad Emerg Med 3(5):524, 1996

53. Kelen GD, Shahan JB, Lucas JM, Bautista JD, Bohn D, Grogan K, Holmes S, Mani S, Shinghal A, Charache P. Rapid HIV testing in the ED. Acad Emerg Med 3(5):536, 1996

54. Hill MN, Bone LR, Stewart MC, Hilton SC, Kelen GD, Levine DM. Recruitment experience in a clinical trial to improve HBP care in young urban African American men. Am J Hyperten 9(4):1A-2A, 1996

55. Hill MN, Bone LR, Stewart MC, Hilton SC, Kelen GD, Levine DM. A clinical trial to improve HBP care in young urban African American men. Am J Hyperten 9(4):172A, 1996

56. Ma MH, MacKenzie EJ, Kelen GD. Triage performance in elder trauma patients: A universal deficiency. Acad Emerg Med 4(5):348, 1997

57. Amalfitano C, Loring K, Kirsch T, Kivela, P, Marel, T, Kelen GD. A prospective analysis of pediatric cervical spine injuries. Acad Emerg Med 4(5):367, 1997

58. Rothman RE, Kelen GD, McClelland LA, Keyl PM, Hemnes AR, Hohimer I, Horn R, Webster PT, Shahan JB, Anderson GA. Effect of patient insurance status on health care worker effort in the emergency department. Acad Emerg Med 4(5):471-72, 1997

59. Kelen GD, Gordon TA, Li G. Importance of emergency department admissions for hospital revenue. Acad Emerg Med 4(5):476, 1997

60. Scheulen JJ, Li G, Kelen GD, Zane RD. The impact of ambulance diversion policies on an urban academic medical center. Acad Emerg Med 5(5):415-16, 1998

61. Scheulen JJ, Li G, Kelen GD, Zane RD. Analysis of ambulance diversion policies between urban, suburban, and rural environments. Acad Emerg Med 5(5):437, 1998

62. Ma MH, Alcorta R, Kelen GD, MacKenzie EJ. Compliance with prehospital triage protocols for major trauma. Acad Emerg Med 5(5):437-38, 1998

63. Rothman RE, Fein S, Quinn TC, Kelen GD. Rapid diagnosis of bacteremia using polymerase chain reaction (PCR) in the emergency department (ED). Acad Emerg Med 6(5):375, 1999

64. Green GB, Skarbek-Borowski GW, Bessman ES, Chan DW, Kelen GD. Myoglobin identifies high risk patients missed by physician judgment, CK-MB and Troponin T. Acad Emerg Med 6(5):417, 1999

65. Tang N, Li, G, DiScala C, Meisel Z, Levick N, Kelen GD. Cardiopulmonary resuscitation in pediatric trauma patients: Survival and functional outcome. Acad Emerg Med 6(5):430, 1999

66. Rothman RE, Londner M, Mehta S, Bartlett JG, Weiss JL, Kelen GD. Developing a 24-hour ED-based diagnostic guideline for ruling-out infective endocarditis (IE) in intravenous drug users (IDUs). Acad Emerg Med 6(5):453, 1999

67. Rothman RE, Majmudar MD, Kelen GD. Defining new criteria for the diagnosis of infective endocarditis in febrile intravenous drug users: A new gold standard for the acute care setting? Acad Emerg Med 7(5):561, 2000 (Oral Abstract)

68. Majmudar MD, Hill PM, Kelen GD, Rothman RE. Diagnostic importance of transthoracic echocardiography in febrile intravenous drug users at risk for infective endocarditis. Acad Emerg Med 7(5):501, 2000

69. Kelen GD, Pezzin LE, Gordon TA. Increasing importance of the ED as the front door of the hospital. Acad Emerg Med 7(5):551, 2000

70. Haddock TA, Kelen GD, Rothman RE. Radiographic infiltrates are strongly associated with vital sign abnormalities: Physician judgment combined with a simple decision aid may reduce unnecessary chest x-rays. Acad Emerg Med 8(5):476, 2001

71. Rothman RE, Ketlogetswe KS, Walker T, Shahan JB, Willoughby S, Kelen GD. Persistence of unrecognized HIV infection among emergency department patients. Acad Emerg Med 8(5): 493, 2001

72. Yang S, Lin S, Kelen GD, Rothman RE. Development of a rapid detection assay for bacterial identification and speciation. Acad Emerg Med 8(5):494, 2001

73. Bhimani MA, Li G, Chanmugam A, Scheulen JJ, Liang HK, Tang N, Kelen GD. The impact of a physician rapid assessment program at triage on ED overcrowding. Acad Emerg Med 8(5): 578, 2001

74. Kelen GD, Shahan JB, Rothman RE, Ketlogetswe K, Quinn TC. Long-term trends in HIV infection in an academic medical center ED. Acad Emerg Med 9(5):368-69, 2002

75. Khalil A, Kelen GD, Neuremberger PG, Getz K, Rothman RE. PORT scores may be insufficient for guiding hospitalization decisions in HIV-positive patients. Acad Emerg Med 9(5):452, 2002

76. Scheulen JJ, Li G, Bragg DM, McCarthy M, Kelen GD. Factors associated with utilization of ambulance diversion. Acad Emerg Med 9(5):513, 2002

77. McCarthy M, Shore A, Li G, Kelen GD, Tang N, Colella R, Scheulen JJ, New J. Prehospital providers compliance with hospital ambulance diversion protocols. Conference of the American Public Health Association, Washington, DC, November 2004

78. Kelen GD, Kraus CK, Brill JD, the CEPAR Research Group. Creation of hospital surge capacity by the early discharge of inpatients. Acad Emerg Med 12(5):23, 2005

79. Trautman DE, McCarthy ML, Kelen GD, Miller NA, Campbell JC. Intimate partner violence and emergency department screening. Acad Emerg Med 12(5):46-47, 2005

80. Kelen GD, the CEPAR Research Group. Reverse triage: Criteria for immediate inpatient disposition for creation of hospital surge capacity. Presented at the 14th World Congress on Disaster and Emergency Medicine (#FPT2.3). Edinburgh, May 16-20, 2005

81. Hsu EB, Thomas TL, Whyne DM, Bass EB, Kelen GD, Green GB. Competencies for healthcare worker disaster training. Presented at the 14th World Congress on Disaster and Emergency Medicine (#FPT18.5). Edinburgh, May 16-20, 2005

82. Kraus CK, Rothman RE, Shahan JB, Quinn TC, Kelen GD. Trends in human immunodeficiency infection in the emergency department: A 16-year review. Acad Emerg Med 13(5):S22, 2006

83. Ding R, McCarthy ML, Li G, Kirsch TD, Jung JJ, Kelen GD. Patients who leave without being seen: Their characteristics and past history of emergency department use. Acad Emerg Med 13(5):S28, 2006

84. Li G, Schull MJ, McCarthy ML, Vermeulen M, Lau JT, Kelen GD. Comparison of emergency department utilization in Canada and the United States. Acad Emerg Med 13(5):S62-63, 2006

85. Kelen GD, Kraus CK, CEPAR Research Groups. Creation of health system surge capacity by the immediate discharge of inpatients. Acad Emerg Med 13(5):S94, 2006

86. McCluskey C, Trautman D, Kelen E, Ding R, McCarthy M, Kelen G. Health-related quality of life as a predictor of future emergency department Use. Acad Emerg Med 2006;13:5S, 97.

87. Li G, McCarthy ML, Peilin S, Kelen GD. In-hospital mortality risk for patients admitted through emergency departments. Acad Emerg Med 14(5):S146, 2007

88. Hill PM, Kirsch TD, DeRuggiero K, Scheulen JS, Ritsema T, Kelen GD. Impact of emergency department triage and pre-bed provider evaluation on walk-out rate, ambulance diversion and patient satisfaction. Acad Emerg Med 14(5):S149, 2007

89. Hsieh YH, Jung J, Moring-Parris D, Kelen GD, Rothman RE. New CDC guidelines for HIV testing: Emergency medicine resident attitudes and perceptions before and after an educational program and testing implementation. Acad Emerg Med 14(5):S176, 2007

90. Kelen GD, Sauer L. Who's publishing disaster medicine? Evaluation of disaster publications pre- and post 9/11. Acad Emerg Med 14(5):S189-90, 2007

91. Lee JL, Ding R, Kelen GD, McCarthy, ML. Are physicians good at turning out to vote? Acad Emerg Med 14(5):S208, 2007

92. McCarthy ML, Zeger S, Ding R, Aronsky D, Hoot N, Kelen GD. The challenge of predicting emergency department arrivals. IVth Mediterranean Emergency Medicine (#OR-208) Sorrento, Italy, 2007

93. DeRuggiero KC, Hill PM, Kirsch TD, Scheulen JJ, Ritsema T, Kelen GD. Impact of emergency department triage and prebed provider evaluation on walk-out rate, ambulance diversion and patient satisfaction. IVth Mediterranean Emergency Medicine (#M1-56) Sorrento, Italy, 2007

94. Kelen GD, Sauer LM. Who's publishing disaster medicine? Evaluation of disaster publications pre and post 9/11. IVth Mediterranean Emergency Medicine (#OR-220) Sorrento, Italy, 2007

95. Beatrice Hoffman, Edward Bessman, Ru Ding, Gabor Kelen, Michael Kelen, Melissa McCarthy, Patrick Um. Influence of provider experience with abdominal aorta sonography on likelihood of a successful exam. Presented at the annual meeting of the European Society of Emergency Medicine, Munich, Germany, September 16, 2008.

96. Um P, Hoffmann B, Ding R, Bone C, Habtemariam Y, Edwards J, Bessman ES, Kelen GD, McCarthy ML. Sonographic screening of abdominal aortic aneurysm in high risk asymptomatic patients in the emergency department. Acad Emerg Med 15(5):S47-48, 2008

97. Hsieh Y, Newman-Toker D, Kelen GD, Rothman RE. National estimate of HIV serology testing in emergency departments 1993-2005: Pre-2006 CDC recommendations for HIV testing in health-care settings era. Acad Emerg Med 15(5):S125, 2008

98. Morton MJ, Kirsch TD, Rothman RE, Hsieh Y, Byerly MM, McManus JG, Kelen GD. Impact of emergency department size on pandemic influenza preparedness in U.S. Emergency Departments. Ann Emerg Med 54;3: S123-S124, 2009

99. Hick JL, Barbera JA, Kelen GD. Refining surge capacity: Conventional, contingency, and crisis capacity. Disaster Med Public Health Preparedness 3(SUPPL. 1):S59-S67, 2009

101. Hsieh Y, Jung JJ, Shahan JB, Moring-Parris D, Kelen GD, Rothman RE. Emergency medicine resident attitudes and perceptions of HIV testing before and after a focused training program and testing implementation. Acad Emerg Med 16(11):1165-1173, 2009

102. Jenkins JL, Kelen GD, Sauer LM, Fredericksen KA, Mccarthy ML. Review of hospital preparedness instruments for national incident management system compliance. Disaster Med Public Health Preparedness 3(SUPPL. 1):S83-S89, 2009

103. Jenkins JL, McCarthy M, Kelen G, Sauer LM, Kirsch T. Changes needed in the care for sheltered persons: A multistate analysis from Hurricane Katrina. Am J Disaster Med 4(2):101-106, 2009

104. Kelen GD, McCarthy ML, Kraus CK, et al. Creation of surge capacity by early discharge of hospitalized patients at low risk for untoward events. Disaster Med Public Health Prep 3(2 Suppl):S10-S16, 2009

105. Kelen GD, Rothman RE. Emergency department-based HIV testing: Too little, but not too late. Ann Emerg Med 54(1):65-71, 2009

106. Kelen GD, McCarthy ML. Developing the science of health care emergency preparedness and response. Dis Med Public Health Prep 3:S2-S3, 2009

107. Lyons MS, Lindsell CJ, Haukoos JS, et al. Nomenclature and definitions for emergency department human immunodeficiency virus (HIV) testing: Report from the 2007 conference of the national emergency department HIV testing consortium. Acad Emerg Med 16(2):168-177, 2009

108. Marco CA, Bessman ES, Kelen GD. Ethical issues of cardiopulmonary resuscitation: Comparison of emergency physician practices from 1995 to 2007. Acad Emerg Med 16(3):270-273, 2009. 125.McCarthy ML, Brewster P, Hsu EB, Macintyre AG, Kelen GD. Consensus and

tools needed to measure health care emergency management capabilities. Disaster Med Public Health Prep;3(2 Suppl):S45-S51, 2009

109. Morton MJ, Kirsch TD, Rothman RE, et al. Pandemic influenza and major disease outbreak preparedness in US emergency departments: A survey of medical directors and department chairs. Am J Disaster Med 4(4):199-206, 2009

110. Morton MJ, Kirsch TD, Rothman RE, et al. The impact of emergency department size on pandemic influenza preparedness in US emergency departments. Ann Emerg Med 54(3):S123-S124, 2009

111. Scheulen JJ, Thanner MH, Hsu EB, Latimer CK, Brown J, Kelen GD. Electronic mass casualty assessment and planning scenarios (EMCAPS): Development and application of computer modeling to selected national planning scenarios for high-consequence events. Ann Emerg Med 53(2):226-232, 2009

112. Brown TW, McCarthy ML, Kelen GD, Levy F. An epidemiologic study of closed emergency department malpractice claims in a national database of physician malpractice insurers. Acad Emerg Med;17(5):553-560, 2010

113. Hill PM, Mareiniss D, Murphy P, et al. Significant reduction of laboratory specimen labeling errors by implementation of an electronic ordering system paired with a bar-code specimen labeling process. Ann Emerg Med 56(6):630-636, 2010

114. Hsieh Y, Chen K, Gaydos CA, Rothman RE, Kelen GD. Antiviral prescriptions to US ambulatory care visits with a diagnosis of influenza before and after high level of adamantane resistance 2005-06 season. PLoS One 5(1):e8945, 2010

115. Kelen GD, Catlett CL. Violence in the health care setting. JAMA 304(22):2530-2531, 2010

116. James JJ, Benjamin GC, Burkle Jr. FM, Gebbie KM, Kelen G, Subbarao I. Disaster medicine and public health preparedness: A discipline for all health professionals. Disaster Med Public Health Preparedness 4(2):102-107, 2010

117. Mathews SC, Kelen GD, Pronovost PJ, Pham JC. A national study examining emergency medicine specialty training and quality measures in the emergency department. Am J Med Qual 25(6):429-435, 2010

118. Catlett CL, Hsu E, Kelen GD. Hospital shootings in the last decade: Can the data reveal a prevention strategy? Acad Emerg Med 18(5):S213, 2011

119. Catlett CL, Kirsch TD, Scheulen JJ, Cole G, Kelen GD. Maximizing utility of a deployable medical team from an academic medical center to a disaster. World Med Health Policy 3(4), 2011

120. Cousins MM, Laeyendecker O, Beauchamp G, et al. Use of a high resolution melting (HRM) assay to compare gag, pol, and env diversity in adults with different stages of HIV infection. PLoS ONE 6(11), 2011

121. Pham J, Story JL, Hicks RW, et al. National study on the frequency, types, causes, and consequences of voluntarily reported emergency department medication errors. J Emerg Med 40(5):485-492, 2011

122. Hill PM, Rothman R, Saheed M, Deruggiero K, Hsieh YH, Kelen GD. A comprehensive approach to achieving near 100% compliance with the joint commission core measures for pneumonia antibiotic timing. Am J Emerg Med 29(9):989-998, 2011

123. Hodge Jr. JG, Anderson ED, Kirsch TD, Kelen GD. Facilitating hospital emergency preparedness: Introduction of a model memorandum of understanding. Disaster Med Public Health Prep 5(1):54-61, 2011

124. Hsieh Y, Jung JJ, Shahan JB, et al. Outcomes and cost analysis of 3 operational models for rapid HIV testing services in an academic inner-city emergency department. Ann Emerg Med 58(1):S133-S139, 2011

125. Kelen GD. Emergency department HIV testing: Reflections forward. Ann Emerg Med 58(1 SUPPL.):S168-S171, 2011

126. McCarthy ML, Ding R, Zeger SL, et al. A randomized controlled trial of the effect of service delivery information on patient satisfaction in an emergency department fast track. Acad Emerg Med 18(7):674-685, 2011

127. Parks J, Levin S, Satjopot S, Rothman R, Kelen G. Examining the relationship between the use of observation status and the likelihood of 1-day stays in patients with circulatory disease. Acad Emerg Med 18(5):S7, 2011

129. Thanner MH, Links JM, Meltzer MI, Scheulen JJ, Kelen GD. Understanding estimated worker absenteeism rates during an influenza pandemic. Am J Disaster Med 6(2):89-105, 2011

130. Kelen GD, Catlett CL, Kubit JG, Hsieh Y-H. Hospital-based shootings in the United States: 2000-2010. Acad Emerg Med 19:S109-S110, 2012

132. McCarthy ML, Ding R, Zeger SL, et al. Pain management practices vary significantly at three emergency departments in a single health care system. Acad Emerg Med 19:S169-S170, 2012

133. Rothman RE, Kelen GD, Harvey L, et al. Factors associated with no or delayed linkage to care in newly diagnosed human immunodeficiency virus (HIV)-1-infected patients identified by emergency department-based rapid HIV screening programs in two urban EDs. Acad Emerg Med19(5):497-503, 2012

134. Hsieh Y, Beck K, Kelen G, Shahan J, Kraus C, Laeyendecker O, Quinn T, Rothman RR. High Prevalence of Undiagnosed HIV Infection in Patients Who Were Not Offered Screening and Patients Who Declined Screening: Evaluation of a Rapid HIV Screening Programme in a U.S. Urban Emergency Department. Sex Trans Infect 89:A342-3 doi:10.1136/sextrans-2013-051184.1072

135. Clattenburg E, Sauer L, Kelen G. Reverse triage in pediatrics. A new method to increase in-hospital surge capacity. Acad Emerg Med 20:S59-60, 2013

136. Sauer L, Beard R, Clattenburg E, France D, Kelen G, Kirsch T, Pham J, Desai S, Levin S. Physician situational awareness in the emergency department. Acad Emerg Med 20:S161, 2013

137. Morton MJ, DeAugustinis ML, Velasquez CA, Kelen GD. Developments in surge research priorities: A systematic review of the literature following the academic emergency medicine consensus conference, 2007-12. Acad Emerg Med 21:S319, 2014

(Stopped Recording Abstracts after 2013)

**NATIONAL/INTERNATIONAL INVITED PRESENTATIONS AND SYMPOSIA**

1. Indications for Lumbosacral Spine Radiography. American College of Emergency Physicians Winter Symposium, San Diego, CA, April 1985

2. Course Director: Advances and Controversies in Emergency Medicine. Johns Hopkins University, Baltimore, MD, 1985

3. Course Director: Regional Seminars in Emergency Medicine, Johns Hopkins University, Baltimore, MD, 1984-85

4. A New Look at Lumbosacral Spine Films. Emergency Medicine Symposium, Johns Hopkins University, Baltimore, MD, May 1985

5. Moderator: Pitfalls and Pearls of Medical Writing. University Association for Emergency Physicians, Cincinnati, OH, May 1988

6. AIDS and Hepatitis B: Risks to Health Care Providers. Pennsylvania Chapter of the American College of Emergency Physicians, Philadelphia, PA, April 1989

7. Nosocomial Risks of AIDS for Emergency Health Care Providers. State of the Art Keynote Session on AIDS. Society for Academic Emergency Medicine, San Diego, CA, May 24, 1989

8. AIDS in the Emergency Department: Dealing with the Patient, the Family and Other Health Care Workers. American College of Emergency Physicians, Washington, DC, September 11, 1989

9. HIV Infection and the Emergency Department: Impact on Emergency Services and Risks to Health Care Providers. Kentucky Medical Society, Louisville, KY, September 20, 1989

10. Human Retrovirus Infection in the JHH Emergency Department. Johns Hopkins University Infectious Disease Research Seminar, Baltimore, MD, November 16, 1989

11. Retrovirus Infections and the Emergency Department. Emergency Medicine Grand Rounds, Henry Ford Hospital, Detroit, MI, December 4, 1989

12. Human Retroviral Infections in the Emergency Department. Emergency Medicine Grand Rounds, Medical Center of Delaware, Newark, DE, February 14, 1990

13. Human Retroviral Infections in the Emergency Department. Emergency Medicine Grand Rounds, Johns Hopkins University, Baltimore, MD, February 16, 1990

14. Strategies for Education and Prevention of HIV Infection for Health Care Providers. Conference Moderator: The HIV Epidemic: Impact on Health Care Providers. Conference on AIDS, Johns Hopkins University, Baltimore, MD, April 3, 1990

15. HIV Epidemic: Impact on Emergency Services. Conference on AIDS, Johns Hopkins University, Baltimore, MD, April 3, 1990

16. Moderator: Hepatitis Update. American College of Emergency Physicians, San Francisco, CA, September 17, 1990

17. Hepatitis Risk and Exposure Management. American College of Emergency Physicians, San Francisco CA, September 17, 1990

18. Retroviruses in the Emergency Department. Emergency Medicine Visiting Professor Lecture Series, Long Island Jewish Hospital, Great Neck, NY, November 11, 1990

19. HIV Infection and Other Blood Borne Pathogens in the Emergency Department: Epidemiology and Health Care Worker Risk. Department of Epidemiology Grand Rounds, The Johns Hopkins University School of Hygiene and Public Health, Baltimore, MD, January 4, 1990

20. Health Risk to Emergency Medicine Personnel in the 90's: Approach to Protection and Exposure Management. Emergency Medicine Conference for the Critically Ill and Injured. Orlando Regional Medical Center, Orlando, FL, February 1991

21. HIV and Other Blood Borne Infections in the ED. Visiting Professor Lecture Series. Royal Victoria Hospital, McGill University, Montreal, Canada, March 20, 1991

22. HIV Testing: Patients and Physicians. Legislative Conference of the American Society of Anesthesiologists. Washington, DC, May 13, 1991

23. Moderator: Clinical Practice Papers. Society for Academic Emergency Medicine, Toronto, Canada, May 26, 1993

24. HIV Infection in Patients and Health Care Providers. Carolinas Medical Center Spring Symposium, Charlotte, NC, May 13, 1993

25. HIV Infection in Health Care Settings: Implications for Nosocomial Transmission from Patients to Health Care Providers and from Providers to Patients. Visiting Scientist Program, Health and Welfare of Canada, Ottawa, Canada, June 11, 1993

26. HIV Positive Health Care Workers: Risk of Transmission to Patients. First Symposium on HIV in the Environment. National Science Foundation/Johns Hopkins School of Hygiene and Public Health, Baltimore, MD, October 21, 1993

27. Moderator: Imaging and Diagnostics Paper Presentations. Society for Academic Emergency Medicine, Washington, DC, May 12, 1994

28. The Importance of Not Being ERnest. Welch Lecture Series, Johns Hopkins University, Baltimore, MD, April, 1995

29. Risk of HIV Transmission in the Work Place. Visiting Emergency Medicine Professor Series. Baylor Medical College, Houston, TX, June 16, 1995

30. Designing Clinical Research in the Emergency Department. Visiting Professor, Divisions of Emergency and Family Practice. University of Toronto, Toronto, Canada, April 2, 1997

31. Risk of HIV Infection and Other Blood Borne Pathogens. Invited Endowed Visiting Professorship. Wright State University, Dayton, OH, April 25, 1997

32. 10 Things You Don't Know about Emergency Medicine. Medicine: A Disciplinary View. Johns Hopkins University, Baltimore, MD, November 17, 1997

33. HIV Screening and Counseling in the ED. VII$^{th}$ International Conference on Emergency Medicine, Toronto, Canada, March 29, 1998

34. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? 1998-1999 Dean's Lectures Series, Johns Hopkins University, Baltimore, MD, May 10, 1999

35. Organization of the Emergency Department. Emergency Medicine Symposium of the American Hospital, Istanbul, Turkey, November 1999

36. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? Visiting Professor, State University of New York at Buffalo, NY, February 1999

37. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? University of Medicine and Dentistry of New Jersey, Camden, NJ, March 2000

38. Moderator: Ultrasound. Society for Academic Emergency Medicine. San Francisco, CA, May 2000

39. Moderator: International Health. Society for Academic Emergency Medicine. San Francisco, CA, May 2000

40. Finding the Right Academic Position. Society for Academic Emergency Medicine. San Francisco, CA, May 2000

41. How the Money Flows in Academic Medical Centers. Society for Academic Emergency Medicine. San Francisco, CA, May 2000

42. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? Department of Pediatrics Grand Rounds, Johns Hopkins University, Baltimore, MD, December 13, 2000

43. Johns Hopkins Department of Emergency Medicine: State of the Union. Department of Emergency Medicine Grand Rounds, Johns Hopkins University, Baltimore, MD, January 19, 2001

44. Blood Borne Infections: Risk of Transmission Between Patients and Providers. 12th Annual Emergency Medicine for the Critically Ill and Injured, Orlando, FL, February 23, 2001

45. Cases in Acid Base Disorders. 12th Annual Emergency Medicine for the Critically Ill and Injured, Orlando, FL, February 23, 2001

46. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? Neurosurgery Grand Rounds, Johns Hopkins University, Baltimore, MD, September 20, 2001

47. Johns Hopkins Department of Emergency Medicine: State of the Union. Department of Emergency Medicine Grand Rounds, Johns Hopkins University, Baltimore, MD, December 7, 2001

48. Major Academic Medical Center=s Role in Critical Event Planning and Response. The Public Health Response to Terrorism Symposium, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, January 14, 2002

49. Johns Hopkins Department of Emergency Medicine: State of the Union. Department of Emergency Medicine Grand Rounds, Johns Hopkins University, Baltimore, MD, December 6, 2002

50. Role of Emergency Medicine and the Academic Medical Center in Local, Regional and National Disaster Preparedness and Response. Emergency Medicine Session, Johns Hopkins Medical and Surgical Biennial Symposium, Baltimore, MD, May 2, 2003

51. HIV Testing in the Emergency Department. II Mediterranean Emergency Medicine Congress, Barcelona, Spain, September 13, 2003

52. Johns Hopkins Office of Critical Event Preparedness and Response. II Mediterranean Emergency Medicine Congress, Barcelona, Spain, September 14, 2003

53. Johns Hopkins Department of Emergency Medicine: State of the Union. Department of Emergency Medicine Grand Rounds, Johns Hopkins University, Baltimore, MD, December 12, 2003

54. Bench to Bedside: How Cutting Edge Molecular Diagnostic Tools Are Being Developed for the Diagnosis and Management of Infectious Diseases in Acute Care. Society for Academic Emergency Medicine, Boston, MA, May 16, 2004

55. Clinical Research and the HIPAA Privacy Rule. Society for Academic Emergency Medicine, Boston, MA, May 18, 2004

56. Johns Hopkins Department of Emergency Medicine: State of the Union. Department of Emergency Medicine Grand Rounds, Johns Hopkins University, Baltimore, MD, December 10, 2004

57. Biodefense Needs: Involvement/Contributions of Universities. University of Alabama, March 3, 2005

58. Risk of Bloodborne Infection in Emergency and Trauma Settings. Department of Surgery, Division of Trauma Lecture Series, Johns Hopkins University, Baltimore, MD, May 14, 2005

59. Course Director. The *AEM* Consensus Conference on the Science of Surge. San Francisco, CA. May 17, 2006

60. How to Develop a Successful Fellowship. Society for Academic Emergency Medicine, San Francisco, CA, May 19, 2006

61. Moderator and Presenter. Medical Surge Capacity, Obstacles and Opportunities. Institute of Medicine, Forum on Surge Disaster Preparedness. Washington DC, June 2006

62. Moderator. Citizen Engagement in Emergency Planning for a Flu Pandemic. National Academies' Disasters Roundtable. Washington DC, October 23, 2006

63. **Keynote Speaker.** State of Science: The Science of Surge. AMA/CDC 2nd Congress on Health System Readiness, Washington, DC, July 18, 2007

64. Track Chair. Disaster Track. IVth Mediterranean Conference on Emergency Medicine, Sorrento, Italy, September 17, 2007

65. Moderator. Medical Implications of Large Scale Disasters (Disaster Track). IVth Mediterranean Conference on Emergency Medicine, Sorrento, Italy, September 17, 2007

66. Creation of Hospital Surge Capacity by Reverse Triage. IVth Mediterranean Conference on Emergency Medicine, Sorrento Italy, September 17, 2007

67. The Science of Surge. Department of Emergency Medicine Grand Rounds, University of Cincinnati, Cincinnati, OH, February 6, 2008

68. Role of First Responder and Expectations of the Emergency Management Systems for Response to Unanticipated Events, in Context of EMS System Fragmentation. U.S. Department of Homeland Security Risk Communication for First Responders Workshop. Queenstown, MD, March 10, 2008

69. Moderator. Health System Preparedness. DHS University Network SUMMIT. March 18th,, 2009

70. Panel: Third National Congress on Health System Readiness: Medicine and Public Health Preparedness in the 21st Century. A Society for Disaster Medicine and Public Health Preparedness for all Health Professionals…The Time is Now. Dec 3rd, 2009

71. Reverse Triage. Fourth National Emergency Management Summit, Washington, D.C., March 4, 2010

72. Moderator: DHS Summit. Altered Standards of Care During Crisis Events, March 12, 2010

73. Strategic Planning. Leadership Academy of the Society of Academic Emergency Medicine, Phoenix, Az, June 2, 2010

74. Future Research of Disaster Health. University of Cincinnati, Cincinnati, Ohio, September 24th, 2010.

75. Future Research of Disaster Health. Vanderbilt University, Memphis, Tennessee, March 15, 2010.

76. Visiting Professor. Brown University, Providence RI, Nov 8-9, 2012.

77. Research Rightness for your Department. AACEM Annual Meeting Leadership Forum, San Diego, CA, April 6, 2014

78. Strategic Planning. SAEM Annual Meeting Leadership Forum, Dallas TX, May 14, 2014

79. Dean's Symposium on Ebola: Crisis, Context and Response, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD, October 14, 2014

80. Moderator and Presenter: Inside the Study Section—Why Great Grants Fail. SAEM Annual Meeting, San Diego, CA, May 2015.

81. Just in Time Research in Disasters. SAEM Annual Meeting, San Diego, CA, May 2015.

82. ED and Hospital Crowding. Annual Emergency Medicine Conference, (AEMC) 2015, Aga Khan University, Karachi, Pakistan. September 16, 2015

83. Organizer: Hospital Crowding and Patient Flow Innovations. Mediterranean Emergency Medicine Conference, Lisbon, Portugal, Sept 11, 2017

84. Novel Solutions to ED Crowding: International Experience. Mediterranean Emergency Medicine Conference, Lisbon, Portugal, Sept 11, 2017

85. Invited Speaker: The Accidental Academic. University of Toronto 2019 Alumni Program, Toronto Ontario, 2019.

86. Grand Rounds Town Hall: National Association of Homecare and Hospice. COVID-19 Update. March 31, 2021. https://report.nahc.org/tag/dr-gabe-kelen/ https://duckduckgo.com/?q=Gabe+Kelen&t=osx&pn=1&ia=videos&iai=https%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv%3DEMvNtCc2a7s&iax=videos

87. Invited Speaker: Boarding. ERMA (zoom), January 5, 2022.

88. Grand Rounds. The Accidental Academic. Department of Emergency Medicine, Stanford University, Sept 2022

89. Boarding. Annual Meeting of the American Association of Academic Chair, Puerto Rico, March 2022.

90. Catching the Wildcard in the Waiting Room. Annual Meeting of the American College of Emergency Physicians, Philadelphia, October 10, 2023

91. State of the Art Seminar Crisis Standards of Care Research Panel at ACEP Research Forum. Annual Meeting of the American College of Emergency Physicians, Philadelphia, October 11, 2023

92. Boarding. Emergency Medicine Resident Association, held at the Annual Meeting of the American College of Emergency Physicians, Philadelphia, October 10, 2023.

93. Boarding Myths: Hidden Causes—Hidden Solutions. Presented at the Annual Meeting of the Emerald Coast ACEP Emergency Medicine Conference, Sandestin, Florida, June 2024.

94. Panelist: AcademyHealth Annual Research Meeting, AHRQ Panel of Boarding. Washington D.C. June 12, 2024

95. Panalist: AHRQ Summit to Address Emergency Department Boarding. AHRQ, Washing D.C. Oct 8, 2024

## CONGRESSIONAL AND GOVERNMENT TESTIMONY (INVITED)

1. The AIDS Epidemic: Public Health and Emergency Medical Care Issues. Testimony given to the **Subcommittee on Health and the Environment** (Chair: Henry Waxman), House Energy and Commerce Committee. Washington, DC, April 4, 1989

2. The AIDS Epidemic: Delivery of Health Services and Emergency Medical Care. Testimony given to the **Subcommittee on Health and the Environment** (Chair: Henry Waxman), House Energy and Commerce Committee. Washington, DC, April 19, 1990

3. Risk of Transmission of Blood-Borne Pathogens to Patients during Invasive Procedures. Testimony given to the **Centers for Disease Control**. Atlanta, GA, February 21, 1991

4. The HIV Infected Health Care Provider: Public Health Issues. Testimony given to the **Subcommittee of Health and the Environment** (Chair: Henry Waxman), House Energy and Commerce Committee. Washington, DC, September 12, 1991

5. Transmission of HIV in the Work Place. Testimony given to the **National Commission on AIDS** (Chair: June Osborn). Washington, DC, November 5, 1991

6. Heroin Epidemic: Public Health and Emergency Medical Care Issues. Testimony given to the **Subcommittee on National Security, International Affairs and Criminal Justice, Government Reform and Oversight Committee** (Chair: William H. Zeliff, Jr.). Washington, DC, September 19, 1996

7. COVID-19 Vaccine Rollout; Testimony given to the **House Health and Government Operations Committee**, Annapolis (via zoom) Maryland House of Delegates, Feb 2, 2021.

## RECENT MEDIA (incomplete)

**Meet the Press (NBC):** Summit on Ebola; Dr. Anthony Fauci, National Institute of Allergy and Infectious Diseases; author Laurie Garrett, Council of Foreign Relations; Dr. Gabe Kelen, Johns Hopkins University; Sen. Bob Casey (D-Pa.); Sen. Roy Blunt (R-Mo.). Season 23, Episode 40, Oct 19, 2014

https://www.google.com/search?client=safari&rls=en&q=KELEN+MTP&ie=UTF-8&oe=UTF-8
http://www.nbcnews.com/watch/meet-the-press/dr-kelen-calls-for-upfront-screening-at-hospitals-on-mtp-344851523553.

**Diane Rehm Show (NPR):** Synthetic Drugs: What's Behind the Nationwide Surge in Related Crime And Overdoses. Aug 13, 2016

http://thedianerehmshow.org/shows/2015-08-13/growing-use-of-synthetic-cannabinoids

**ABC News** New study suggests an ambulance might lower survival chances for gunshot and stabbing victims. September 21, 2017. http://www.abc2news.com/news/health/new-study-suggests-an-ambulance-might-lower-survival-chances-for-gunshot-and-stabbing-victims

Hopkins doctor on confronting coronavirus. "What aren't we doing". https://www.bizjournals.com/baltimore/news/2020/03/05/hopkins-doctor-on-confronting-coronavirus-what.html (Mar 5, 2020)

Issam Ahmed. Why the US is leading the world in confirmed coronavirus cases. https://news.yahoo.com/why-us-leading-world-confirmed-coronavirus-cases-202915812.html. (March 29th, 2020)

https://www.msn.com/en-us/news/us/why-we-should-keep-trying-to-contain-the-coronavirus-and-flatten-the-curve/ar-BB116B6n

**NYT** https://www.nytimes.com/2020/03/12/us/hospitals-coronavirus.html

**NYT** https://www.nytimes.com/2020/03/18/business/coronavirus-ventilator-shortage.html

https://www.baltimoresun.com/coronavirus/bs-md-contact-tracing-20200313-hhxfybi43zb6bfi2qxe7xfhrxu-story.html

https://www.chicagotribune.com/coronavirus/ct-nw-nyt-coronavirus-ventilators-shortage-20200318-yrkn2jq23rc2ribx76rl5ddyni-story.html

https://www.wbal.com/article/442126/114/the-battle-to-protect-healthcare-workers-on-the-front-lines-of-the-coronavirus-pandemic

https://abcnews.go.com/Health/battle-protect-healthcare-workers-front-lines-coronavirus-pandemic/story?id=69625036

https://www.bizjournals.com/baltimore/news/2020/03/05/hopkins-doctor-on-confronting-coronavirus-what.html

https://news.yahoo.com/why-us-leading-world-confirmed-coronavirus-cases-202915812.html

https://news.yahoo.com/coronavirus-conquered-america-ways-fight-back-191400995.html

*https://www.fox5ny.com/news/johns-hopkins-expert-warns-of-several-peaks-still-to-come-in-covid-19-pandemic Johns Hopkins expert on why we're still early in coronavirus outbreak*

https://www.nbcnews.com/news/us-news/nation-hits-5-million-coronavirus-cases-few-signs-slowing-n1236231 Dennis Romero, August 8, 2020 NBC News.

VERIFY: It's suggested, but not mandatory for vaccine providers to provide both doses. https://www.wusa9.com/article/news/verify/verify-covid-19-vaccine-providers/65-27e880e1-2b13-4a59-b7af-460b6058f4d6. Adriane Datil, April 12, 2021

**BBC. Max Metza.** 'No masks for the vaccinated': What the latest US mask guidance means. https://www.bbc.com/news/world-us-canada-57160923

**The Daily Record.** June 25, 2021. Gabe Kelen. https://thedailyrecord.com/2021/06/25/gabe-kelen.

**Bloomberg Quick Take U.S Tops 3 Million Daily Vaccinations as Cases Increase, March 3, 2021. https://www.msn.com/en-us/news/other/us-tops-3-million-daily-vaccinations-as-cases-increase/vi-BB1f5fqY**

Jaimey Lee: As COVID-19 cases surge and concerns about breakthrough infections grow, masks. Come back and anxiety kick in. July 28, 2021. https://www.marketwatch.com/story/the-new-surge-in-covid-19-cases-is-putting-the-vaccinated-and-the-unvaccinated-on-high-alert-as-masks-come-back-and-anxiety-kicks-in-11627494883

Delta variant symptoms differ from original COVID-19 strand. https://www.wmar2news.com/news/local-news/delta-variant-symptoms-differ-from-original-covid-19-strand. Ray Strickland, Aug 9, 2021

Haillie Miller, Meredith Cohn. Younger, sicker: Covid delta variant worries weary Maryland hospital workers as cases and hospitalizations rise. Aug 16, 2021. https://www.baltimoresun.com/coronavirus/bs-md-hospitals-delta-variant-covid-surge-20210816-htkjqte4ondyffktr3etlmlqpi-story.html

**WaPo** Can you get a covid booster and a flu shot together? Here's what you need to know. Allison Chiu. Washington Post. Sept 23, 2021. https://www.washingtonpost.com/lifestyle/2021/09/13/covid-booster-flu-shot-timing/

**WaPo** America Samoa, one of the last places without coronovarirus, has first infection. Pualina Firozi and Brittany Shammas. Washington Post. Sept 19, 2021. https://www.washingtonpost.com/health/2021/09/19/american-samoa-first-covid-case/

More hospitals forced to ration care amid delta surge. Justine Coleman. The Hill. https://thehill.com/policy/healthcare/573897-more-hospitals-forced-to-ration-care-amid-delta-surge. 9/26/21

**Baltimore Sun.** Hallie Miller. A raging COVID wave is crashing into Maryland hospitals' emergency department. Dec 21, 2021. https://www.baltimoresun.com/coronavirus/bs-md-emergency-departments-covid-omicron-20211231-pq2dj5y5vzdjpm6pelw5iinhbe-story.html.

**NYT** This COVID Feels Different. Annie Correal. The Daily, New York Times Jan 11, 2022. https://www.nytimes.com/2022/01/11/podcasts/the-daily/omicron-surge-hospitals.html?

**NPR.** Covid Hospitalizations. Up First, NPR, Jan 12, 2022 https://www.npr.org/2022/01/09/1071706245/covid-hospitalizations-the-view-from-ukraine-interview-with-former-president-tru.

**NPR.** Will Stone**.** ERs are overwhelmed as omicron continues to flood them with patients. https://www.npr.org/sections/health-shots/2022/01/13/1072902744/ers-are-overwhelmed-as-omicron-continues-to-flood-them-with-patients

**CNBC.** Spencer Kimball. Omicron disrupts transmit, emergency services as workers call out sick: 'Most people are going to get Covid." Jan 12, 2022. https://www.cnbc.com/2022/01/12/covid-news-omicron-disrupts-essential-services-as-workers-call-out.html.

**The HUB.** Marlene Cimons. Hospitals on the Brink. Jan 31, 2022. https://hub.jhu.edu/2022/01/31/omicron-surge-pushes-hospitals-to-the-brink.

**WaPo.** Jeanna Portnoy. Patient safety top concern as emergency physicians fill up. Dec 22, 2021. https://www.washingtonpost.com/dc-md-va/2021/12/22/emergency-departments-overwhelmed/

**WaPo.** Paulina Firozi. Omicron hasn't peaked in U.S., surgeon general says, warning that "next few weeks will be tough". Jan 18, 2022. https://www.washingtonpost.com/health/2022/01/18/omicron-national-peak-surgeon-general-fauci/

**WaPo.** Jeana Portnoy and Teo Armus. D.C.-area covid hospitalizations fall, but hospitals are still suffering. Jan 31, 2022. https://www.washingtonpost.com/dc-md-va/2022/01/31/dmv-hospitals-omicron-wave-staff-shortage/

**CNBC**. Annika Constantino. Here's what might happen the second—or third—time you get Covid, experts say: 'There's no guarantee'. Oct 5, 2022. https://www.cnbc.com/2022/10/05/what-happens-when-you-get-covid-a-second-or-third-time-experts.html

**US News and World Reports.** Denise Mann. U.S. Hospitals under strain as ER Wait Times Lengthen. https://www.usnews.com/news/health-news/articles/2022-10-11/u-s-hospitals-under-strain-as-er-wait-times-lengthen. Oct. 11, 2022.

**MSN.** Deb Lotti. The fascinating history of vaccines and why people are afraid of them. https://www.msn.com/en-us/health/other/the-fascinating-history-of-vaccines-and-why-people-are-afraid-of-them/ss-AA1gHe0E#image=19. Jan 2024

**Boston Glove.** Liz Kowalczyk. Emergency patients in Boston are waiting longer than ever for care. Feb 6, 2024. https://www.msn.com/en-us/health/other/emergency-patients-in-boston-are-waiting-longer-than-ever-for-care/ar-BB1hOXZj.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

## Ryan A. Stanton MD, FACEP

***Question #1:*** **How will you best support members, especially trainees, navigate the upcoming changes in emergency medicine training and certification?**

Supporting emergency medicine trainees, fellows, medical students, and attending physicians, is vital to the future of our specialty. As training models and certification pathways evolve, the American College of Emergency Physicians and the Emergency Medicine Residents' Association must remain committed to helping trainees navigate change while upholding the high standards of emergency medicine. We must balance the vast expectations of an ever-expanding specialty, with the realities of ensuring that the foundation of the healthcare system and safety net for our patients strengthens in every community across this country and around the world.

Our priority is equipping every student and resident with the tools to excel, clinically, professionally, and personally. EMRA and ACEP offer high-quality educational resources, mentorship, leadership development, and career guidance that meet trainees at every stage. From the Match and intern year to board preparation and early career decisions, these tools help build confident, well-rounded emergency physicians.

But success also depends on the system surrounding trainees. As the cost and structure of graduate medical education evolve, ACEP and EMRA continue to advocate for sustainable, high-value programs that maintain educational integrity while evolving for a profession that is defined by growth and change. We are working with accrediting bodies, certification boards, and training institutions to ensure that new pathways align with the needs of trainees without compromising the quality of care or the identity of the specialty. Whether that is 3-year or 4-year, we must remain at the table to ensure that the future of emergency medicine is bright and that we move forward as a specialty.

Just as important is ensuring that our members at all levels and others that will hopefully be future members have a voice in shaping that future. EMRA and ACEP are committed to giving students and residents a platform to speak, lead, and influence. From councils to national committees, we ensure that early-career voices are heard and valued in decision-making spaces. As I have said in the past, "we are valued and unique as individuals, but the strength of our collective voice gives us a seat at the table and the opportunity to move the needle." We must build to provide the best opportunities for our individual members while using the strength of ACEP to mold and build the future that we want to see for emergency physicians, or profession, and patients.

As emergency medicine faces ongoing change, our united commitment to the current and future workforce of emergency medicine will define the upcoming decades of our specialty. Through support, advocacy, and empowerment, ACEP and EMRA ensure that we not only adapt to the future, but we also lead it.

Lead from the front with a strong voice so that EVERY emergency physician can "find their WHY" and leave their community better because they were there, no matter the zip code or model.

***Question #2:*** **Describe your leadership style and how do you think that distinguishes you from the other president-elect candidate?**

My leadership style is rooted in energy, vision, and connection. I lead with enthusiasm and forward momentum, always focused on where emergency medicine is heading and how we can best prepare for that future. What distinguishes me is not just what I bring to the table, but how I bring others with me. I believe true leadership means creating a space where people feel seen, heard, and empowered to contribute. Whether I'm talking with a resident at their first meeting, a student still pondering their future, or a long-time leader navigating complex issues, I connect with people where they are and help build relationships that move ACEP and our specialty forward.

With 34 years of experience as a national spokesperson and media expert, I have a proven ability to communicate clearly, advocate effectively, and represent our specialty with both strength and authenticity. I've used that skill to elevate emergency medicine's voice on major platforms, bringing public understanding to the challenges we face and the value we deliver. Whether

it's the ACEP Frontline podcast, helping others find their voice, or recurring segments that air across the country, I give your work a platform across the country and around the world.

I've had the unique opportunity to lead within academic medicine, large corporate groups, and small democratic practices. I am currently the president of a small, two hospital independent group, and use the skills of my experience to build my group and our 15 physicians for the future. That breadth of experience gives me a comprehensive understanding of what physicians are facing across all practice settings. I understand the challenges of the community physician because I am one. I understand the complexities of administration and systems-based practice because I've been there. I bring a perspective that is both broad and grounded, rooted in the day-to-day realities of emergency physicians, yet focused on where we need to go as a specialty.

What sets me apart is my ability to translate vision into action. I don't just talk about the future; I work to build it. I've built programs, coalitions, and relationships that produce real results. I lead with a collaborative spirit and a bias toward solutions. I don't believe in coming forward with a problem without contributing to a solution that improves the environment for everyone.

My leadership is not about me, it's about us. The president of ACEP is the voice of 37,000 emergency physicians at all levels, leading a mission to improve our specialty today and into the future. Together, I believe we can create a stronger, more unified ACEP that is equipped to lead emergency medicine into the future!

***Question #3:*** **In one sentence, describe what you would like your legacy to be at the conclusion of your term as president and then explain why.**

I want my legacy to be that I brought people together, amplified our collective voice, and led with energy and vision to move emergency medicine, and ACEP, forward in a way that empowered EVERY emergency physician to thrive.

"Find Your WHY."

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Ryan A. Stanton MD, FACEP

***Contact Information***

106 Stonewall Drive
Nicholasville KY, 40356
***Phone:*** 859-948-2560
***E-Mail:*** RStanton@acep.org

***Current and Past Professional Position(s)***

Central Emergency Physicians – 2013-Present
-President of CEP – 2025-Present
Medical Director – Lexington Fire/EMS – 2012-Present
Medical Director – GMR Motorsports/NASCAR/SRX/USF – 2017-Present
Founder/CEO – Everyday Medicine – 2012-Present
Chief Medical Contributor – Fox 56 News – 2022-Present
Kentucky Trauma Advisory Council – KMA Position – 2024-Present
Kentucky Opioid Prescribing Council – KMA Position – 2023-Present
Emergency Medicine Lead – KHA Kentucky Statewide Opioid Stewardship and Bridge Program – 2019-Present
Medical Director- UK Good Samaritan EM – 2008-2013
Faculty- University of Kentucky Chandler Medical Center – 2008-2013
Chief Medical Contributor- WKYT TV 27 – 2019-2021
Chief Medical Contributor- WTVQ ABC-36 – 2008-2018
Clear Channel Radio- 2005
National Public Radio- WETS-FM 89.5 – 1996-2008

***Education (include internships and residency information)***

University of Kentucky Emergency Medicine – 2005-2008
East Tennessee State University – Surgery Internship – 2003-2004

East Tennessee State University – James H. Quillen College of Medicine – Class of 2003

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

ABEM – Emergency Medicine – 2009-2019, recert 2019-2029
ABEM – Emergency Medical Services – 2021-2031

***Professional Societies***

American College of Emergency Physicians – 2005-Present
Kentucky Chapter of the American College of Emergency Physicians – 2005-Present
Kentucky Medical Association/LMS – 2003-Present
American Academy of Emergency Medicine – 2019-2021

***National ACEP Activities – List your most significant accomplishments***

Vice-President of Communications(Inaugural) – 2023-2024
ACEP Frontline Podcast – Creator/Host – 2017-Present
Member – Communications/PR Committee – 2008-Present
ACEP/EDPMA Joint Task Force on Reimbursement – PR Chair – 2016-2017
Chair – Communications/PR Committee – 2014-2016
9-1-1 Network Advocacy Member of the Year – 2014
ACEP Spokesperson of the Year - 2012

***ACEP Chapter Activities – List your most significant accomplishments***

KACEP President – 2012-2014
KACEP PR Chair – 2008-Present
KACEP Education Chair – 2008-2013

***Practice Profile***

***Total hours devoted to emergency medicine practice per year:*** **1000** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **100** % Research **0** % Teaching **0** % Administration **0** %

Other: **About another 2400 hrs per year of EMS and motorsports medicine.** ____ %

***Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)***

I am a partner in a two-hospital physician owned democratic group with 24 physicians serving community hospitals with a volume of 80k per year. My primary site is a comprehensive stroke and heart center.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Emergency Physician – Central Emergency Physicians
President – Central Emergency Physicians(Baptist Health Lexington and Richmond)

***Expert Witness Experience***

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert 3 Cases Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Ryan A. Stanton MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Global Medical Response

Address: 4400 Hwy 121, Suite 700

Lewisville, TX 75056

Position Held: GMR Motorsports Medical Director

Type of Organization: Emergency Medical Services

Employer: EMSConnect

Address: PO Box 8648

Spokane, WA 99203

Position Held: Educator

Type of Organization: EMS Education

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Opioid Response Network

Address: ORN@aaap.org

Type of Organization: Not for Profit

Leadership Position: Educator and Content Creator

Term of Service: 2019-Present

Organization: EMSConnect

Address: PO Box 8648

Spokane, WA 99203

Type of Organization: EMS Education

Leadership Position: Minority Owner

Term of Service: 2018-Present

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: Teleflex – Clinical Advisor

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Ryan A. Stanton MD, FACEP** Date 7/24/25

# KENTUCKY CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

KACEP
PO Box 2831
Louisville, KY 40201-2831

**OFFICERS**
*President*
Hugh Shoff, MD, FACEP

*Immediate Past President*
Christopher Pergrem, MD, FACEP

*President- Elect*
Beth Spurlin, MD, FACEP

*Secretary/Treasurer*
Jeffery Baker, MD

*Education*
Jonathan Bronner, MD

*Emergency Medical Services*
Timothy Price, MD, FACEP

*Governmental Affairs*
Christopher Pergrem, MD, FACEP

*Membership*
Diana Labrada, MD

*Pediatric Emergency Medicine*
Danielle Graff, MD
Beth Spurlin, MD, PhD, MBA

*Public Relations*
Ryan Stanton, MD, FACEP

*Emergency & Preparedness*
Andrew Pacitti, DO

*Medical Reimbursement*
Karan Shah, MD

*Wellness*
Martin Huecker, MD, FACEP

*Young Physicians*
Patrick Grace, MD
Diana Labrada, MD

**Councillors**
Chris Pergrem, MD, FACEP
Melissa Platt, MD, FACEP
Hugh Shoff, MD, FACEP

**Alternate Councillors**
Beth Sprulin, MD
Steven Stack, MD, FACEP
Salvator Vicario, MD, FACEP
Daniel O'Brien, MD, FACEP
Timothy Price, MD, FACEP

**Staff**
*Executive Director*
Ashlee Melendez, MSPH, BSN

July 25, 2025

ACEP Councillors,

It is with great pleasure that the Kentucky Chapter of ACEP (KACEP) endorse Dr. Ryan A. Stanton as a candidate for President-Elect for the American College of Emergency Physicians. We have had the pleasure of serving with Ryan over many years. He has shown exemplary state and national involvement in ACEP. Ryan is currently serving on ACEP Board of Directors and has held many state leadership roles; Councilor, Public Relations Committee Chair, Vice President, and President of KACEP. He remains an integral member of the state Board of Directors and is active in local, state, and federal roles, fighting for emergency physicians, our specialty, and patients.

Ryan is our "go-to" member for all things public relations. His background in television and radio makes him very comfortable in front of crowds and the camera. He has natural leadership ability and is very charismatic. He serves in leadership and medical directorships for many different entities; Lexington Fire/EMS, GMR Motorsports Safety Team, AirMed International, and throughout Kentucky and beyond for several opioid, pain, and addiction recovery efforts.

Ryan works clinically in the emergency department and yet he always finds time to advocate for emergency medicine with the legislators in Frankfort and Washington DC. No matter how busy, we know we can always count on Ryan to testify on behalf of emergency physicians throughout the state and nation. He takes every opportunity to promote strategies that manage acute and chronic pain in emergency medicine. He has provided many educational presentations on the treatment of patients with opiate addiction.

Ryan always hosts our KACEP EMRA grant awardees at the ACEP Leadership and Advocacy meetings in Washington, DC. He provides our residents a view of the Hill that most would not be able to offer. This has opened many young minds to emergency medicine advocacy, leadership, and action.

Ryan's curriculum vita illustrates his numerous achievements during his career. His medical work, Fire/EMS leadership, media roles, and his young physician mentorships have touched many lives. It is our pleasure to endorse Dr. Ryan Stanton.

Sincerely,

Hugh Shoff, MD, MS, FACEP
President
KY Chapter of ACEP

# Ryan A. Stanton, MD, FACEP

Dear Colleagues,

I want to take a moment to personally inform you and your chapter that I intend to run from the floor for President-Elect of the American College of Emergency Physicians.

Following the ACEP Council meeting in Las Vegas, I was approached by a number of state leaders and councilors who encouraged me to reconsider entering the race. After thoughtful reflection, I am honored to answer that call.

Let me begin by sharing why I did not initially submit my candidacy. First and foremost, my wife and I have been focused on supporting our 17-year-old daughter, Ava, as she prepares for the next chapter in her life. This spring and summer have been dedicated to college visits and quality time at home; moments that are increasingly rare and deeply meaningful.

Professionally, I also took on the role of President of Central Emergency Physicians, a democratic group of 15 physicians staffing two emergency departments. Over the past year, I've worked to restructure and position our group for the future of small-group emergency medicine. At the same time, my wife and I were engaged in serious conversations about a potential run for Congress. With our local congressional seat opening due to a Senate campaign, I was encouraged by political and community leaders to consider the opportunity. In the end, I chose to stay true to who I am and what I stand for; values that I feel are increasingly difficult to maintain in today's political landscape.

Now, I am ready and eager to bring my full energy and commitment to ACEP.

I believe I am the right candidate at the right time for our college. Emergency medicine is at a crossroads, facing complex challenges in a rapidly evolving landscape. We need a strong, experienced, and respected voice who can lead, advocate, and unite. With over 34 years of experience in media across multiple platforms, I bring a unique ability to communicate effectively and represent our specialty on a national stage. My decades of advocacy work have prepared me to bridge divides, build coalitions, and advance the mission of emergency medicine.

In addition to leading Central Emergency Physicians, I serve as Medical Director for Lexington Fire/EMS, Medical Director for GMR Motorsports, and lead the EM arm of the Kentucky Statewide Opioid Stewardship and Bridge Program. These roles reflect my commitment to building strong systems, supporting providers, and improving care for our patients.

I respect the past, understand the present, and am committed to building the future of emergency medicine. Our specialty must be the foundation, not just the front porch, of a health care system that delivers high-quality, accessible care to anyone, anywhere, anytime.

Thank you for your time, your leadership, and your support.

Sincerely,

Ryan Stanton, MD, FACEP

# Ryan A. Stanton MD, FACEP

For ACEP President-Elect



## Define the Moment…Be the Movement!!!

**We are at a defining moment for ACEP and for the future of emergency medicine. Our physicians are calling out for bold leadership, a powerful voice, and a clear path forward, and it's time we answer that call. Our strength lies in our numbers, our unity, and our shared purpose. Together, we will rise as a college to defend our profession, shape the future we believe in, and deliver the care our patients deserve.**

**My mission is to help every emergency physician reconnect with their "why", to rediscover the purpose that brought them to this specialty, and to empower them to build a career that aligns with their skills, passions, and goals. By focusing on the needs of the individual physician, we strengthen the entire house of emergency medicine.**

**This is more than a moment. It's a movement. One voice, one purpose, one future. We are ACEP.**



*A Strong Voice for Emergency Medicine*



*Community EM/EMS Leader*



*Ryan A. Stanton MD, FACEP*

**ADDRESS**
106 Stonewall Dr.
Nicholasville, KY 40356

**PHONE**
859-948-2560

**EMAIL**
ryanastanton@gmail.com
youreverydaymedicine@gmail.com

**WEB**
www.StantonMD.com

## Profile

***Board certified emergency and EMS physician in Lexington, Kentucky with involvement in community, pre-hospital, and motorsports medicine. Interests in media and public education through internet, podcast, print, and television. Active in leadership with local and national organizations through work with Central Emergency Physicians, KACEP, ACEP, AMR, and NASCAR.***

## Experience

### EMERGENCY PHYSICIAN, CENTRAL EMERGENCY PHYSICIANS, LEXINGTON, KY – 11/2013-PRESENT

Emergency Physician at Baptist Health Lexington

President of CEP – 1/1/2025-Present

### MEDICAL DIRECTOR, LEXINGTON FIRE/EMS LEXINGTON, KY - 3/2013-PRESENT

Medical Director for one of the premier fire departments and EMS services in Kentucky, overseeing the EMS operations for over 48,000 EMS runs annually.

### MEDICAL DIRECTOR, GMR MOTORSPORTS – 4/2017-PRESENT

On-track response physician for NASCAR as part of the AMR/NASCAR Safety Team at tracks throughout the country. Named GMR Motorsports Medical Director as of 1/1/20.

### KENTUCKY/FLORIDA STATE MEDICAL DIRECTOR, AIRMED INTERNATIONAL – 1/2014-PRESENT

Kentucky and Florida state medical director for AirMed International which provides air medical services throughout the world.

### EVERYDAY MEDICINE AND ACEP FRONTLINE PODCASTS, 1/2010-PRESENT

Production of two emergency medicine based podcasts. Everyday Medicine in conjunction with Emergency Medicine News and ACEP Frontline with the American College of Emergency Physician

**EMSConnect- 5/2019-Present**

EMS minority owner and educator for EMSConnect. One of four physician educators for this nationwide company.

**CHIEF MEDICAL CONTRIBUTOR, WDKY FOX-56 NEWS, LEXINGTON, KY – 1/2022-PRESENT**

Chief Medical Contributor for Fox-56 News with weekly “Doc Is In” live segments and weekly taped segments that go out to 6 stations.

**CHIEF MEDICAL CONTRIBUTOR, WKYT-27, LEXINGTON, KY – 1/2017-12/2021**

Medical Services for Kentucky Speedway 2006-2014 and Talladega Super Speedway 2015-2017

**INFIELD CARE CENTER FOR NASCAR SANCTIONED AND OTHER RACING EVENTS KENTUCKY SPEEDWAY AND TALLADEGA SUPER SPEEDWAY – 6/2006-4/2017**

Medical Services for Kentucky Speedway 2006-2014 and Talladega Super Speedway 2015-2017

**"DOCTOR ON CALL" FOR ABC-36, LEXINGTON, KY – 1/2009-12/2016**

On-Air physician for weekly "ask the doc" segments, weekly "what's going around" segments, and as needed for health-related interviews.

**EMERGENCY PHYSICIAN, MESA/TEAMHEALTH, LEXINGTON, KY -7/2008-7/2014**

Emergency Physician and past Medical Director at UK Good Samaritan Hospital in Lexington, KY

**ASSISTANT PROFESSOR OF EMERGENCY MEDICINE, UK HEALTHCARE, LEXINGTON, KY – 7/2008-6/2013**

Emergency Physician and Assistant Professor for the UK Emergency Medicine Residency Program.

**ABC NEWS MEDICAL UNIT INTERN, BOSTON, MA, FALL 2005**

Worked with the ABC Medical Unit on story research, composition, interviews and writing for ABCNews.com and ABC News programs under the direction of Dr. Tim Johnson.

**WETS-FM 89.5 NATIONAL PUBLIC RADIO PRODUCER, JOHNSON CITY, TN - 10/1996-12/2015**

Produced "Everyday Medicine", a weekly segment pertaining to common medical topics focused towards patients and the lay public. Past roles as a board operator and announcer, as well as producer of several programs including "Reel Music" and "Ritmo Latino".

**WJHL-TV CBS PRODUCTION ASSISTANT, JOHNSON CITY, TN – 4/1999-8/1999**

Production assistant duties including camera operation, sound board, editing, story composition, and directing.

## Board Certification

American Board of Emergency Medicine, Board Certified, 2009-Present

American Board of Emergency Medicine-, Emergency Medical Services, Board Certified, 2021-Present

American Board of Emergency Medicine, Board Eligible, 2008-2009

## Medical Licensure

Primary

Kentucky, 6/26/2008-Active -License #41963

Resident License- 1/2007-6/2008

Currently maintain 27 state licenses for motorsports activities. Inquire for states and details.

## Residency Training

**University of Kentucky**, Emergency Medicine, 7/2005-6/2008

**East Tennessee State University**, General Surgery Preliminary, 7/2003-6/2004

## Education

**ETSU James H. Quillen College of Medicine**, Medical Doctor, 8/1999-5/2003

**East Tennessee State University**, BS- Chemistry, 8/1995-5/1999

## Leadership Positions

**Founder/CEO,** Everyday Medicine LLC, 7/2013-Present

**Board of Directors,** American College of Emergency Physicians, 2019-Present
**Vice-President of Communications** – 10/2023-Present

**President,** Central Emergency Physicians, 1/2025-Present

**Medical Director**, GMR Motorsports, 1/2020-Present

**Medical Director**, Lexington Fire/EMS, Lexington-Fayette Urban County Government, 3/2013-Present

**Kentucky Trauma Advisory Council**, Frankfort, KY 10/2024-Present

**Kentucky Opioid Prescribing Council**, Frankfort, KY 1/2024-Present

**President**, KACEP(Kentucky Chapter of the American College of Emergency Physicians), 1/2013-12/2014

**Chairman of Public Relations Committee**, American College of Emergency Physicians, 10/2014-10/2016

**Assistant Medical Director**, AirMed International, 1/2014-Present

**Director of PR, Media, and Education**, Mesa Medical Group, Lexington, KY, 1/2013-7/2014

**Medical Director**, UK Good Samaritan Emergency Room, University of Kentucky Healthcare, 7/2008-7/2013

**Assistant Medical Director**, Kentucky Motor Speedway Emergency Medical Services, 2010-2013

**President Elect**, KACEP(Kentucky Chapter of the American College of Emergency Physicians), 1/2010-12/2012

**Vice President**, KACEP, 1/2010-12/2012

**Public Relations Committee Chairman**, KACEP, 7/2008-Present

**Vice Chairman UK ED Executive Committee**, UK Healthcare, 1/2010-6/2013

**Counselor**, American College of Emergency Physicians, 10/2011- Present

**PR Committee**, American College of Emergency Physicians, 10/2008-Present

**National Spokesman**, American College of Emergency Physicians, 10/2008-Present

**Medical Operations Subcommittee Member**, UK Good Samaritan Hospital, 2008-2013

**Emergency Medical Advisory Board**, Lexington/Fayette County, KY, 7/2008-Present

**Chief Resident**, UK Healthcare Emergency Medicine, 7 / 2007-6/2008

## Awards/Honors

**NASCAR MVVP Award,** Received the national MVVP award for the NASCAR industry for 2024

**GMR Motorsports Most Valuable Physician 2023**, Global Medical Response, March 2024

**East Tennessee State University, James H. Quillen College of Medicine Outstanding Alumni,** Commencement Speaker, May 2023

**East Tennessee State University, James H. Quillen College of Medicine Outstanding Alumni,** 2022

**ACEP 911 Network Member of the Year**, American College of Emergency Physicians, 2014

**Spokesman of the Year**, American College of Emergency Physicians, 2011-2012

**Preceptor of the Year**, UK Physician Assistant Program, 2010-2011

**UK Leadership Legacy Mentor**, University of Kentucky, 2011-2012

**Gatton School of Business Executive Leadership Program**, University of Kentucky, 2009-2010

# Publications/Presentations/Talks

## Recurring Media Productions

ACEP Frontline Podcast- 10/2015-Present

StantonMD TV Show- 3/2016-9/2018

The Doc is In TV Segment- 2012-Present

Six television markets around the southeast United States

Chief Medical Contributor- WDKY Fox-56 News- 1/2022-Present

Chief Medical Contributor- WKYT-TV Lexington- 1/2017-12/2021

WVLK 97.3FM/590AM- Weekly Medical Contributor and Guest Host(Various Shows)- 2010-Present

American College of Emergency Physicians- Spokesperson- 2008-Present

Everyday Medicine for Physicians Podcast- 1/2010-12/2019

Everyday Medicine Podcast- 1/2006-12/2015

## Presentations/Talks

**Recurring**

Kentucky Statewide Opioid Stewardship and KY Bridge- 2019-Present

Texas Opioid Response Network- 2019-Present

Emerald Coast Conference- 2014-Present

Emergencies in Medicine- 2019-Present

EMSConnect- 2018-Present

**Individual Presentations**

Emergencies in Medicine – “Managing Your Spheres of Control” – Park City, UT 2/24/2025

Independent Emergency Physicians Consortium(IECP) – “Managing Your Spheres of Control” – 2/24/2025

Keynote Address – NASCAR Summit 2025 – “The Heat is On” – Daytona Beach, FL 1/14/2025

GOWME – “Finding Your Why” – 10/23/2024

Keynote Address - Ohio ACEP Resident Assembly – “Finding Your Why”

8/14/2024

Emerald Coast Conference – ACEP Hot Topics and “Putting the Lines in Headlines” – Sandestin, FL 6/2024

Grand Rounds – Johns Hopkins Emergency Medicine – “Finding Your Why” – Baltimore, MD 4/12/2024

Keynote Address – THFW 25th Annual Trauma Conference - “It’s Getting Hot In Here” – Fort Worth, TX 4/3/2024

ACEP Accelerate 2024 – Tips and Sips: Media and Medicine – Arlington, TX 3/12/2024

Tennessee ACEP – Putting the Lines in Headlines – Chattanooga, TN 3/7/2024

Virginia ACEP – Putting the Lines in Headlines – Homestead, VA 2/25/2024

Virginia ACEP – Doc In Traffic: Motorsports Medicine – Homestead, VA 2/25/2024

Mass Gathering Medicine Summit – It’s Getting Hot in Here – New York, NY 11/17/2023

ACEP23 – Closing Keynote Moderator – FTC Chair Khan – 10/10/2023

ACEP23 – Panel and Moderator – Medical Student Forum – Why EM – 10/8/2023

Michigan ACEP – It’s Getting Hot in Here – Mackinaw, MI 8/1/2023

Emerald Coast Conference – It’s Getting Hot in Here – Destin, FL 6/6/2023

East Tennessee State University – James H. Quillen College of Medicine – Commencement Keynote Address – Finding Your Why – Johnson City, TN 5/12/2023

Louisiana ACEP – Finding Your Why – Baton Rouge, LA 3/8/2023

Emergencies in Medicine – It’s Getting Hot in Here – Park City, UT 2/26/2023

Emerald Coast Conference – Epidemic in a Pandemic – Destin, FL 6/7/2022

Louisiana ACEP – Epidemic in a Pandemic – New Orleans, LA 3/9/2022

Emergencies in Medicine – Motorsports Medicine – Park City, UT 2/26/2022

ACEP19- Moderator: SoMe in EM- Denver, CO 10/29/19

Emerald Coast Conference- Mythbusting: EM Medication Myths- Destin, FL 6/3-5/2019

Emerald Coast Conference- Law and Order: EM Medical Malpractice- Destin,

FL 6/3-5/2019

Emerald Coast Conference- He Said, She Said: Vaccine Refusals- Destin, FL 6/3-5/2019

Kentucky Hospital Association- KY Statewide Opioid Stewardship- ALTO in EM and Beyond, Multiple Sites in KY 2019

Tennessee ACEP 2019- Opioids State of the Union- Chattanooga, TN 3/4/2019

ANC-AHE Annual Conference- State of the Union: Opioids in America- Savannah, GA, 2/20/19

NASCAR Summit 2019- What Can You Actually Do in a Racecar- Concord, NC 1/2019

Kentucky Hospital Association Leadership Academy- Moderator for Opioid Panel Discussion- Louisville, KY, November 2018

PHI Regional Outreach Critical Care Symposium- Sepsis in the EMS Setting- Morehead, KY, November 2018

ACEP18- Becoming Unjaded: The Opioid Epidemic- San Diego, CA, October 2018

ACEP18- Social Media: Collaboration or Litigation- San Diego, CA, October 2018

ACEP18- Mills Memorial Lecture- ACEP Past, Present, and Future- San Diego, CA, October 2018

SEC ACEP- Mythbusting in Emergency Medicine- Destin, FL, June 2018

SEC ACEP- Frontline Live: The Evolution of Medical Education- Destin, FL, June 2018

SEC ACEP- Opioid Epidemic: State of the Union- Destin, FL, June 2018

ACEP Leadership and Advocacy 2018- Advocacy Panel- Washington DC, May 2018

Tennessee ACEP- 2018 Annual Meeting- Opioid Epidemic: State of the Union- Chattanooga, TN, March 2018

NASCAR Summit 2018- AMR/NASCAR Year in Review- Concord, NC, January 2018

NASCAR Summit 2018- The Approach to the Car and Driver- Concord, NC, January 2018

KY ENA State Educational Conference- Surviving Dreamland: The Opioid

Crisis, Lexington KY, August 2017

SEC ACEP- Opioids: Why That Didn't Work, Destin FL, June 2017

SEC ACEP- The Physician Pilot: Keeping the Skies Friendly, Destin FL, June 2017

Ohio ACEP Emergency Medicine Forum- Faces of Physician Leadership, Columbus OH, May 2017

11th Annual Intermountain Brain Injury Conference- Approach to the Acutely Agitated Patient, Johnson City TN, March 2017

11th Annual Intermountain Brain Injury Conference- TBI 101, Johnson City TN, March 2017

ACEP Leadership and Advocacy 2017- Where the Rubber Meets the Road: Emergency Medicine and SoMe, Washington DC, March 2017

TN ACEP Annual Meeting- Narcotics to Narcan: State of the Opioid Union Address, Chattanooga TN, February 2017

KACEP Medical Director Conference- From IV to IO and In-Between, Louisvile KY, November 2016

ACEP16- Rapid Fire: Narcotics to Narcan, Las Vegas NV, October 2016

ACEP16- Rapid Fire: Do Your Patients Know You Care?, Las Vegas NV, October 2016

ACEP16- Feel the Burn: Preventing Burnout in EM, Las Vegas NV, October 2016

CECentral- Opioid Symposium, Narcotics to Narcan: Tackling the Opioid Epidemic, Lexington KY, October 2016

SEC ACEP- Critical Findings for the Community Doc, Destin FL, June 2016

SEC ACEP- Malpractice Minefield, Destin FL, June 2016

TN ACEP- Narcotics to Narcan, Chattanooga TN, March 2016

Can't Miss Trauma for the Community Physician, SEC ACEP, Destin FL, June 2016

NASCAR Summit- I Will Take CO for an Answer, Concord NC, January 11, 2016

SEC ACEP- Implementing Narcan, Destin FL, June 2015

SEC ACEP- Building a Disaster Plan, Destin FL, June 2015

NASCAR Summit- Metropolis in a Cornfield, Charlotte NC, January 2015

CECentral- Heroin: Old Dog with New Tricks, Lexington KT, October 2014

FACOS Annual Clinical Assembly- Building the Framework for a Disaster, Boston MA, September 2014

TN ACEP- Heroin: Old Dog with New Tricks, Chattanooga TN, March 2014

SEC ACEP- Opioid Legislation: That Just Happened, Destin FL, June 2014

SEC ACEP- Frequent Flyers: Can We Cut the Sky Miles, Destin FL, June 2014

NASCAR Summit- That Just Happened, Charlotte NC, January 2014

CECentral- The Good, Bad, and Ugly of Substance Abuse, The Frontline of Addiction and Substance Abuse, Lexington KY, August 2013

SEC ACEP- Encephalitis and Meningitis Make My Head Hurt, Destin FL, June 2013

SEC ACEP- Street Drug Abuse, Destin FL, June 2013

SEC ACEP- Opioid Crisis in the US, Destin FL, June 2013

The Faces of Substance Abuse- "KASPER Update Panel", Lexington KY, January 23, 2013

NASCAR Summit- "They Could Be Drunk...Or They Could Be Dying", Concord NC, January 8, 2013

ACEP Spokesman Network- "Prescription Drug Abuse Prevention", Multiple Presentations, 2012

KMA Annual Meeting- "HB1 Update", Louisville KY, September 2012

SEC ACEP Back to Basics- "The Weakest Link", Destin Fl, June 12, 2012

SEC Hot Topics in Emergency Medicine- "Green Tobacco Sickness", Destin FL, June 2011

SEC Hot Topics in Emergency Medicine- “Scan Them Until They Glow: Risks of CT Radiation and Emergency Care”, Destin FL, June 2010

AAEM National Conference Photo Contest- “Purulent Pericardial Effusion”, February 2008

AAEM National Conference Open Mic Competition- “Anatomy of a Plane Crash”, February 2008

## Research Publications

Ryan Stanton, Jeff Schoondyke, Rebecca Copeland, "Papillary Fibroelastoma in the Left Ventricular Wall", Cardiology Review, Volume: Fall 2003,

Ryan Stanton, Ted Parks, "Bilateral Anterior Compartment Syndrome and Creatine Monohydrate Usage", Journal of Emergency Medicine, 2003

Ryan Stanton, Floranne Wilson, and Kyle Colvett, "Metastatic Basal Cell Carcinoma", Southern Medical Journal, October 2003

## References

Dr. Mark Spanier, Baptist Health Lexington ED Medical Director, Central Emergency Physicians, 859-260-6180, markspanier1@gmail.com

BC Eddie Crews, Battalion Chief- Lexington Fire/EMS, 859-231-5644, crewse@lexingtonky.gov

Dr. Chris Doty, Residency Director UK Department of Emergency Medicine, 859-323-5908, chris.doty@uky.edu

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

# Board of Directors Candidates

Scientific Assembly

SALT LAKE CITY 25

Scientific Assembly SALT LAKE CITY 25

# 2025 Board of Directors Candidates



**Daniel Frees, MD, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



**Robert Hancock, DO, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



**Steven B. Kailes, MD, MPH, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Scientific Assembly SALT LAKE CITY 25

# 2025 Board of Directors Candidates



**Kristin B. McCabe-Kline, MD, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



**Bing S. Pao, MD, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

## Daniel Freess, MD, FACEP

***Question #1:*** **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

I am a collaborator who values making progress and completing tasks. I come from a small chapter, but do not think size limits the impact one can have on Emergency Medicine. Small groups can have big voices and our chapter has had a large impact on national issues. From reimbursement to boarding, our chapter has led the way. As chair of the Emergency Medicine Practice Committee, I led a diverse group of emergency physicians from across the country in creating policies, guidelines, and informational papers regarding national standards for emergency care. As Chair of ACEP's Task Force on the Utilization of PAs and NPs in Emergency Medicine, I brought together representatives from over 10 separate organizations including physicians, PAs, NPs, and nurses to create general guidelines and a framework in which everyone could function collaboratively and respectfully. As prior Chair of multiple Council Reference Committees, I managed to distill everyone's collective, while sometimes disparate, passion for emergency medicine into resolutions that could be supported by the Council.

Furthermore, I am a bedside clinician and educator. I am not an administrator, a chair, a researcher, or otherwise in hospital leadership. I spend my time at bedside with patients and mentoring residents. I live with boarding on a daily basis, working with under-resourced populations in an inner city while accepting transfers from across state lines. I see the direct effects of our national policies and advocacy on a daily basis. I lecture to the residents regularly, serve as an academic advisor, and have become the go-to person for employment/contract advice. This gives me a front-seat view of the state of emergency medicine, patient care, the job market, and the goals, dreams, and frustrations of our next generation.

Finally, I am a good listener, but have no problem speaking truth to those in power. Colleague, politician, fellow Board Member, hospital administrator, or patient, I will be firm, honest, and clear. I feel there is nothing more ineffective than placating words without follow though or action. ACEP needs Board Members who are willing to take a stand, communicate our needs, and convey our message to a broad spectrum of audiences. While I come from a small state, I have made big things happen over the years and hope I can expand this impact as a Member of the Board, for our colleagues, patients, and our specialty.

***Question #2:*** **What is your biggest concern about serving on the Board of Directors?**

Our emergency departments and our healthcare system are in crisis, and we find ourselves in a time necessitating both bold ideas and a unified voice within the house of emergency medicine. Unfortunately, both in medicine and society, we have become too dichotomized. Pushed to the extremes of opinion. One must be completely for something or completely against it. New ideas are either terrible or brilliant. Even colleagues and friends are viewed as either for us or against us at all time. This creates division, and divided, meaningful change is difficult. We need to work together with both internal and external groups to find solutions to problems. We must work collegially to stand against our adversaries.

Right or wrong, a criticism of ACEP I hear frequently is that we are fearful of taking firm stances, of making powerful statements on behalf of our colleagues and our specialty. ACEP tries to walk the line between factions and varying opinions. While information gathering, consensus building, and walking the political high wire are key components of a successful Board, I hope that we can avoid what could be deemed "paralysis by analysis" and speak for our specialty and our colleagues in a unified voice. This is a time to be aspirational, to state our case to the world in order to defend our physician colleagues and protect our patients. While this takes time, outreach, and even direct communication with those that have sought to divide us, I believe ACEP can continue to serve as the primary voice of emergency medicine and continue to make a difference for our specialty.

***Question #3:*** **What are the two most pressing issues facing members and how would you address them?**

How long can we keep doing this? Emergency physicians are experiencing increased work-related stressors and this threatens our career sustainability. Every day we are faced with the influences of private equity and corporations, changing training and workforce standards, and increased violence in the workplace. Though multifactorial, I feel two of the most pressing factors affecting our future outlook are threats to reimbursement from payors, and the ED boarding crisis.

Here in Connecticut, Medicaid rates have not changed in 17 years. There are currently additional efforts to limit out-of-network reimbursement, which will impact hospitals, emergency physicians, and the healthcare safety net. On the national front, Medicare rates are declining compared to inflation and the No Surprises Act has been badly misinterpreted to heavily favor insurance companies. Mandates under EMTALA leave us little negotiating power. Despite ACEP's tireless work on the legislative and regulatory front, we need help. We need the press to spotlight our crumbling healthcare safety net. We need patients to convince politicians, administrators, and the public that emergency medicine matters. We need to highlight how Medicaid patients have no access to consultant care. We need patients calling their legislators to discuss predatory high-deductible health plans and lack of access to follow-up. We need to stimulate a national grassroots effort in order to stabilize financial insecurities, allowing for the maintenance of the high-quality care we provide.

The fight to reduce boarding begins with metrics and transparency. In Connecticut we have passed novel legislation requiring hospitals to submit their boarding data and metrics to the state for public reporting. While this does not fix the problem, it lifts the veil of secrecy and denial on the part of the government, administrators, and health systems. We need to highlight boarding as a patient safety and quality issue. Until hospitals and health systems are externally pressured to improve boarding, they will continue to follow the financial incentive of increased volume and decreased staffing. The Leapfrog Group has already committed to making boarding part of their quality surveys, but this must only be the beginning. We need to expand our coalition and engage patients, communities, regulators, and even payors to hold hospitals responsible for deficits in ED capacity and boarding. This will not only improve patient experiences, but also our own workplace wellbeing.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Daniel Freess, MD, FACEP

***Contact Information***

55 Soby Drive
West Hartford, CT 06107

***Phone:*** 860-989-1449
***E-Mail:*** danfreess@gmail.com

***Current and Past Professional Position(s)***

Hartford Hospital Emergency Department
- Full Time Attending 05/2017 - Present
- Per Diem Physician 05/2011 – 05/2015

Midstate Medical Center Emergency Department
- Full Time Physician 07/2010 – 05/2017

UConn Health/John Dempsey Hospital
- Per Diem Physician 05/2015 – 10/2016

Assistant Professor, Dept. of Traumatology and Emergency Medicine, University of Connecticut School of Medicine
- 09/2017 - Present

Assistant Clinical Professor, Dept. of Traumatology and Emergency Medicine, University of Connecticut School of Medicine
- 06/2012 – 09/2017

Assistant Clinical Professor, Dept. of Emergency Medicine, Frank H. Netter School of Medicine
- 09/2012 – 09/2017

***Education (include internships and residency information)***

University of Connecticut Integrated Residency in Emergency Medicine
- Class of 2010

Doctorate of Medicine - Jefferson Medical College, Thomas Jefferson University
- Class of 2007

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

ABEM Board Certified
- 2011 - Present

***Professional Societies***

American College of Emergency Physicians
- 2003 – Present

Connecticut College of Emergency Physicians
- 2007 – Present

Emergency Medicine Residents Association
- 2003 – 2011

American Medical Association
- 2003 – 2010

***National ACEP Activities – List your most significant accomplishments***

ACEP EM Practice Committee (2009 – Present)
- Committee Chair (2019 - 2022)
- Subcommittee Chair – Policy Review/Revision (2012 - 2013)
- Subcommittee Chair – Careers in Emergency Medicine (2014 - 2015)
- Subcommittee Chair – Policy creation on Geriatric Emergency Medicine (2015-2016)
- Subcommittee Chair – Policy creation on Ketamine Administration By Nursing (2015-2017)
- Subcommittee Chair – Creation of resource/white paper on Sub-Dissociative Ketamine use in the ED (2017)
- Subcommittee Chair – Information and Resources on Opiate-Free EDs (2016-2018)
- Subcommittee Chair – ED Medication Assisted Therapy for Substance Abuse (2017-2019)
- Subcommittee Chair – ACEP Policy on "Safe Discharge" Criteria (2019
- Contributor – National Forum to Secure America's Supply Chain for Essential Medications (2020-2021)
- Subcommittee Chair – ACEP Policy on Boarding of Admitted and Intensive Care Patients in the Emergency Department (2022 - 2023)
- Subcommittee Chair – ACEP Policy on Boarding of Admitted and Intensive Care Patients in the Emergency Department (2022-2023)
- Subcommittee Chair – ACEP Policy on Specialty Hospitals
- Subcommittee Chair – Boarding of Admitted and Intensive Care Patients in the Emergency Department

ACEP Council
- Reference Committee Chair – 2022, 2023
- Reference Committee Member – 2014, 2017, 2018, 2021-2024
- CT Delegation Member – 2010-2011, 2013 – Present

ACEP Steering Committee (2018 - 2020)

NEMPAC Board Of Trustees – (2012 – 2015)

ACEP Young Physicians Section (2010 – Present)
- Chair (2014 - 2015)
- Steering Committee (2010 – 2021)

ACEP Emergency Data Institute Governance Team (2022 – 2023)
- Member

ACEP ED Accreditation Task Force (2021 – 2022)
- Representative

ACEP Clinical Resource Review Committee (2020 – 2023)
- Chair (2020 – 2023)

ACEP Workforce Task Force (2020 - 2021)
- Member

ACEP State Legislative Committee (2017-2019)
- Subcommittee Chair – Insurance Reimbursement Within High Deductible Health Plans (2019)

ACEP Task Force on ED PA/NP Utilization (2018-2020)
- Chair

ACEP Task Force on Best Practice For EM Contract Transition (2017)
- Member

ACEP 911 Legislative Action Network (2009 – Present)
- Member

***ACEP Chapter Activities – List your most significant accomplishments***

CCEP Board of Directors (2011 – Present)

- President (2017 - 2018)
- Councilor to ACEP Council (2010 – Present)
- Education Committee (2012 - Present)
    - Education Chair (2012 - Present)
- Legislative Committee (2012 – Present)
    - Legislative Chair (2019 – Present)
- Treasurer (2015 - 2016)
- President-Elect (2016 - 2017)
- Representative to State Appointed Task Force on High Deductible Heath Plans (2019 – 2020)
- Representative to State Appointed Task Force on ED Boarding (2024-2025)

***Practice Profile***

***Total hours devoted to emergency medicine practice per year:*** **1600** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **85** % | Research | **0** % | Teaching | **13** % | Administration | **2** % |
| Direct Patient Care | | | | | | | |
| Other: | | | | | | | % |

***Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)***

Single Site Academic Employed Practice at Level 1 Residency Teaching Site with 110,000 patient per year volume.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Emergency Physician

***Expert Witness Experience***

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert** **0** **Cases** **Plaintiff Expert** **0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Daniel Freess, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Hartford Hospital

Address: 80 Seymour St.

Hartford, CT 06106

Position Held: Attending Physician

Type of Organization: Hospital

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Connecticut College of Emergency Physicians

Address: 60 Kings Highway

North Haven, CT 06473

Type of Organization: ACEP Chapter

Leadership Position: Board of Directors, Legislative Chair, Education Chair

Term of Service: BOD – 3 year renewing term, Chair – Ongoing

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Daniel Freess** Date 5/11/2025

# CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS

*A Chapter of the AMERICAN COLLEGE OF EMERGENCY PHYSICIANS*

60 KINGS HIGHWAY • NORTH HAVEN, CT 06473 • (203) 234-8055 • FAX: (203) 234-2852


**Endorsement of Dr. Daniel Freess for ACEP Board of Directors**

The Connecticut College of Emergency Physicians (CCEP) is pleased to endorse Dr. Daniel Freess for election to the ACEP Board of Directors. As a dedicated physician and advocate for the emergency medicine community, Dr. Freess has demonstrated exceptional leadership within our College, a deep commitment to advancing emergency care with the state, and a consistent track record of service to both his fellow Connecticut emergency physicians and the patients we serve.

Dr. Freess has been an active member of CCEP since early in his residency and has been a member of our Board of Directors since graduating. During his 14 years on the CCEP Board, Dr. Freess has served as CCEP Treasurer, President-Elect, and President. Additionally, he has been the Chair of the Legislative Committee for the past 5 years, and Chair of the Education Committee for over 10 years. In these roles, he has shown exceptional leadership, driving initiatives that directly benefit both physicians and patients.

Dr. Freess has represented CCEP on two critical state task forces: one focused on the detrimental effects of High-Deductible Health Plans and the other dedicated to legislative solutions for Emergency Department Boarding. His involvement in these initiatives showcases his ability to navigate complex policy environments with competing agendas and advocate for meaningful, sustainable changes that benefit both emergency physicians and patients.

Beyond his work on state-level policy, as Chair of the Education Committee, Dr. Freess has organized and led our annual meeting for over 12 years. His work has significantly contributed to the educational opportunities available to emergency physicians in Connecticut, providing a platform for ongoing learning, collaboration, and growth. His leadership has helped elevate CCEP's educational offerings, ensuring that members and our residents are well-equipped with the knowledge and tools necessary to excel in their practice.

Overall, Dr. Freess's leadership extends beyond CCEP to the broader emergency medicine community. His ability to unite colleagues around shared goals, his thoughtful approach to policy, and his commitment to improving both patient care and physician well-being make him an ideal candidate for the ACEP Board of Directors. With his extensive experience in clinical practice, healthcare policy, and organizational leadership, Dr. Freess will bring invaluable insight to the ACEP Board, advancing the interests of emergency physicians and our patients nationwide.

The Connecticut College of Emergency Physicians is pleased to endorse Dr. Daniel Freess for the ACEP Board of Directors. We strongly encourage all members to support his candidacy, as his proven leadership and vision will help shape the future of emergency medicine and ensure that our profession continues to thrive.

Sincerely,

Tricia Priebe
Executive Director
CCEP
203-464-3793
tricia@grassrootsct.com

# Daniel Freess, MD, FACEP

Dear Councillors and Colleagues,

I am honored to have been chosen as a candidate for the ACEP Board of Directors and I seek your support in this important election. As an emergency physician with a deep commitment to our profession, I have spent my career advocating for our patients, our practices, and our colleagues. If elected to the ACEP Board, I will bring a wealth of ACEP experience, a collaborative approach to advocating for change, and a passion to better the future of emergency medicine.

Within ACEP, I have had the honor of serving in multiple leadership positions that have shaped my understanding of the complex issues facing our field.

A few highlights of my time within ACEP are:

- Resident representative to the EM Practice Committee
- Chair of the Young Physicians Section
- Chair of the ACEP Task Force on the Utilization of PAs/NPs Within Emergency Medicine
- Chair of the Emergency Medicine Practice Committee
- Member of the NEMPAC Board of Directors
- Member of the ACEP Council Steering Committee
- ACEP Councillor for 15 years

On the state level, I have served in various leadership roles, including:

- CCEP Treasurer
- CCEP President
- Chair of the Legislative Committee
- Chair of the Education Committee.
- State-appointed member of Task Force on Out-Of-Network Balance Billing
- State-appointed member of Task Force on Legislative Solutions For Emergency Department Boarding.

As I look to the future of emergency medicine, I am excited about the role ACEP can continue to play in shaping our profession. If elected, in addition to performing any duties asked of me by the Board, I hope to highlight the following key priorities:

- **Advocate for fair payment and reimbursement from all payors:** Ensuring that emergency physicians are compensated fairly is one of my top priorities. I will work tirelessly to secure equitable reimbursement from all payors, advocating for policies that protect emergency medicine and our patients from unfair trade practice, policy decisions, and the unfunded mandate of EMTALA.
- **Address assaults on physician wellness and autonomy:** The growing challenges of burnout and diminishing physician autonomy are affecting emergency physicians nationwide. I am committed to advancing solutions that protect our colleagues, ensuring that we remain capable of providing the best possible care to our patients without sacrificing our own health or professional satisfaction.
- **Protect residency training and support our young physicians:** Residency programs are the foundation of our profession, and I will fight to ensure that emergency medicine residency training is protected and supported. It is critical that medical students and residents have choice in their residency options and that the residencies training them are of the highest standards.
- **Solidify ACEP as the national voice for EM and all emergency physicians:** ACEP must remain the unifying force for emergency physicians across the country. I will work to ensure that ACEP continues to advocate effectively for our needs, positioning the College as the undisputed leader in shaping public policy and advancing the interests of emergency medicine.

I am grateful for the opportunity to run for the ACEP Board of Directors and hope to serve our profession at the national level. I am proud of the leadership roles I have held within ACEP and CCEP, and I am committed to continuing this work on behalf of emergency physicians across the country. Together, we can ensure that emergency medicine continues to thrive, and that emergency physicians have the support and resources they need to provide the highest quality care.

I ask for your support in this election, and I look forward to working together to shape the future of our profession.

Sincerely,

Daniel Freess, MD, FACEP

# ELECT

# DR. DANIEL FREESS

**For ACEP Board of Directors**

***Small State, Big Solutions***

## Vision

**Fair Pay, No Exceptions**

Advocate for equitable payment from all payors

**Wellness & Autonomy Matter**

Champion physician well-being and workplace safety

**Protect the Pipeline**

Safeguard residency training and support future EM leaders

**Amplify Our Voice**

Strengthen ACEP as the national voice for all of emergency medicine



# Daniel B. G. Freess MD FACEP

55 Soby Dr.
West Hartford, CT 06107
860-989-1449
danfreess@gmail.com

## EDUCATION

Emergency Medicine Residency, Class of 2010
University of Connecticut Integrated Residency in Emergency Medicine

Doctorate of Medicine, June 2007
Jefferson Medical College, Thomas Jefferson University

Honors Bachelor of Arts in Liberal Studies, Medical Studies and Biology, June 2003
University of Delaware

## WORK EXPERIENCE

Hartford Hospital Emergency Department
- Full Time Attending 05/2017 - Present
- Per Diem Physician 05/2011 – 05/2015

Midstate Medical Center Emergency Department
- Full Time Physician 07/2010 – 05/2017

UConn Health/John Dempsey Hospital
- Per Diem Physician 05/2015 – 10/2016

## APPOINTMENTS

Assistant Professor, Dept. of Traumatology and Emergency Medicine, University of Connecticut School of Medicine – 09/2017 - Present

Assistant Clinical Professor, Dept. of Traumatology and Emergency Medicine, University of Connecticut School of Medicine – 06/2012 – 09/2017

Assistant Clinical Professor, Dept. of Emergency Medicine, Frank H. Netter School of Medicine - 09/2012 – 09/2017

## AFFILIATIONS

American College of Emergency Physicians (2003 – Present)
Connecticut College of Emergency Physicians (2007 – Present)
Emergency Medicine Residents Association (2003 – 2011)
American Medical Association (2003 – 2010)

## CERTIFICATIONS

ABEM Board Certified (11/2011 – Present)
Fellow of ACEP (2014 – Present)

## PROFESSIONAL LEADERSHIP ACTIVITIES

ACEP Council
- Reference Committee Chair – 2022, 2023
- Reference Committee Member – 2019, 2021-2023
- CT Delegation Member – 2010-2011, 2013 – Present

ACEP Steering Committee (2018 - 2020)
NEMPAC Board Of Trustees – (2012 – Present)
- Board Member (2012 – 2015)
- Participating Member (2015 – Present)

CCEP Board of Directors (10/2011 – Present)
- President (2017 - 2018)
- Councilor to ACEP Council (2010 – Present)
    - Council Reference Committee (2014, 2017, 2021)
- Education Committee Chair (2012 - Present)
- Legislative Committee (2012 – Present)
    - Legislative Chair (2019 – Present)
- Treasurer (2015 - 2016)
- President-Elect (2016 - 2017)
- Representative to State Appointed Task Force on High Deductible Heath Plans (2019 – 2020)
- Representative to State Appointed Task Force on ED Boarding (2024-2025)

ACEP Young Physicians Section (2010 – Present)
- Chair (2014 - 2015)
- Steering Committee (2010 – 2021)

ACEP Emergency Data Institute Governance Team (2022 – 2023)
- Member

ACEP ED Accreditation Task Force (2021 – 2022)
- Representative

ACEP Clinical Resource Review Committee (2020 – Present)
- Chair (2022 – Present)

ACEP Workforce Task Force (2020 - 2021)
- Member

ACEP EM Practice Committee (2009 – Present)
- Committee Chair (2019 - 2022)
- Subcommittee Chair – Policy Review/Revision (2012 - 2013)
- Subcommittee Chair – Careers in Emergency Medicine (2014 - 2015)
- Subcommittee Chair – Policy creation on Geriatric Emergency Medicine (2015-2016)

- Subcommittee Chair – Policy creation on Ketamine Administration By Nursing (2015-2017)
- Subcommittee Chair – Creation of resource/white paper on Sub-Dissociative Ketamine use in the ED (2017)
- Subcommittee Chair – Information and Resources on Opiate-Free EDs (2016-2018)
- Subcommittee Chair – ED Medication Assisted Therapy for Substance Abuse (2017-2019)
- Subcommittee Chair – ACEP Policy on "Safe Discharge" Criteria (2019
- Contributor – National Forum to Secure America's Supply Chain for Essential Medications (2020-2021)
- Subcommittee Chair – ACEP Policy on Boarding of Admitted and Intensive Care Patients in the Emergency Department (2022 - 2023)
- Subcommittee Chair – ACEP Policy on Boarding of Admitted and Intensive Care Patients in the Emergency Department (2022-2023)
- Subcommittee Chair – ACEP Policy on Specialty Hospitals
- Subcommittee Chair – Boarding of Admitted and Intensive Care Patients in the Emergency Department

ACEP State Legislative Committee (2017-2019)
- Subcommittee Chair – Insurance Reimbursement Within High Deductible Health Plans (2019)

ACEP Task Force on ED PA/NP Utilization (2018-2020)
- Chair

ACEP Task Force on Best Practice For EM Contract Transition (2017)
- Member

ACEP 911 Legislative Action Network (2009 – Present)
- Member

EMRA Health Policy Committee (2008 – 2010)
- Member

EMRA International Medicine Committee (2008 – 2010)
- Member

EMRA Representative Council (2008-2010)
- Representative for UConn

**HOSPITAL ACTIVITIES**

Midstate Emergency Department Case Review Committee (2014-2017)
- Member

Hartford Healthcare Central Region Claims Review Committee (2016-2017)
- Member and Emergency Medicine Representative

Midstate's STEMI Committee (2016–2017)
- ED Representative

Hartford Healthcare Opioid Management Council (2018-Present)
- Member

Member Hartford Healthcare Opioid Addiction Subcommittee (2018-Present)

- Member

## TEACHING EXPERIENCE/LECTURES/PODCASTS

Panelist. Roundtable on Non-Compete Clauses and the Workforce Mobility Act. Sen. Christopher Murphy and FTC Chair Lina Khan. June 14, 2024.

Lecturer/Panelist. "ED Boarding Advocacy: Sharing Your Stories from the Frontlines." ACEP Leadership & Advocacy Conference. May, 1 2023.

Guest Lecturer/Presenter. EShadowing – Emergency Medicine. Medical School Headquarters Podcast/Webinar Series. May 8, 2022.

Guest Lecturer/Presenter. ACEP Emergency Medicine Practice Management and Health Policy Section. Utilization of PAs and NPs in the Emergency Department. October 26, 2020.

ACEP Summit On The Future Of Emergency Medicine – People. Panelist/Presenter. July 22, 2020.

ACEP Summit On The Future of Emergency Medicine – Practice. Invited Guest/Commentator. July 24, 2020.

The Red Book: The UConn Emergency Medicine Residency Guide To Critical Care In the Emergency Department. Contributing Editor. 2018

"We're not #1: United States Health Policy and The Future." Scholarly Lecture Series. Channing Memorial Church. Newport, RI. November 2017.

Community Lecture Series. "The Opioid Epidemic." Elmwood Community Center. Oct. 23, 2017.

Podcast: "ED Pain Management/Alternatives To Opioids." ACEP So What Podcast with Howie Mell. Posted August 25, 2017.

Webinar: "Finances For Early Career Physicians." ACEP Fiscal Rx Webinars. April 2017. www.ACEP.org

Podcast: "What is Emergency Medicine." The Premed Years Podcast. Medical School Headquarters: Online. December 2016.

UConn Residency Year Directed Lectures

- Life After Residency (Annually 2012–Present)
- Cadaver Lab Instructor (Annually 2018–Present)
- Introduction to Emergency Medicine Health Policy (2017 - Present)
- History of the American Health Care System Parts 1 & 2 (2018 – Present)
- Life After Residency Primer (2017 - Present)
- EMTALA and The Art Of The Transfer (2016)

UConn Residency "House Parent" (2014-Present)

- Organize and Administer Small Group Sessions

Advisor to UConn Residents (1 Resident 2014-2015, 2 Residents 2015-Present)

UConn Emergency Medicine Lecture Series

- Glycogenic Hepatopathy (2007)
- Anatomy of a Lawsuit (2008)
- Bullous Impetigo (2008)

- Traumatic Aortic Dissection (2008)
- Update On Health Policy and Reform (2009)

EMRA Advocacy Online Lecture Series (2009)

- Problems of Consultant Retention

University of Delaware Mentorship Program (2020 – Present)

- Formal mentor for current undergraduate students in the health sciences

## EDUCATIONAL EXPERIENCES

ACEP Scientific Assembly (2008 - Present)
ACEP Leadership and Advocacy Conference (2009 - Present)
Connecticut College of Emergency Physicians Annual Conferences (2007 - Present)
Clinical Rotation in Mountain Community Medicine, Cajamarca, Peru (Apr - May 2007)
Clinical Rotation in Internal Medicine, Panama City, Panama (Summer 2004)

## AWARDS

University of Connecticut Emergency Medicine Residency Silver Tongue Award (2010)

- Best Resident Lecture

Award of Distinction – Connecticut College of Emergency Physicians – 2018
ACEP President's (Paul Kivela) Coin for Outstanding Service – 2018
ACEP Board of Directors (John Finnell) Coin for Outstanding Service – 2019
ACEP Speaker's Coin for Outstanding Service 2019-2021
The Cynthia LaVerne Price Humanism in Emergency Medicine Award - UConn Integrated Residency In Emergency Medicine, 2023
ACEP Speaker's Coin for Outstanding Service 2021-2023
ACEP Certificate of Appreciation: Chair Clinical Resource Review Committee 2023-2024

## PUBLICATIONS AND PROJECTS

ACEP EMPC – Editor of multiple ACEP Clinical Policies 2019-Present

- Cultural Awareness and Emergency Care
- Deferral of Care After Medical Screening of Emergency Department Patients
- Emergency Department Patient Advocate Role and Training
- Emergency Department Planning and Resource Guidelines
- Emergency Medicine Telehealth
- Freestanding Emergency Departments
- Guideline Regarding the Role of PAs and NPs in the ED
- Recognition of Subspecialty Boards in Emergency Medicine
- Retail-Based Clinics
- Third-Party Payers and Emergency Medical Care
- Use of Patient Restraints
- Use of the Title "Doctor" in the Clinical Setting

- Role of the Medical Director in the Development of Clinical Provider Staffing Models
- Availability of Food and Beverage for Clinical Physicians in the ED
- The Role of Emergency Physicians in Acute Trauma Management
- Emergency Physician Pay Transparency
- Patient Support Services
- Telehealth Inclusion In ACEP Policies and Standards
- Clinical Pharmacist Services in the ED
- Compensation Arrangements for Emergency Physicians
- Definition of and Emergency Service
- Definition of Emergency Medicine
- Emergency Department Observation Services
- Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy
- Emergency Physician Rights and Responsibilities
- Orders Received From Outside the ED
- Standardized Protocols for Optimizing ED Care
- The Patient-Centered Medical Home
- Deferral of Care after Medical Screening of ED Patients
- ED Planning and Resource Guidelines
- Boarding of Admitted and Intensive Care Patients in the Emergency Department
- Patients Leaving The ED Prior To The Completion of Care

Freess, Daniel. Olympia, Robert, et al. (Editors). An Emergency Physician's Path: What To Expect After An Emergency Medicine Residency. 2024; Springer Publishing.

- Chapter 36: Choosing The Academic Job Of Your Dreams
- Chapter 37: Committee Participation And The Development of Policies and Procedures
- Chapter 48: Advocacy

Freess, Daniel. EMRA/ACEP. Practice Essential of Emergency Medicine: Personal Finance: Insurance. Online. 2024

ACEP EMPC – Projects and Information Papers 2019 - 2021

- ED Boarding Toolkit
- Patients with Autism Spectrum Disorder Point-Of-Care Tool
- Psychiatric Boarding Toolkit

ACEP EMPC - Subcommittee On Patient Satisfaction Surveys. "Emergency Department Patient Satisfaction Surveys." ACEP News. August 2012; ACEP: 34.

ACEP EMPC (Daniel Freess). ACEP News. "What Do ACOs Mean For EM?" November 2012; ACEP:1,14.

ACEP EMPC (Lead Author and Editor). "Hospital Employment and Careers Outside the Emergency Department: An Information Paper." Online. ACEP.org. June 2016.

Freess, Daniel. "ACEP Task Force Examining Collaboration with Advanced Practice Providers."

ACEP Now. July 17, 2019.
Freess, Daniel. "Health Insurance Offers Access and Affordability. Or So We Think." Hartford Courant: Op-Ed. May 5, 2019.
Freess, Daniel. "How Much Do You Have Saved Up For Graduation?" Young Physician Section Newsletter – May 2014. Online. May 19, 2014.
Freess, Daniel. "Bills, Bills, Bills." Young Physician Section Newsletter – September 2016. Online. September 1, 2016.
Freess, Daniel. "Picking The Right Job For You." Young Physician Section Newsletter – October 2014. Online. October 8, 2014.
Freess, Daniel. "President's Message." CCEP Summer Newsletter. June 2018.
Freess, Daniel. "Problems in Consultant Retention." EMRA Emergency Medicine Advocacy Handbook. 2009; EMRA: 24-28.
Freess, Daniel. "The Shifts Before the "First Shift."" Young Physician Section Newsletter – March 2018. Online. March 22, 2018.
Freess, Daniel. "Want To Get Involved… Start Now." Young Physician Section Newsletter – Winter 2017. Online. Jan 25, 2017.
Freess, Daniel and Suozzi, James. "Images In Emergency Medicine – Traumatic Tension Pneumocephalus." Annals of Emergency Medicine. 2009; 53: 544.
Karfunkle, Benjamin. "Understanding EM's Evolving Workforce, Job Outlook: Q&A with Daniel Freess."

**PERSONAL INTERESTS**

Health Policy
Emergency Medicine Advocacy
Sports and Exercise
Travel
Food and Wine
More Food and Wine

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

## Robert Hancock, DO FACEP

***Question #1:*** **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

As an emergency physician that has practiced in extremely diverse environments, I understand the unique challenges of these different environments and the patient populations they serve. During my career I have worked in inner city trauma centers, suburban hospitals, academic centers, rural hospitals, free-standing emergency departments and served as an EMS medical director for multiple agencies. This has given me insight into the unique challenges encountered in these vastly different environments. For instance, I understand the absolute frustration of attempting to transfer a critical patient from a rural hospital for definitive care while also understanding the frustration of being on the other end of the phone at a tertiary care facility already overwhelmed with incoming patients.

For the past 4 years I have served as the board chair for the Texas Alliance for Patient Access. This is the organization that successfully lobbied for and passed landmark tort reform in Texas in 2003. This experience has given me a unique perspective and expertise in medical liability reform and advocacy. Chairing a board that is comprised of physicians, medical malpractice insurers, hospital systems, medical associations, hospital associations and long-term care associations has taught me how to gain consensus even when there are many competing interests at the table. I have found this ability to find common ground to be a critical skill that I have used in many aspects of my professional career. Additionally, we have worked with other states to help develop a roadmap to passing medical liability reform. This is a unique skillset that I hope to bring to the ACEP Board of Directors.

***Question #2:*** **What is your biggest concern about serving on the Board of Directors?**

As an emergency physician, I am used to identifying a problem and addressing it quickly. Unfortunately, the wheels of advocacy turn slowly and progress is often made in years and not days. My only concern would be the frustration of wanting to effect change more quickly than is practical. Fortunately, many years of advocacy has taught me that the "long game" can be frustrating but the ultimate results are well worth the frustration.

***Question #3:*** **What are the two most pressing issues facing members and how would you address them?**

While ACEP has made progress on many key issues, emergency physicians continue to face many frustrating issues that are only exacerbated by a somewhat chaotic and uncertain political environment. These issues include boarding, fair reimbursement, workplace violence, due process, malpractice litigation, burnout, and many others. While all of these are important for various reasons, boarding and fair reimbursement are the two most pressing issues.

While boarding has been an issue since the beginning of our specialty, it has continued to worsen until it has become a crisis that threatens patient safety and adds unnecessary work and stress to a specialty that already has the highest rate of physician burnout. During the Covid crisis, boarding went from a longstanding dangerous practice to a crisis that compromised patient care and likely resulted in unnecessary morbidity and mortality. As emergency physicians, we quickly adapted and found new and innovative ways to continue to move patients through overwhelmed and saturated emergency departments. Unfortunately, many hospitals saw our innovation as a new solution to an old problem. Rather than working to resolve the root causes of boarding, they began to simply demand that we continue

to do “more with less”. Fortunately, the Covid crisis did bring boarding to the attention of the media and advocacy groups. This momentum has forced some forward progress on the issue. Addressing boarding will undoubtedly improve physician burnout, reduce moral injury, and improve patient outcomes.

ACEP needs to continue to lobby for legislation that directly addresses boarding by developing systems to streamline transfers and direct EMS traffic to less saturated facilities when possible. We can utilize AI to power these systems so bed status and patient volumes can be updated in real time. Additionally, legislation is needed to address the lack of psychiatric facilities which has created a crisis of psychiatric holds languishing in emergency departments for days and weeks. ACEP must continue to work with CMS to re-establish boarding as a quality metric with real world ramifications and offer solutions for poorly performing facilities. Boarding is a complex issue and ACEP must continue to look for new and innovative ways to address a decades old issue.

Fair reimbursement is another long-term issue in emergency medicine which has only worsened in recent years. Recently, the RAND report highlighted the decrease in emergency physician reimbursement from both governmental and commercial insurers. Health insurers have consistently demonstrated bad behavior in denials and underpayment to emergency physicians. This was most noticeable in their manipulation of the “No Surprises Act” to cut reimbursements. Since 2001 Medicare reimbursement to physicians has actually decreased by 33% when adjusted for inflation. None of this is sustainable.

ACEP must continue to fight back against the bad behavior of the health insurers. This can be tackled through the legal system, legislation, and the media. ACEP must continue to lobby Congress to pass legislation to hold the insurers accountable and reinforce the “prudent layperson standard.” Additionally, ACEP must continue to work with Congress to create a permanent reform to the Medicare payment system that is both fair to physicians and sustainable for the future.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Robert Hancock, DO, FACEP

***Contact Information***

6 Heatherstone Court
Trophy Club, TX 76262
***Phone:*** 972-740-0079
***E-Mail:*** robhancock.tcep@gmail.com

***Current and Past Professional Position(s)***

Emergency Physician – Elite Hospital Partners. 2021-Present
Clinical Assistant Professor – Oklahoma State University Center for Health Sciences. 2021-Present
Core Faculty – Comanche County Memorial Hospital Emergency Medicine Residency. 2021-Present
BEST EMS – EMS Medical Director. 2016-Present
Texas Alliance For Patient Access – Board Chair. 2021-Present
Texas Governor's EMS and Trauma Advisory Council – EMS Medical Director Committee. 2019-2021
Baylor Scott & White Grapevine – Emergency Dept Vice Chair and Assistant Medical Director. 2015-2017
Co-Medical Director – Methodist Dallas Medical Center. 2011-2014
Assistant Clinical Professor Dept of Surgery. UT Southwestern Medical Center. 2011-2013

***Education (include internships and residency information)***

UT Southwestern/Parkland Memorial Hospital
Dallas, TX
2004-2007
Chief Resident 2006-2007

Doctor of Osteopathic Medicine - 2004
UNT Health Science Center, Fort Worth, Texas

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

American Board of Emergency Medicine (Initial 2008, Recert 2018)

***Professional Societies***

American College of Emergency Physicians
Texas Medical Association
Texas Alliance for Patient Access

***National ACEP Activities – List your most significant accomplishments***

Council Steering Committee (2023-2025)
Served on ACEP council for over 6 years
ACEP Spokesperson of the Year - 2021

***ACEP Chapter Activities – List your most significant accomplishments***

Texas College of Emergency Physicians – President. 2020-2021

***Practice Profile***

***Total hours devoted to emergency medicine practice per year:*** **1680** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **80** % Research ____ % Teaching **20** % Administration ____ %

Other: _____ ____ %

***Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)***

I currently am an attending physician at a busy rural facility in Lawton, Oklahoma. I am core faculty in the emergency medicine residency program which is affiliated with Oklahoma State University. The facility is staffed by Elite Hospital Partners which is a small physician owned emergency medicine group. I also work part-time at a suburban level 2 trauma center in the Dallas/Fort Worth area.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Core Faculty – Comanche County Memorial Hospital EM Residency
Clinical Assistant Professor – Oklahoma State University

***Expert Witness Experience***

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert 0 Cases** **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Robert Hancock, DO, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Elite Hospital Partners
Address: P.O. Box 201328
Dallas, TX. 75320
Position Held: Emergency Physician
Type of Organization: Physician Owned Emergency Medicine Group

Employer: Integrative Emergency Service
Address: 4835 LBJ Fwy
Dallas, TX 75244
Position Held: Emergency Physician, EMS Medical Director
Type of Organization: Physician Owned Emergency Medicine Group

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Texas Alliance For Patient Access
Address: 6514 McNeil Drive, 2-200
Austin, TX 78729
Type of Organization: Statewide Coalition for Medical Liability Reform
Leadership Position: Board Chair
Term of Service: 2022-Present

Organization: Texas College of Emergency Physicians
Address: P.O. Box 26164
Austin, TX 78755
Type of Organization: State Chapter of ACEP
Leadership Position: President, Board Member, Councilor
Term of Service: 2015-Present

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Robert Hancock, DO, FACEP** Date 05/20/2025

**2025-2026 Board of Directors**

A.J. Kirk, MD, FACEP
*President*

Bryan Dunn, MD, FACEP
*President Elect*

Marcus Sims, II, DO, FACEP
*Treasurer*

Angela Cornelius, MD, FACEP, FAEMS
*Secretary*

Doug Jeffrey, MD, FACEP
*Immediate Past President*

*Directors*
Sara Andrabi, MD, FACEP

Jessica Best, MD, FACEP

Justin Hacnik, MD
(Young Physician Director)

Ryan Johnson, MD
(Candidate/Resident Director)

Ben Leeson, MD, FACEP

Julien Mahler, MD

Michael Parsa, MD, FACEP

Catherine Pivalizza (Medical Student Representative)

J. Robert Rosillo, MD, FACEP

TCEP
TEXAS COLLEGE of EMERGENCY PHYSICIANS

July 15, 2025

Melissa Costello, MD, FACEP
Chair, Nominating Committee; ACEP

Dear Dr. Costello,

On behalf of the Texas College of Emergency Physicians (TCEP), it is with great pride that we offer our strongest endorsement of Robert Hancock, DO, FACEP, for the American College of Emergency Physicians (ACEP) Board of Directors.

Dr. Hancock is a seasoned leader, a respected clinician, and a tireless advocate for emergency medicine. Since joining ACEP in 2000, he has demonstrated an unwavering commitment to our specialty, with a career that spans both rural and urban practice settings and leadership roles at the state and national levels.

As President of TCEP from 2020 to 2021, Dr. Hancock guided our chapter through the most challenging public health crisis of our time. He became a trusted voice for emergency physicians across Texas and beyond – participating in more than 120 media interviews and addressing critical topics such as vaccine education, COVID-19 testing, and combating misinformation. His efforts earned him national recognition and the ACEP Spokesperson of the Year Award in 2021.

Dr. Hancock's contributions extend far beyond his media presence. He currently serves on ACEP's Council Steering Committee and has been an active Councillor since 2018. He is a longtime member of both the Bylaws and Government Relations Commiteees and has played a pivotal role in legislative advocacy. As President of the Texas Alliance for Patient Access (TAPA), he continues to lead efforts to preserve and strengthen tort reform protections critical to emergency medicine in our state..

Dr. Hancock brings deep experience, integrity, and a collaborative spirit to every role he undertakes. His passion for advancing emergency care and supporting the physicians who provide it make him exceptionally well qualified to serve on the ACEP Board of Directors.

We are proud to support Dr. Hancock's candidacy and are confident that he will be a tremendous asset to the ACEP Board and our entire specialty. him our highest endorsement.

Thank you for your consideration. Please feel free to reach out to me or our Executive director, Jill Sutton, at jill@texacep.org, with any questions.

Sincerely,

A.J. Kirk, MD, FACEP
President
Texas College of Emergency Physicians

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.*

# Robert Hancock, DO FACEP

While ACEP has made some great progress over the past year, our organization continues to face significant challenges and headwinds. Our membership numbers have stabilized but there remains significant opportunity for improvement when it comes to increasing membership.

I continue to believe that ACEP needs to remain focused on those issues that impact the vast majority of our membership. These include reimbursement, medical liability, clinical guidelines, due process, ED violence, physician autonomy, boarding and psychiatric holds. While ACEP has made great strides in these areas, there is still work to do. As a proven leader that has been faced with guiding several organizations through difficult times, I feel that I am the right person at the right time to help guide this organization going forward.

One of my primary areas of interest is medical liability reform. As the Board Chair of the Texas Alliance for Patient Access, I lead the organization that successfully passed and protects tort reform in Texas. Over the past 3 years we have been faced with 2 federal lawsuits and multiple Texas Supreme Court cases which sought to undo tort reform in the state. Fortunately, we have won every time and Texas physicians continue to enjoy some of the best tort protection in the country. We are currently working with multiple other states to help them develop a roadmap to tort reform.

I served as the President of the Texas College of Emergency Physicians during the height of the covid pandemic. This was obviously a tense and uncertain time for all emergency physicians and the organization worked to educate physicians and the public to stop the spread of misinformation. During my tenure as President, I performed over 100 media interviews for outlets ranging from CNN to medical journals. My goal was always to educate the public and also alleviate the fear of seeking emergency care when needed. I was subsequently named ACEP Spokesperson of the year for 2021.

I am confident that I have the skills and dedication to help lead ACEP as a member of the Board of Directors. I greatly appreciate the opportunity to run for a leadership position in an organization that has meant so much to me over the years. I appreciate your service to ACEP as a Councillor and look forward to working with you in the future!

Robert J. Hancock, DO FACEP
ACEP Board of Directors Candidate



Background
Baylor University – Undergraduate
UNT Health Science Center – Medical School
Parkland Hospital – Emergency Medicine Residency
Diplomate – American Board of Emergency Medicine

Goals as an ACEP Board Member
Expand and retain members
Advocate for those issues most relevant to the majority of ACEP membership

Leadership

| | |
|---|---|
| Council Steering Committee | 2024-Present |
| ACEP Councillor | 2018-Present |
| Board Chair – Texas Alliance for Patient Access | 2021-Present |
| Texas College of Emergency Physicians – President | 2020-2021 |
| Texas College of Emergency Physicians – Board Member | 2015-2022 |
| ACEP Spokesperson of the Year | 2021 |
| Texas Governor's EMS/Trauma Advisory Committee | 2021-2022 |
| Texas State Board of Medical Examiners – Expert Panelist | 2017-Present |

Clinical Practice
I have practiced in inner city trauma centers, academic medical centers, rural critical access hospitals, free-standing emergency departments, and community emergency departments. I am currently core faculty in an emergency medicine residency program in Lawton, Oklahoma. Additionally, I work part-time in a busy community hospital (Level 2 trauma center) in the Dallas/Fort Worth metroplex; and I currently serve as an EMS Medical Director for 7 Fire/EMS departments and 2 large corporations.

# *Robert Hancock, DO, FACEP*

*robhancock73@att.net*

**MARCH 2025**

## MEDICAL SPECIALTY

Diplomate of the American Board of Emergency Medicine
Fellow of the American College of Emergency Physicians

## PREMEDICAL EDUCATION

1996-2000: Bachelor of Science in Biology
Baylor University, Waco, Texas

## MEDICAL EDUCATION

August 2000 – May 2004: Doctor of Osteopathic Medicine with Honors
University of North Texas Health Science Center, Fort Worth, Texas

## RESIDENCY

June 2004- June 2007: Emergency Medicine
Parkland Hospital, Dallas, Texas

## LEADERSHIP POSITIONS

ACEP Councilor, 2018-Present
Clinical Assistant Professor, Emergency Medicine, Oklahoma State University Center for Health Sciences, Comanche County Emergency Medicine Residency Program, 2021-Present.
Comanche County Emergency Medicine Residency Teacher of the Year, 2021.
ACEP Spokesperson of the Year, 2021
Texas Alliance for Patient Access, Board Chair, 2021-Present
Texas College of Emergency Physicians, President, 2020-2021
Medical Director Committee, Texas Governor's EMS/Trauma Advisory Council, 2020-2022
Interim Medical Director, NWT Medical Center, Amarillo, TX, 2019
Texas College of Emergency Physicians, Board of Directors, 2017-2022
Methodist Dallas Medical Center Emergency Department, Co-Medical Director, March 2010 - October 2013
Assistant Clinical Professor, Department of Surgery, UT Southwestern Medical School, January 2010 – March 2014
Chief Resident, Parkland Hospital, June 2006 – June 2007

**EMS EXPERIENCE**

Euless Fire Department, Medical Director, 2016 - Present
Keller Fire and Rescue, Medical Director, 2016 - Present
Travis County ESD#1, Medical Director, 2016 – Present
Westlake Fire Department, Medical Director, 2018-Present
Roanoke Fire Department, Medical Director, 2018-Present
Trophy Club Fire Department, Medical Director, 2022-Present
Denton County ESD#1 Fire Department, Medical Director, 2023-Present
Fidelity Investments, Westlake Campus Medical Director, 2021-Present
Sabre Corporation, Westlake Campus Medical Director 2021-Present

## HOSPITAL STAFF POSITIONS

Comanche County Memorial Hospital, Lawton, OK, 2019-Present
Northwest Texas Medical Center, Amarillo, TX, 2018-2023
Baylor Scott & White Regional Medical Center - Grapevine, Grapevine, Texas, 2014-Present
Baylor Scott & White Regional Medical Center – McKinney, Mckinney, Texas, 2017-Present
Texoma Medical Center, Denison, Texas, February 2013-2022
John Peter Smith Hospital, Fort Worth, Texas, 2013-2015
Parkland Memorial Hospital, Dallas, Texas, 2010 – 2014
Methodist Dallas Medical Center, Dallas, Texas, 2006 – 2013
Methodist Charlton Medical Center, Dallas, Texas, 2006 – 2013
Methodist Mansfield Medical Center, Dallas, Texas, 2006 – 2013

## PUBLICATIONS

Robert Hancock, DO and Timothy Rupp, MD. "Evaluation and Management of Foot Pain in the Emergency Department". Emergency Medicine Reports. January 21, 2007.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

## Steven B. Kailes, MD, MPH, FACEP

***Question #1:*** **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

I bring a rare and underrepresented combination of frontline clinical insight, deep reimbursement expertise, and tested leadership across military, community, and professional arenas.

As a full-time emergency physician and independent contractor in a physician-led community group, I experience firsthand the challenges our members face daily: clinical overload, staffing instability, and shrinking compensation. Too often, these realities are discussed abstractly. My perspective is grounded in the day-to-day realities of our specialty. I bring a grounded, real-world lens that can help shape policies and advocacy efforts that resonate with practicing emergency physicians.

My reimbursement background equips me to navigate one of the most urgent threats facing our profession: the erosion of fair, sustainable compensation. I've served as Chair of ACEP's Reimbursement Committee and was an inaugural fellow in ACEP's Reimbursement Leadership Development Program. I understand the complex forces that determine how we are paid, and I've helped educate others through small group talks, lectures, and content like EMRA and ACEP's *Practice Essentials of Emergency Medicine*. As we face increasing threats to fair compensation, this expertise is critical to ensuring that emergency physicians continue to be valued and that our practice remains sustainable.

I also bring a distinct leadership style shaped across multiple spheres. I spent nine years as a Navy physician, including service in a combat zone and as a Battalion Surgeon. I've led in crisis, practiced under pressure, and learned to inspire teams in the most demanding environments—skills that translate directly to board-level decision-making and governance. As president of the Florida ACEP (FCEP) chapter during our state's balance billing fight, I led FCEP in uniting the state medical association and other specialty societies to craft and pass physician-friendly legislation—delivering a clear, coordinated message against insurer overreach. Beyond medicine, I've led a multi-million-dollar nonprofit as President of a pre-K–12 school board and served in executive and/or leadership roles in medical societies at the county, state, and national levels. This breadth of leadership and experience allows me to bring both a strategic mindset and operational insight to the Board.

The current Board is filled with outstanding, dedicated individuals, but there are concerns it does not fully reflect the breadth of our membership. With my combination of frontline clinical insight, advanced reimbursement acumen, and tested leadership across a multitude of settings, I can represent the interests of ACEP members. I'm ready to serve—not just to represent, but to advocate, lead, and act. My commitment is to bring a grounded, forward-thinking voice to help ACEP shape a stronger, more sustainable future for emergency medicine.

***Question #2:*** **What is your biggest concern about serving on the Board of Directors?**

Serving on ACEP's Board is a serious commitment—one I've considered carefully. My biggest concern has been whether I could dedicate the time and sustained focus this role demands without compromising other responsibilities.

After thoughtful reflection, I've intentionally restructured my commitments. I've stepped back from other leadership roles, and with the full support of both my family and my physician group, I've created the space to serve with the attention this role deserves. This is the right time in both my life and career to contribute meaningfully at the national level.

ACEP faces several significant challenges, including fiscal constraints, political factors affecting patient care, changes in the healthcare landscape, and the need to reconnect with and expand our physician membership. These aren't abstract issues—they're the real-world pressures I confront every day as a practicing emergency physician. My background in reimbursement, grassroots advocacy, and clinical leadership has prepared me to help ACEP respond with clarity, resolve, and focus.

Rather than deter me, these challenges deepen my motivation to serve. This is a moment that demands clear-eyed, action-oriented leadership. I'm ready—not just to serve, but to lead with purpose, integrity, and the commitment our specialty deserves.

***Question #3:*** **What are the two most pressing issues facing members and how would you address them?**

The two most pressing issues facing emergency physicians are the erosion of physician autonomy and the growing burdens on our specialty without adequate support or resources.

First, the erosion of autonomy. Emergency physicians are being asked to do more with less: less time, support, compensation, and say in how we practice. Decisions that impact care and physician well-being are increasingly made by non-clinicians—administrators, insurers, and regulators. This fuels burnout and disconnection, as we're sidelined from decisions central to patient care.

To address this, ACEP must continue advocating for fair reimbursement, protection of independent practice models, and policies that return clinical decision-making to the bedside. Just as important, we must equip members with the tools to lead in their own institutions and communities—to advocate for themselves, their teams, and their patients.

Second, emergency medicine is increasingly stretched as the safety net for a fractured healthcare system. Patients arrive sicker and with more complex needs—often because they've been denied care or have nowhere else to go. Meanwhile, reimbursement continues to fall. Adjusted for inflation, we earn roughly 33% less than 20 years ago, even as the cost of becoming a physician has soared.

This threatens not just morale—but staffing and sustainability. To meet this moment, ACEP must fight for systemic reforms that improve access to care and reduce administrative burdens that interfere with the physician-patient relationship. This includes addressing insurer denials, down coding, excessive documentation, workplace violence, and ED crowding.

The recent RAND report on sustaining emergency care outlines needed policy changes: funding for unfunded mandates, legal and physical protections for our workforce, social support resources, and fairer insurer reimbursement.

These are solvable challenges—but they require bold, informed action. I bring deep experience in reimbursement, advocacy, and leadership. I believe ACEP must go on offense: challenging harmful payer behavior, defending physician-led care, and opposing inappropriate expansions of non-physician independent practice. We must also ensure physicians have the tools to sustain their careers and well-being.

ACEP must lead with clarity and urgency. I'm ready to help guide that work—amplifying our members' voices and fighting to keep our specialty strong.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Steven B. Kailes, MD, MPH, FACEP

***Contact Information***

3780 Waterside Drive
Orange Park, FL 32073

***Phone:*** 904-254-0613
***E-Mail:*** skailes@gmail.com

***Current and Past Professional Position(s)***

Emergency medicine physician, Emergency Resources Group (ERG), Jacksonville, FL – 2013 - present
Director, Governmental Relations, ERG. 2023 - present
Director of Quality, ERG – 2017 - 2022
Medical Director, Camden Campus, ERG – 2017 - 2018
Emergency medicine physician, Titan Emergency Group, 2007 - 2013
Board of Directors, 2010-2013
Vice-Chair, Dept. of EM, Orange Park Medical Center, Titan Emergency Group, 2013
Emergency medicine physician, US Naval Hospital, Jacksonville, FL, 2004 - 2007
Battalion Surgeon, 2/4, 1st Marine Division, USMC, Camp Pendleton, CA, 1999 - 2001

***Education (include internships and residency information)***

Emergency Medicine residency, Naval Medical Center, San Diego, CA, 2001 - 2004
Basic Surgery internship, Naval Medical Center, San Diego, CA, 1998 - 1999

MD, Tufts University School of Medicine, 1998
MPH, Tufts University School of Medicine, 1998

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

ABEM. Certified 2005, Recertified 2015. Will recertify in 2025

***Professional Societies***

ACEP – American College of Emergency Physicians, 2006 - present
ACEP Council, 2008 - present
FCEP – Florida College of Emergency Physicians, 2006 - present
Past-President, Florida College of Emergency Physicians – 2015 - 2016
AAEM - American Academy of Emergency Physicians, 2005 - present
AMA – American Medical Association, 2012 - present
FMA – Florida Medical Association, 2008 - present
FMA House of Delegates, 2016 - present
DCMS – Duval County Medical Society, 2017 - present
Past President, Duval County Medical Society – 2022 - 2023

***National ACEP Activities – List your most significant accomplishments***

Fellow, Reimbursement and Leadership Development Program – 2019 - 2020
Member, State Legislative & Regulatory Committee, 2015 - present
Member, Reimbursement Committee, 2017 - present
Past-Chair, ACEP Reimbursement Committee – 2021 – 2023

Member, Clinical Resource Review Committee, 2021 - 2023
Member, Council Steering Committee, 2020 - 2022
Member, National Chapter Relations Committee, 2023 - present
Member, ACEP-EDPMA Joint Task Force on Balance Billing, 2016 – 2019

Leadership and Advocacy Conference attendee, 2010 – present
Presenter, "State strategies to deal with Out of Network/Balance Billing," 2016
Presenter, "How ACEP Can Be a Resource and Help Facilitate State Needs in Their Advocacy Efforts?" 2024
Presenter, "best Practices for Building Future Advocacy Leaders," 2025
Councillor, FCEP, 2008 – present
Fellow, ACEP, 2007 - present

***ACEP Chapter Activities – List your most significant accomplishments***

FCEP Past-President, 2015 – 2016
FCEP Governmental Affairs Committee, 2006 – present
Past chair, 2011 – 2014
FCEP Medical Economics Committee, 2006 – present
FCEP Councilor to ACEP Council, 2008 - present

***Practice Profile***
***Total hours devoted to emergency medicine practice per year:*** **1400** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **90** % Research **0** % Teaching **0** % Administration **10** %
Other: _____ ____%

***Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.***
***)***
Independent contractor (1099) for clinical/patient care. Employed (W-2) for administrative duties working for Emergency Resources Group (ERG), a multi-hospital group located primarily in the Jacksonville, FL, area.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Director, Governmental Relations. Former Director of Quality and former medical director at our Camden Campus

***Expert Witness Experience***
*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert** **0 Cases** **Plaintiff Expert** **0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Steven B. Kailes, MD, MPH, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Emergency Resources Group

Address: 841 Prudential Dr., #1400

Jacksonville, FL 32207

Position Held: Staff physician, Director of Quality (former), Director of Government Relations

Type of Organization: Emergency medicine staffing group

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: ACEP

Address: 1125 Executive Circle

Irving, TX 75038

Type of Organization: National medical specialty organization

Leadership Position: Chair, Reimbursement Committee

Term of Service: 2021 - 2023

Organization: Florida College of Emergency Physicians

Address: 400 N. Wymore

Winter Park, Fl 32789

Type of Organization: State Medical specialty organization

Leadership Position: President

Term of Service: 2015 -2016

Organization: Duval County Medical Society

Address: 555 Bishopgate Lane

Jacksonville, FL 32204

Type of Organization: Local Medical specialty organization

Leadership Position: President

Term of Service: 2022 - 2023

Organization: St. Johns Board of Trustees

Address: 3100 Doctors Lake Drive

Orange Park, FL 32073

Type of Organization: Independent private day school, grades pre-K3 through 12

Leadership Position: President

Term of Service: 2013 - 2015

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☒ If YES, Please Describe: My spouse is a pediatric dentist and has a private practice

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ N/A
☒ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Steven B. Kailes, MD, MPH, FACEP** Date 05/16/2025

FCEP | Florida College of Emergency Physicians

*A CHAPTER OF THE*
**AMERICAN COLLEGE OF EMERGENCY PHYSICIANS**
**400 N Wymore Rd • Winter Park, FL 32789**
**(407) 281-7396 • FAX (407) 281-4407**
**www.fcep.org**

**Officers:**

Todd Slesinger, MD, FACEP, FCCM
President

Saundra Jackson, MD, FACEP
President-Elect

Blake Buchanan, MD
Vice-President

Shayne Gue, MD
Secretary-Treasurer

Jordan Celeste, MD, FACEP
Immediate Past President

Melissa Keahey
Executive Director and CEO

**Board of Directors:**

Rajiv Bahl, MD, MBA, MS, FACEP
Tom Bentley, MD, FACEP
Ricki Brown, MD
Blake Buchanan, MD, FACEP
Latha Ganti, MD, FACEP
Kyle Gerakopoulos, MD, MBA, FACEP
Jesse Glueck, MD
Eliot Goldner, MD, FACEP
Shayne Gue, MD, FACEP, FAAEM
Sara Kirby, MD
David Lebowitz, MD, FACEP
Brandy Milstead – Hollingsworth, MD
Diana Mora-Montero, MD, FACEP
Jeremy Selley, DO, FACOEP
Zach Terwilliger, MD
Michael Thompson, MD
Josef Thundiyil, MD, MPH, FACEP
Christine Van Dillen, MD, FACEP
Cristina Zeretzke-Bien, MD, FAAP,

## FCEP Proudly Endorses Steven Kailes, MD, MPH, FACEP, FAAEM for ACEP Board of Directors

The Florida College of Emergency Physicians (FCEP) is proud to endorse our esteemed colleague, **Steven Kailes, MD, MPH, FACEP, FAAEM**, as a candidate for the national ACEP Board of Directors. Dr. Kailes has been an engaged and dedicated member of both ACEP and FCEP for 19 years, consistently demonstrating exceptional leadership, advocacy, and commitment to advancing emergency medicine.

At the state level, Dr. Kailes has left a lasting mark. He has served in every officer position, in addition to committee leadership positions, within FCEP where his leadership has elevated the chapter's impact and reputation. Dr. Kailes has been a tireless advocate for emergency physicians and their patients, playing a central role in advancing critical issues such as balanced billing, fair reimbursement, dispute resolution, and transparency in patient-provider relationships. His commitment is especially evident through his longstanding participation in FCEP's annual EM Days at the Florida Capitol, where he regularly provides expert testimony and builds meaningful relationships with policymakers.

Beyond policy leadership, Dr. Kailes has been an invaluable mentor and supporter of FCEP chapter executives, helping to foster leadership development and strengthen the chapter's operational excellence. His steady guidance has strengthened organized medicine at both the state and national levels.

On the national stage, Dr. Kailes has proven his dedication to ACEP over nearly two decades. A Fellow of the American College of Emergency Physicians (FACEP) since 2007, he has represented Florida on the ACEP Council for 17 years. His national leadership includes service on key committees such as the National Chapter Relations, Reimbursement, and State Legislative/Regulatory Committees. As a member of ACEP's inaugural Reimbursement Leadership Development Program (RLDP), Dr. Kailes deepened his expertise in emergency medicine reimbursement and emerged as a trusted leader in this highly complex space. He went on to chair the ACEP Reimbursement Committee and has contributed his talents to numerous national task forces and working groups.

Dr. Kailes' professional experience further underscores his exceptional qualifications. As Director of Government Relations, he has successfully navigated complex regulatory, legislative, and reimbursement landscapes. As a Navy Reserve officer, he deployed during Operation Iraqi Freedom, delivering emergency and trauma care to coalition forces, civilians, and enemy combatants. His outstanding service has been recognized with multiple military honors and civilian awards, including being named the 2021 Baptist Medical Center Physician of the Year.

Dr. Kailes also maintains active involvement in several professional associations and medical societies, including serving in every officer role within the Duval County Medical Society. He has published articles in local, state, and national publications and served on the boards of numerous community and professional organizations.

Dr. Kailes approaches this candidacy with unwavering enthusiasm, dedication, and vision. He seeks to build upon his extensive record of service, introduce innovative ideas, and collaborate with ACEP leadership to shape the future of emergency medicine. His reputation for thoughtful, respectful dialogue and his integrity in addressing complex challenges position him as an exceptional candidate for the ACEP Board.

Above all, Dr. Kailes is known for his compassion, humility, and commitment to service. He is a devoted father, husband, physician, veteran, and leader—qualities that define his approach to both medicine and professional service.

FCEP is honored to support **Steven Kailes, MD, MPH, FACEP, FAAEM**, knowing he will bring valuable expertise and thoughtful leadership to the ACEP Board of Directors.

# Steven B. Kailes, MD, MPH, FACEP

I'm a full-time, frontline emergency physician with deep expertise in reimbursement and a proven leadership record across military, community, and professional settings. I bring a grounded, forward-thinking perspective and a resolute commitment to strengthening our specialty.

I've chaired ACEP's Reimbursement Committee, helped lead the Florida College of Emergency Physicians (FCEP) through legislative victories during the state's balance billing fight, and served in key roles at the county, state, and national levels. I was selected as an inaugural fellow of ACEP's Reimbursement Leadership Development Program and continue to help educate others through programs like EMRA and ACEP's *Practice Essentials of Emergency Medicine*. I've practiced in academic and community settings and served in the U.S. Navy, including deployments with the Marine Corps. These experiences have shaped my leadership style – practical, mission-driven, and deeply connected to the realities physicians face every day.

My clinical work keeps me grounded. As a full-time emergency physician in a physician-led group, I experience firsthand the growing strain on our specialty: shrinking resources, increasing administrative burdens, and compensation that has not kept up with the demands placed on us. Payers and policymakers too often make decisions without input from those providing care, and our autonomy continues to erode.

That's why I'm running for the ACEP Board. Our members need representation that isn't abstract or theoretical—but rooted in real-world challenges and solutions. We need leadership that will not just respond to crises, but anticipate and act with clarity, speed, and purpose.

My top priorities are clear:

- **Strengthen our advocacy at every level**—from the bedside to Capitol Hill. We must sharpen our message, mobilize our members, and hold policymakers and payers accountable.
- **Reclaim physician autonomy** by pushing back on non-clinical interference, administrative overload, and inappropriate expansion of non-physician independent practice.
- **Ensure emergency physicians are equipped**—with the tools, protections, support, and fair compensation we need to do our jobs and care for our patients.

This is a defining moment for emergency medicine. The goodwill earned during the pandemic has not translated into lasting support or relief. Instead, we continue to face declining reimbursement, increasing expectations, and burnout at every level. These challenges are solvable, but they demand bold, informed leadership and a unified front.

ACEP must go on offense with urgency, unity, and clarity. That means challenging payer behavior that undermines care, advocating for sustainable funding models, and restoring the central role of physicians in decision-making. It also means empowering our members to lead in their own institutions and communities because real change doesn't just happen in Washington. Real change happens wherever physicians raise their voices.

I've spent my career fighting for emergency physicians through legislation, advocacy, education, and leadership. I'm ready to bring that experience, energy, and resolve to ACEP's Board of Directors. I'm running to serve—not just to represent, but to act.

I'm Steve Kailes and I ask for your support – and your partnership – as we fight for a stronger future for our specialty.

# Steven Kailes

## MD, MPH, FACEP, FAAEM

## Candidate for ACEP Board of Directors



- Past-president, Florida College of Emergency Physicians (FCEP) – led FCEP as we united the state medical association and other specialty societies in crafting physician friendly legislation for state balance billing ban
- Past-President Duval County Medical Society
- ACEP past-Chair Reimbursement Committee
- ACEP inaugural fellow Reimbursement Leadership Development Program
- Member of following ACEP committees: National Chapter Relations Committee, State Legislative and Regulatory Committee, Reimbursement Committee
- Past member of ACEP-EDPMA Joint Task Force on Balance Billing, ACEP Council Steering Committee, and ACEP Clinical Resource Review Committee
- ACEP Councillor for FCEP since 2008
- Past-president Board of Trustees for St. Johns Country Day School
- Nine years of service with US Navy. Deployed with USMC to Iraq in 2005 and to Okinawa in 2000
- Past experience as vice-chair of a level II trauma ED and other site ED medical director

**I'm a full-time frontline emergency physician with deep expertise in reimbursement and a proven leadership record across military, community, and professional settings. I bring a grounded, forward-looking perspective and a steadfast commitment to serving our specialty.**

**My top priorities are clear: strengthen our advocacy, reclaim physician autonomy, and ensure we are equipped—with tools, support, and fair compensation—to deliver the care our patients need and deserve.**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Steven B. Kailes

## MD, MPH, FACEP, FAAEM

3780 Waterside Dr., Orange Park, FL, 32073
(904) 254-0613 skailes@gmail.com

*I am an emergency physician conscientiously providing care for my patients. I am determined to offer compassionate, dignified and quality care to my patients. I strive to improve the lives in my community through advocacy and engagement, while bringing substance to discussions and respect of differing opinions. I am a devoted father, husband, and a veteran.*

## *EDUCATION and TRAINING*

*2001 – 2004* **Naval Medical Center, San Diego, CA**
Residency in Emergency Medicine

*1998 – 1999* **Naval Medical Center, San Diego, CA**
Internship in Basic Surgery

*1994 – 1998* **Tufts University School of Medicine, Boston, MA**
Doctor of Medicine

*1994 – 1998* **Tufts University School of Medicine, Boston, MA**
Masters in Public Health

*1991 - 1993* **University of California, Los Angeles, CA**
Bachelor of Science, Physiological Science, cum laude

*1988 – 1991* **Modesto Junior College, Modesto, CA**
Associate of Science, Physical Sciences and Mathematics, with honors

## *LICENSURE and SPECIALTY CERTIFICATION*

*2017* **State of Georgia**
Unrestricted Physician License #77284, Expires May 31, 2026

*2013* **State of North Carolina**
Retired Volunteer License #2013-0220, Expires May 24, 2025

*2005* **American Board of Emergency Medicine**
Diplomate of the American Board of Emergency Medicine. Recertification expires December 31, 2025. Certificate number 35497

*2004* **State of Florida**
Unrestricted Medical Doctor License #ME 91282. Expires January 31, 2027

*2000* **State of California**
Retired - Physicians and Surgeons License #A71665. Expires May 31, 2025

## *WORK HISTORY and MILITARY ASSIGNMENTS*

*2013 - now* **Emergency Resources Group**, an independent practice with contracts at the Baptist Medical Center hospitals, Jacksonville, FL, area, Flagler Hospital in St. Augustine, FL, and Southeast Georgia Health System with campuses in Brunswick and St. Marys, GA, and Lakeland Regional Medical Center, Lakeland, FL

**Emergency Department Medical Director and Chief of Emergency Medicine** - Southeast Georgia Health System, Camden Campus,
*February 2017 - September 2018*

**Director of Government Relations and (former) Director of Quality**, in charge of helping steer us through CMS' MACRA and MIPS requirements, keeping abreast of legislative and regulatory issues and improving our evidenced-based clinical quality and documentation quality to maximize our revenue opportunities.
*March 2017 - now*

*2014* **Independent Contractor** - CMP Staffing
- Services at Cape Fear Valley Medical Center. Fayetteville, NC

*2007- 2013* **Staff Physician, Titan Emergency Group, Jacksonville, FL**

- Emergency Medicine Physician with medical staff appointments at multiple contracted medical facilities, including:
  - Memorial Hospital, Jacksonville, FL
  - Orange Park Medical Center, Orange Park, FL
    - Vice Chairman, *2013*
  - Capital Regional Medical Center, Tallahassee, FL
  - Putnam Community Medical Center, Palatka, FL
  - Gadsen County Medical Center, Quincy, FL
  - West Florida Hospital, Pensacola, FL

*2004 - 2007* **Staff Physician, Emergency Department, Naval Hospital, Naval Air Station, Jacksonville, FL**

- Graduate Medical Education Committee and Medical Student Rotation Coordinator for the Emergency Department
- Deployment in support of Operation Iraqi Freedom 04-06.2, Assigned to Combat Logistics Battalion 2, 2nd MLG, II MEF, providing emergency medical and trauma support services for coalition forces, enemy combatants and civilians in Al Anbar Province, Iraq, *2005 - 2006*
- Resigned USN Commission with Honorable Discharge from Active Duty Service, September 2007

*2004* **Lieutenant Commander, Medical Corps, US Navy Reserves**

*2001 – 2004* **Resident, Emergency Medicine, Naval Medical Center, San Diego, CA**

*1999 - 2001* **Battalion Surgeon, 2nd Battalion, 4th Marines, 5th Marine Regiment, 1st Marine Division, Camp Pendleton, CA**

- Officer-in-charge, Medical Section, Headquarters Company. Responsible for supervision and training of over thirty hospital corpsmen, and for providing the primary medical and emergency care services for over 1,000 US Navy and Marine Corps personnel

- Deployment with **Battalion Landing Team Surgeon, BLT 2/4, 31st Marine Expeditionary Unit**, Okinawa, Japan, July 2000 – January 2001

*1999* **Field Medical School, Fleet Marine Force, Camp Pendleton, CA**

*1998 – 1999* **Intern, Basic Surgery, Naval Medical Center, San Diego, CA**

*1998 - 2004* **Lieutenant, Medical Corps, United States Navy Reserves**

*1994 – 1998* **Ensign, Medical Corps, United States Navy Reserves, Armed Forces Health Professions Scholarship Program**

## *PROFESSIONAL ORGANIZATIONS*

*2016 - now* **Duval County Medical Society**, Member
Board of Directors, *2017 - now*
- Immediate Past-President*, 2023 - 2024*
- President, *2022-2023*
- President-Elect, *2021 - 2022*
- Vice President, *2019 - 2021*

*2014 - now* **American Medical Association**, Member

*2011 - now* **Florida Medical Association**, Member
Delegate for Duval County Medical Society, *2017 - now*
Delegate for Florida College of Emergency Physicians, *2016*

*2006 - now* **Florida Chapter of the American College of Emergency Physicians (FCEP),** Member
Board of Directors, *2010 - 2017*
- Immediate Past-President, *2016 - 2017*
- President, *2015 - 2016*
- President-Elect, *2014 - 2015*
- Vice-President, *2013 - 2014*
- Secretary-Treasurer, *2012 - 2013*
- Chairman, Governmental Affairs Committee, *2011 - 2014*

*2006 - now* **American College of Emergency Physicians (ACEP)**, Member
- Fellow, *2007 - now*
- Member, National Chapter Relations Committee, *2023 - now*
- Member, Steering Committee, *2020 - 2022*
- Member, Reimbursement Committee, *2017 - now*
  - Chair, *2021 - 2023*
- Member, Clinical Resource Review Committee, *2021 - 2023*
- Reimbursement Leadership Development Program fellow, *2018 - 2020*
- Member, State Legislative & Regulatory Committee, *2015 - now*
- Member, ACEP/EDPMA Joint Task Force, *2016 - 2019*
- Councillor, representing FCEP, *2008 - now*

*2008 - now* **Board of Trustees, St. Johns Country Day School** – Pre-K3 through 12th grade college preparatory school located in Orange Park, FL
- Trustee Emeritus, *2016 - 2023*
- President, *2013 - 2015*
- Vice-President, *2011 - 2013*

*2010* **Titan Emergency Group**
Board of Directors, *2010*
Member, Growth and Marketing Committee*, 2010 - 2011*

*2010 - 2012* **Southeast Practice Management,** a billing and coding company
- Member, Board of Directors

*2005 - now* **American Academy of Emergency Medicine (AAEM)**
- Fellow, *2005 - now*

## *RESEARCH and PUBLICATIONS*

*2023* **Rahman N, Cain A, Premrajan G, Sharma V, Smiley A. Reimbursement Module, In: Stark N, Cozzi N, Pasichow S, ed. ACEP & EMRA Practice Essentials of Emergency Medicine. ACEP Online Learning Center;** Module Editors Kailes S, Maurer L, McKenzie D, Shoemaker J. October 2023. https://ecme.acep.org/.

*2011 - 2016* ***EMpulse*****,** contributing author for the quarterly news magazine for members of the Florida College of Emergency Physicians (FCEP)

*2015* Kailes SB, Gutierrez MA, **"Chapter 12: Hematologic and Immune System Disorders**." ***Emergency Medicine: A Focused Review of the Core Curriculum, 2nd Edition.*** Editors Schofer JM, Mattu A, Kessler C, Lu LN, Parker T, Rogers R, Lex JR, Bottoni T, and farad A. Milwaukee: American Academy of Emergency Medicine Resident and Student Association, 2015. 377-412.

*2008* Kailes SB, Costello T, Mossallam U, **"Chapter 11: Hematologic/ Oncologic and Immune System Disorders**." ***Emergency Medicine: A Focused Review of the Core Curriculum.*** Ed. Schofer JM, Mattu A, Coletti JE, Gray EA, Rogers RL, and Shih RD. Milwaukee: American Academy of Emergency Medicine Resident and Student Association, 2008. 301-335.

*2007* **"Pneumococcal bacteremia in febrile infants presenting to the Emergency Department before and after the introduction of the heptavalent pneumococcal vaccine."** Carstairs KL, Tanen DA, Johnson AS, Kailes SB, Riffenburgh RH. *Annals of Emergency Medicine*, Volume 49, Number 6, June 2007, pages 772-777

*2004* **"Bacteremia in febrile infants presenting to the ED after the introduction of heptavalent pneumococcal vaccine."** Carstairs KL, Tanen DA, Kailes SB, Riffenburgh RH, Danish DC, Johnson AS. *Academic Emergency Medicine* Volume 11, Number 5, May 2004, page 596, abstract

- Society for Academic Emergency Medicine Annual Meeting, Orlando, FL, May 2004, poster presentation

*2001 & 1998* **"Arthroscopic vs. Open Bankart Reconstruction: A Comparison using Expected Value Decision Analysis."** Kailes SB, Richmond JC. *Knee, Surgery, Sports, Traumatology, Arthroscopy* Volume 9, Issue 6, November 2001, pages 379-385

- Steven B. Kailes, B.S., and John C. Richmond, M.D., Arthroscopy Association of North America's 1998 Annual Meeting, Orlando, FL, April 29 – May 02, 1998, abstract

## *PRESENTATIONS*

*2024* **ACEP Leadership & Advocacy Conference 2024.** How ACEP Can Be a Resource and Help Facilitate State Needs in Their Advocacy Efforts? Round Table Discussion Moderator. Washington, DC, April 2024.

*2023* **Healthcare Symposium 2023.** Brooks College of Health at the University of North Florida and Duval County Medical Society. Panel discussion: The role of organized medicine in population health. Panel Discussion: The next generation of leaders. Jacksonville, FL, October 2023.

*2022* **Florida College of Emergency Physicians Symposium by the Sea, 2022.** General Session panel: Identifying, recruiting and retaining future leaders. Presented by Drs. N. Cozzi, S. Kailes, and J. Shoemaker. Bonita Springs, FL, August 2022.

*2021* **Emergency Department Practice Management Association Solutions Summit, 2021. Beyond Resilence: Restoring Order In A Post-Pandemic World.** General Session panel: Identifying, recruiting and retaining next years' advocacy stars: Tips for building your bench at the State and National level. Presented by Drs. S. Good, B. Graham, S. Kailes, L. Mauer, and J. Shoemaker. Ft. Worth, TX, September 2021.

*2021* **Emergency Medicine Reimbursement & Innovation Summit, 2021**. Panel discussion moderator for "Payer Shifts," virtual summit on February 25, 2021.

*2020* **Insurance Summit 2020,** December 2020. Profits vs. Payments: Why physicians need a working venue to challenge underpayment by out-of-network insurers. Virtual summit presented on behalf of FCEP/EMLRC in cooperation with the Florida Orthopedic Society, Florida Society of Rheumatology, Duval County Medical Society, et al.

*2020* **Emergency Medicine Reimbursement & Innovation Summit,** February 2020. Panel discussion moderator for Legs & Regs. Orlando, FL.

*2017* **Emergency Medicine Payment Reform Summit: Action Plans for Federal and State Regulations**, February 2017. Panel discussion moderator for Telemedicine and EMS Innovations, Orlando, FL

*2016* **Georgia College of Emergency Physicians Leadership and Medical Director's Forum**, December 2016, Presenter, "Fair Coverage: The Florida Experience, " Lake Oconee, Greensboro, GA

*2016* **ACEP Leadership & Advocacy Conference,** May 2016. Presenter, "State Strategies to Deal with Out of Network/Balance Billing," Washington, DC

*2015* **Florida College of Emergency Physicians Town Hall Forum: Florida and EM Healthcare -** Moderator, Symposium by the Sea 2015, Amelia Island, FL

*2015* **Emergency Department Practice Management Association Solutions Summit XVIII -** Martin Gottlieb & Associates luncheon speaker presentation regarding Healthcare Issues in Florida. Amelia Island, FL.

*2011 - now* **Legislative updates -** Florida College of Emergency Physicians, *EM Pulse* quarterly magazine article contributions and Governmental Affairs Committee meetings

*2007* **"Ultrasound Basics for the Emergency Department"** Southeast Emergency Consultants continuing education lecture series, May 2007

*2004* **"Shock"** NMCSD Emergency Medicine Residency Program, February 2004

*2003* **"Colchicine Toxicity – Case Presentation"** NMCSD Emergency Medicine Residency Program, July 01, 2003

*2003* **Morbidity and Mortality Presentation**, including topics on Posterior Shoulder Dislocation, Conscious Sedation, and a literature review of the efficacy for non-contrast head CT scans in the minor head injury patient on Warfarin anticoagulation. NMCSD Emergency Medicine Residency Program, November 4, 2003

*2003* **"Hypoglycemia"** NMCSD Emergency Medicine Residency Program, January 2003

*2002* **"Sickle Cell Anemia"** NMCSD Emergency Medicine Residency Program, October 2002

*2002* **"Genitourinary Trauma"** NMCSD Emergency Medicine Residency Program, June 2002

*2002* **"Phlegmasia cerulea dolens- Photographic Case Presentation"** Society for Academic Emergency Medicine Annual Meeting, St. Louis, MO, May 2002

*2002* **"Amphetamines – Case Presentation"** NMCSD Emergency Medicine Residency Program, January 2002

*2002* **"Low Back Pain"** NMCSD Emergency Medicine Residency Program, January 2002

*1998 & 1999* **"Arthroscopic versus Open Bankart Reconstruction: A Comparison Using Expected Value Decision Analysis"**

- A comparison of two treatment alternatives for model patients using literature and experience derived probabilities. Arthroscopy Association of North America's 1998 Annual Meeting, Orlando, FL, April 29 – May 02, 1998
- American Academy of Orthopaedic Surgeons Annual Meeting, February 04-08, 1999

*1998* **"Peyronie's Disease"** NMCSD Urology Residency Program, December 1998.

*1997* **"Osteochondromas"** Tufts University Orthopaedic Residency Program, October 1997

*1997* **"Tufts-New England Medical Center Work-site Fitness Center"**
Feasibility study of a public health project for Health Promotion and Disease Prevention Course, TUSM MD/MPH Combined Degree Program

*1996* **"An Update on Renal Transplantation"**
Surgical Grand Rounds, Newton-Wellesley Hospital, September 1996

*1995* **"Asbestosis Awareness Program for Former Quincy Shipyard Workers"**
Created an awareness and screening program for Occupational and Environmental Health Course, TUSM MD/MPH Combined Degree Program

*1994* **"Teenage Pregnancy Prevention Program for Mattapan, Massachusetts"**
Developed a public health program for a Boston community, Introduction to Public Health Course, TUSM MD/MPH Combined Degree Program

## *HONORS and AWARDS*

*2022* **Physician Quality Champion of the Month**, *May 2022,* Baptist Medical Center, South, Jacksonville, FL

*2021* **Physician of the Year**, Baptist Medical Center, Clay Campus, Spirit of Magnet Awards

*1995 - 2007* **Military Awards**
Fleet Marine Force (FMF) Warfare Officer Qualification, Navy and Marine Corps Commendation Medal, Iraq Campaign Medal with the FMF Combat Operations Insignia, Global War on Terrorism Service Medal (2nd award), Fleet Marine Force Ribbon, National Defense Medal (2nd award), Sea Service Deployment Ribbon (2nd award), Expert Pistol Marksman Medal

*1998* **Commencement Committee Award**, **Tufts University School of Medicine (TUSM),** "Awarded to the student who has contributed the most to the medical school"

*1994 - 1998* **President, TUSM Class of 1998**, Years I – IV
**President, TUSM Student Council,** Years III- IV
**Executive Council Member, TUSM,** Years III- IV
**Medical School Representative, Trustees of Tufts College**, Years I – III

*1996 -1997* **Clinical Honors, TUSM** -- Emergency Medicine, Obstetrics/Gynecology, Adult Orthopaedics

*1995 - 1997* **Preclinical Honors, TUSM -** Neuroscience, Surgical Anatomy

*1993* **Cum Laude**, academic honors upon graduation from UCLA

*1988 - 1991* **Dean's Honor List**, Modesto Junior College

## *HOBBIES*

Spending time with my family

Golf, exercise, boating, and reading non-fiction

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

## Kristen B. McCabe-Kline, MD, FACEP

***Question #1:*** **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

I bring the background of an EM physician and leader who converted my community to having EM board certified physicians in all of our EDs. I have experience as a Hospice Medical Director and currently serve as a subspecialty board certified EMS Medical Director in my community providing line of sight across the continuum of care. I have a current role as Chief Medical Information Officer overseeing Growth and Acquisitions enterprise wide and CMIO for the East Florida Division for the health system that I have been affiliated with for nearly 20 years. EM physicians being at the table to provide input with regard to health care infrastructure, electronic health record evidence-based medicine best practices, and influencing leaders of other specialties is critical for EM to continue to lead in the improvement of health care provided in our communities as well as improving the working conditions for all EM physicians.

The knowledge I have gained having served on the ACEP BOD over the last three years has given me a deeper understanding of the issues we face and the strategic approach we are taking to address these issues with historical context. There are many projects that exceed a single BOD term as they require ongoing work. The importance of previous service on the BOD and opportunity to further contribute to ACEP's work cannot be overstated. Exposure to differing points of view, complex political landscapes, and effective methodologies for effective navigation in these spaces have been essential aspects of my learnings thus far.

***Question #2:*** **What is your biggest concern about serving on the Board of Directors?**

My biggest concern about serving on the BOD is ensuring we are focusing on the onboarding of the new Executive Director and CFO in a manner that sets us up for success. The onboarding will be occurring simultaneously with other work that is being done so it is imperative that it is not marginalized. There is no question that the Search Committee and BOD are working together closely to clearly outline governance, expectations, and the importance of our culture as an organization. Nevertheless, we will need to be very mindful and diligent as we work through this time of change for ACEP.

***Question #3:*** **What are the two most pressing issues facing members and how would you address them?**

I think the two most pressing issues facing our members are a sense of powerlessness and isolation.

Over the last decade, we have seen many changes in the healthcare landscape which have resulted in consolidation, employer/contract transitions, altered working conditions, and changes in reimbursement. Many EM physicians feel reduced to pieces on a chess board that are moved about without control or autonomy and given the respect of a widget maker or RVU producer. Continuing to provide our members with employer transparency in a forward-facing manner is a key task that we are focused on. Every EM physician deserves to know what options they have and consider what employer would give them the opportunity to do their best work based on their individual goals. One of the most profound undertakings of ACEP has been the launch of the ED Accreditation Program which will also help to improve transparency while simultaneously pressing health systems to improve the infrastructure EM physicians depend upon to provide exceptional care to our patients. In order for EM to attract the best and the brightest and ensure that EM boarded physicians are encouraged to work in all areas of our country, reimbursement will continue to be a strong focus for ACEP with advocacy efforts.

As our specialty evolves, many practice environments are changing with EM physicians not always feeling supported. The pandemic also contributed to isolation, sometimes even from our families. There are a variety of other issues that contribute to isolation such as difficult cases with poor outcomes and the polarization of attitudes or mindsets when confronted with differing opinions. Working to ensure that every member has a voice, an opportunity to connect with other members that have similar interests or needs and feels supported by ACEP is a key priority. There are far more components of our shared experience that unite us than divide us which should be highlighted, celebrated, and part of the infrastructure we provide for our members.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Kristin B. McCabe-Kline, MD, FACEP

***Contact Information***

91 Island Estates Parkway
Palm Coast, FL
32137

***Mobile Phone:*** (386) 283-2326
***E-Mail:*** kmccabemd@gmail.com

***Current(*) and Past Professional Position(s)***

*VP/Chief Medical Information Officer, AdventHealth Corporate Growth and Acquisitions
*VP/Chief Medical Information Officer, Adventhealth East Florida Division
*EMS Medical Director, Flagler County/City of Palm Coast/City of Flagler Beach
*Chief Medical Officer, WaterSafe
*Medical Director, Flagler Technical College EMT Training Program
*Medical Director, AllCare Medical Transport
VP/Chief Medical Information Officer, AdventHealth Central Florida Division
Vice President/Regional Operations Coordinator/Shareholder, Emergency Medicine Professionals
Regional Market Medical Director, AdventHealth Central Florida Division North Region
Chief of Staff, AdventHealth Palm Coast
Interim Department of Medicine Chair, AdventHealth Palm Coast
Medical Director, AdventHealth Palm Coast
Medical Director, AdventHealth New Smyrna Beach
Medical Director, 2010-2014, Stroke Program, Bert Fish Medical Center
Medical Director, Stuart F. Meyer Hospice House
Associate Medical Director, Greenville Health System Behavioral Annex (Psychiatric Hold Unit)
Shareholder, Carolina Emergency Medicine Physicians Association

***Education (include internships and residency information)***

Advocate Christ Medical Center Emergency Medicine Residency Program
Program Director: Robert Harwood, M.D.
Oak Lawn, Illinois, June 2002 – June 2005

M.D. University of Texas Medical School, San Antonio, Texas, 1998-2002
*Top 20% of Graduating Class*

B.A. Rice University, Houston, Texas, 1994-96 (Major: English)
*Rice University President's Honor Roll*

University of Michigan, Ann Arbor, Michigan, 1992-94, 1996
*University of Michigan Class Honors*

Harvard University, Cambridge, Massachusetts, Summer 1993

***Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

ABEM Subspecialty Certified in EMS 2021
ABEM Specialty Certified in 2007 and recertified in 2017

***Professional Societies***

ACEP
FCEP
FAEMSMD
AMA
FMA
AAEM
ACHT
ACHE

***National ACEP Activities – List your most significant accomplishments***

VP Membership, American College of Emergency Physicians, 2024-present
Treasurer, American College of Emergency Physicians, 2023-2024
Board Member, American College of Emergency Physicians, 2022-present
Board Liaison, ED Accreditation Program Board of Governors, 2022-present
Board Liaison, EMS Committee, 2022-present
Board Liaison, Quality&Patient Safety Committee, 2022-2023
Faculty, Indy Master Class, American College of Emergency Physicians, 2021-present
Councillor, American College of Emergency Physicians, 2013-2022
Council Steering Committee, American College of Emergency Physicians, 2020-2022
Candidate Forum Subcommittee of the Council Steering Committee, American College of Emergency Physicians, 2021
Annual Meeting Subcommittee of the Council Steering Committee, 2021, American College of Emergency Physicians
Chair, Council Reference Committee B 2018, American College of Emergency Physicians
Council Reference Committee B 2015, American College of Emergency Physicians
Quality&Patient Safety Committee, 2020-2022, American College of Emergency Physicians
Measure Lifecycle Subcommittee of the Quality & Patient Safety Committee, 2020-2022, American College of Emergency Physicians
Reimbursement Committee, 2019-present, American College of Emergency Physicians
Surprise Medical Billing (SMB)/Independent Dispute Resolution (IDR) Implementation Joint Task Force, 2021-2022, American College of Emergency Physicians and EDPMA
Emergency Medicine Practice Committee, 2017-2022, American College of Emergency Physicians
Best Practices for Incidental Findings in the Emergency Department National Working Group, 2021-2024, Selected representative of the ACEP Emergency Practice Committee for this Joint Venture Project with the American College of Radiology
Chair, Policy Statement Supporting Safer Working Conditions for Emergency Care
Workers Subcommittee of the EM Practice Committee, 2020-2021, American College of Emergency Physicians
Award Selection Subcommittee of the EM Practice Committee, 2021, American College of Emergency Physicians
Disaster Preparedness Joint Subcommittee of the EM Practice Committee and the Disaster Management Section, 2021, American College of Emergency Physicians
Chair, EM Subspecialty Board Certification Subcommittee of the Emergency Medicine Practice Committee, 2019-2020, American College of Emergency Physicians
Disaster Preparation Standards Related to Personal Protection Equipment in the ED, Subcommittee of the EM Practice Committee, 2021, American College of Emergency Physicians
EMS Committee, 2017-2022, American College of Emergency Physicians
Democratic Group Practice Section, 2016- present, American College of Emergency Physicians
Emergency Medical Services-Prehospital Care Section, 2016-present, American College of Emergency Physicians
Freestanding Emergency Centers Section, 2016-present, American College of Emergency Physicians
Well Being Committee, 2016-2017, American College of Emergency Physicians
Physician Representative, 2013 Rand Corporation Study US Value of Emergency Medicine

***ACEP Chapter Activities – List your most significant accomplishments***

Immediate Past President, Florida College of Emergency Physicians, 2021-22
President, Florida College of Emergency Physicians, 2019-2021
- Served Two Consecutive Terms (1 of 3 people to have done so over 50 years)
- Completed Executive Search/Transitioned CEO and Organizational Restructure
- Revised Bylaws
- Established Women in Medicine Committee

Established Florida EM Physician Owned Corporation Consortium
President Elect, Florida College of Emergency Physicians, 2018-2019
Vice President, Florida College of Emergency Physicians, 2017-2018
Treasurer, Florida College of Emergency Physicians, 2016-2017
Bylaws Task Force, Florida College of Emergency Physicians 2020
Executive Committee, Florida College of Emergency Physicians, 2016-present
Finance Committee, Florida College of Emergency Physicians, 2016-present
Board of Directors, Florida College of Emergency Physicians, 2013-present
Women in Emergency Medicine Committee, Florida College of Emergency Physicians, 2019-present
Florida EM Physician Owned Corporation Consortium, Florida College of Emergency Physicians, 2019-present
Government Affairs Committee, Florida College of Emergency Physicians, 2013-present
Medical Economics Committee, Florida College of Emergency Physicians, 2013-present
Pediatrics Committee, Florida College of Emergency Physicians, 2013-present
EMS Committee, Florida College of Emergency Physicians, 2013-present
Readmissions Stakeholder Summit Panelist, 2017, Florida Hospital Association
Florida Office of Insurance Regulation and Insurance Consumer Advocate, Emergency Medical Transportation Work Group, 2016-2017
Faculty/Panel Moderator, FCEP Emergency Medicine Payment Reform Summit, 2017-2019

***Practice Profile***

***Total hours devoted to emergency medicine practice per year:*** **2,500** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **5** % Research **0** % Teaching **10** % Administration **85** %

Other: _____ ____%

***Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)***

EMS Medical Director primarily for government agencies located within Flagler County, Florida.

Previously worked for an independent group and successfully doubled the size of the group in terms of number of ED visits per year as well as number of shareholders/employees during my tenure.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Please see ***Current and Past Professional Positions*** noted above.

***Expert Witness Experience***

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

| **Defense Expert** | **Cases** | **Plaintiff Expert** | **Cases** |
|---|---|---|---|

I worked very part time as an independent contractor for Abbason and Associates, an entity contracted with the Florida Department of Health Medical Licensing Board to provide case reviews to opine upon standard of care from 2010-2020. During that time, I never provided oral or written evidence under oath, at trial, or in an affidavit or deposition.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Kristin B. McCabe-Kline, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: AdventHealth
Address: 900 Hope Way
Altamonte Springs, FL 32714
Position Held: Chief Medical Information Officer, Central Florida Division
Type of Organization: Health System

Employer: Flagler County Fire Rescue
Address: 1769 E. Moody Blvd.
Bunnell, FL 32110
Position Held: EMS Medical Director
Type of Organization: EMS Agency

Employer: City of Palm Coast
Address: 160 Lake Avenue
Palm Coast, FL 32164
Position Held: EMS Medical Director
Type of Organization: EMS Agency

Employer: City of Flagler Beach
Address: 105 South 2nd Street, PO Box 70
Flagler Beach, FL 32136
Position Held: EMS Medical Director
Type of Organization: EMS Agency

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Florida College of Emergency Physicians

Address: 3717 S. Conway Road

Orlando, FL 32812

Type of Organization: Florida State Chapter of ACEP

Leadership Position: Immediate Past President

Term of Service: August 2021- August 2022

Organization: Flagler County EMS Advisory Board

Address: 1769 E. Moody Blvd, Building 3

Bunnell, FL 321102

Type of Organization: Advisory Board to the County Commissioner

Leadership Position: Chair

Term of Service: 2014-present

Organization: WaterSafe, Inc.

Address: Virtual – no physician address

Type of Organization: Non-Profit providing free swim lessons and water safety awareness in my community

Leadership Position: Co-Founder and Chief Medical Officer

Term of Service: 2016-present

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☒ If YES, Please Describe:

My husband is an optometrist working in an ophthalmology practice.

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ NO
☐ If YES, Please Describe:

He has never worked in the ED, but does see patients in follow up after being referred by emergency physicians.

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Kristin Bond McCabe-Kline** 6/4/25

FCEP | Florida College of Emergency Physicians

*A CHAPTER OF THE*
**AMERICAN COLLEGE OF EMERGENCY PHYSICIANS**
**400 N Wymore Rd ● Winter Park, FL 32789**
**(407) 281-7396 ● FAX (407) 281-4407**
**www.fcep.org**

**Officers:**

Todd Slesinger, MD, FACEP, FCCM
President

Saundra Jackson, MD, FACEP
President-Elect

Blake Buchanan, MD
Vice-President

Shayne Gue, MD
Secretary-Treasurer

Jordan Celeste, MD, FACEP
Immediate Past President

Melissa Keahey
Executive Director and CEO

**Board of Directors:**

Rajiv Bahl, MD, MBA, MS, FACEP
Tom Bentley, MD, FACEP
Ricki Brown, MD
Blake Buchanan, MD, FACEP
Latha Ganti, MD, FACEP
Kyle Gerakopoulos, MD, MBA, FACEP
Jesse Glueck, MD
Eliot Goldner, MD, FACEP
Shayne Gue, MD, FACEP, FAAEM
Sara Kirby, MD
David Lebowitz, MD, FACEP
Brandy Milstead – Hollingsworth, MD
Diana Mora-Montero, MD, FACEP
Jeremy Selley, DO, FACOEP
Zach Terwilliger, MD
Michael Thompson, MD
Josef Thundiyil, MD, MPH, FACEP
Christine Van Dillen, MD, FACEP
Cristina Zeretzke-Bien, MD, FAAP, FAAEM, FACEP

## The Florida College of Emergency Physicians (FCEP) is proud to endorse Kristin Bond McCabe-Kline, MD, FACEP, FAAEM, FACHT, for re-election to the ACEP Board of Directors

Dr. McCabe-Kline has been a steadfast leader and voice for emergency medicine both within our state and across the nation. Since her election to the ACEP Board in 2022, she has brought the same strategic focus, steady leadership, and unrelenting advocacy that defined her tenure with FCEP to her national role. Her re-election will ensure continuity of strong leadership and a deep understanding of the challenges and opportunities facing emergency physicians today.

In Florida, Dr. McCabe-Kline has held nearly every leadership position within our chapter, culminating in her presidency during a pivotal time of transition and uncertainty. She continues to serve our chapter with distinction as a senior advisor, speaker, and mentor.

Nationally, Dr. McCabe-Kline's engagement is unparalleled. She has served on the ACEP Council Steering Committee, the Candidate Forum Subcommittee, and numerous standing committees including Reimbursement, EMS, Emergency Medicine Practice, and Quality & Patient Safety. She is a member of multiple ACEP sections and continues to serve as a trusted advocate through ACEP's 911 Legislative Network.

Professionally, Dr. McCabe-Kline exemplifies clinical and operational excellence. She currently serves as the Chief Medical Information Officer for one of the largest nonprofit health systems in the country and remains the Chief Medical Officer of Watersafe, Inc., a nonprofit organization dedicated to drowning prevention. She continues to serve as EMS Medical Director for multiple agencies in Flagler County, where her innovative leadership launched a Community Paramedicine program that enhances care coordination, patient safety, and resource utilization.

Her portfolio of published work, national speaking engagements, and award recognitions — including being named AdventHealth Palm Coast Foundation's 2019 Humanitarian of the Year — only further reflect her commitment to the specialty and to the broader public health landscape.

Dr. McCabe-Kline brings the ideal balance of experience, intellect, humility, and forward-thinking leadership. As the specialty continues to face complex challenges, her continued presence on the ACEP Board will be an asset to the College's strategic direction and a steadfast voice for frontline emergency physicians.

FCEP enthusiastically supports **Kristin Bond McCabe-Kline, MD, FACEP, FAAEM, FACHT,** for re-election to the ACEP Board of Directors, recognizing the exceptional value she brings to the governance, advancement, and integrity of our specialty.

# Kristin B. McCabe-Kline, MD, FACEP

Dear Councillors,

This is a critical time for Emergency Medicine physicians. We are the safety net for our communities and health care systems. Nevertheless, we are under reimbursed, devalued, and considered a "given". ACEP members have been made to feel that they are RVU producers, widget makers, and pieces on a chess board rather than human beings with consistent commitment to all comers, inclusive of everyone regardless of the circumstances where our patients and care team members find themselves, and willing to do whatever we know will improve the care we provide.

Our specialty is evolving and we are experiencing consistent requests to expand beyond the 4 walls of emergency departments and hospitals. We have a unique skillset and are well positioned to identify the gaps in care as they currently exist. ACEP needs to ensure that every creative mind of our membership contributes to our evolution as a specialty. There is also a need for us to elevate and grow our members so their ideas have appropriate spotlights and platforms to ensure our collective voice is heard loud and clear.

I am confident that turbulent times lead to innovation, resiliency, and camaraderie which has long been the DNA of Emergency Medicine physicians. I have been honored to serve on the ACEP BOD for the last three years and have had the opportunity to learn and absorb a considerable amount of knowledge. In service as Secretary/Treasurer two years ago and VP of Membership this last year, my knowledge has deepened. While ACEP has been and continues to be in a period of organizational and leadership change, these challenges allow us to evolve in a way that reinforces our value to Emergency Medicine physicians and our specialty.

"What lies behind us and what lies before us are tiny matters compared to what lies within us."
-Ralph Waldo Emerson

Respectfully,
Kris McCabe

# Kristin B. McCabe-Kline, MD, FACEP



***"What lies behind us and what lies before us are tiny matters compared to what lies within us."***

*-Ralph Waldo Emerson*

This is a critical time for Emergency Medicine physicians. We are the safety net for our communities and health care systems. Nevertheless, we are under reimbursed, devalued, and considered a "given". ACEP members have been made to feel that they are RVU producers, widget makers, and pieces on a chess board rather than human beings with consistent commitment to all comers, inclusive of everyone regardless of the circumstances where our patients and care team members find themselves, and willing to do whatever we know will improve the care we provide.

Our specialty is evolving and we are experiencing consistent requests to expand beyond the 4 walls of emergency departments and hospitals. We have a unique skillset and are well positioned to identify the gaps in care as they currently exist. ACEP needs to ensure that every creative mind of our membership contributes to our evolution as a specialty. There is also a need for us to elevate and grow our members so their ideas have appropriate spotlights and platforms to ensure our collective voice is heard loud and clear.

I am confident that turbulent times lead to innovation, resiliency, and camaraderie which has long been the DNA of Emergency Medicine physicians. I have been honored to serve on the ACEP BOD for the last three years and have had the opportunity to learn and absorb a considerable amount of knowledge. In service as Secretary/Treasurer two years ago and VP of Membership this last year, my knowledge has deepened. While ACEP has been and continues to be in a period of organizational and leadership change, these challenges allow us to evolve in a way that reinforces our value to Emergency Medicine physicians and our specialty.

# Kristin Bond McCabe-Kline, MD, FACEP, FAAEM

**91 Island Estates Pkwy**
**Palm Coast, FL**
**32137**
Cell (386) 283-2326
kmccabemd@gmail.com

## EMERGENCY MEDICINE RESIDENCY TRAINING

**Advocate Christ Medical Center Emergency Medicine Residency Program**
Program Director: Robert Harwood, M.D.
Oak Lawn, Illinois, June 2002 – June 2005

## EDUCATION

**M.D.** **University of Texas Medical School**, San Antonio, Texas, 1998-2002
***Top 20% of Graduating Class***

**B.A.** **Rice University**, Houston, Texas, 1994-96 (Major: **English**)
***Rice University President's Honor Roll***

**University of Michigan,** Ann Arbor, Michigan, 1992-94, 1996
***University of Michigan Class Honors***

**Harvard University**, Cambridge, Massachusetts, Summer 1993

## PROFESSIONAL WORK EXPERIENCE

### Vice President/Chief Medical Information Officer, Growth & Acquisitions
### Divisional Chief Medical Information Officer, East Florida Division
### AdventHealth

*Altamonte Springs, Florida (7/24-present)*
Chief Medical Information Officer of AdventHealth Growth and Acquisitions responsible for working with greenfield projects as well as acquisitions across the organization to understand and execute upon change management needs while confirm adhering to AdventHealth governance and standards. This includes incorporation of the AdventHealth single platform of Epic, integration with local third party applications, consideration of local bylaws/rules and regulations, and medical staff cultures. Reports directly to the AdventHealth Corporate Chief Medical Information Officer. Equivalent responsibilities to both AdventHealth Clinical and AdventHealth Information Technology. Collaborates with senior leadership to meet market needs while ensuring that systems development is enterprise applicable. Works with Epic, EI Agfa, and other vendors to develop and mature their products, particularly as clinical practice evolves and complex needs of service lines are accommodated. Evaluates a variety of clinical pathways working closely with the AdventHealth Evidence Based Medicine team. Also responsible for overseeing difficult service lines requiring integration of multiple vendor products to execute on deliverables including Cardiology, Pediatric Cardiology, Medical Oncology, and Radiation Oncology in close coordination with the corresponding

AdventHealth Institutes. Regular participation in meetings and strong alignment/collaboration with the Advent-Health Legal, Risk, and Compliance experts along with Corporate Responsibility leadership.

## Vice President/Chief Medical Information Officer, AdventHealth Central Florida Division

*Altamonte Springs, Florida (10/21-6/24)*

Chief Medical Information Officer of the AdventHealth Central Florida Division responsible for more than 50% of the corporation and reports directly to the AdventHealth Corporate Chief Medical Information Officer. Equivalent responsibilities to both AdventHealth Clinical and AdventHealth Information Technology. Works to collaborate with CEOs, COOs, CMOs, CNOs, and CFOs to meet market needs while adhering to corporate governance ensuring that systems development is applicable across the enterprise. Works with Epic and other vendors to develop and mature their products, particularly as clinical practice evolves and complex needs of service lines are accommodated. Evaluates a variety of clinical pathways working closely with the AdventHealth Evidence Based Medicine team. Transitioned quickly into this role while AdventHealth was leveraging Cerner and on the eve of transitioning to Epic. Took the Central Florida Division East Region live on Epic in March 2022, followed by the Central Florida Division South Region live on Epic in July 2022. Subsequently assisted with change management and operational planning for all Go Lives including the West Florida Division in December 2022, Multi-State Division in March 2023, Great Lakes Region in October 2023, and Rocky Mountain Region January 2024.

## Flagler County Fire Rescue Emergency Medicine Services Medical Director,

*Bunnell, Florida (8/14-present)*

## City of Palm Coast Emergency Medicine Services Medical Director,

*Palm Coast, Florida (8/14-present)*

## Flagler County Sheriff's Department Medical Director,

*Bunnell Florida (8/14-present)*

## City of Flagler Beach Emergency Medical Services Medical Director,

*Flagler Beach, Florida (10/14-present)*

Providing medical direction for all EMS agencies in Flagler County including ongoing work group of Field Training Officers to continually keep guidelines up to date. Oversight of Flagler County Fire Rescue Fire Flight program. Initiated monthly QA meetings utilizing technology to achieve 100% participation of all medics. Work with Flagler County Emergency Manager, Chiefs of all First Responder agencies as well as AdventHealth Palm Coast administration to perform periodic disaster drills. Oversight of SWAT Medic program in coordination with the Sheriff's Department. ***Developed a Community Paramedicine program for Flagler County Fire Rescue incorporating close communication with AdventHealth Care Management, community providers, and local agencies to improve access to care and promote health equity. Empowered all first responders to initiate treatment with intranasal Narcan when appropriate. Coordinated "Leave Behind Narcan" program for first responders.***

## Flagler Technical College EMT Training Program Medical Director

*Palm Coast, Florida (7/18-present)*

Providing medical direction for all EMT program instructors and oversight of all EMT students. Responsible for adherence of the program to state statute and coordination of field training with local EMS agencies as well as in hospital clinical training at AdventHealth Palm Coast. Proctor of final clearing exam upon completion of the classroom and clinical training assuring proficiency to graduate the EMT course.

## AllCare Medical Transport Medical Director

*Flagler County, Florida (4/21-present)*

Assisted this medical transport company in becoming a BLS transport entity and an ALS entity throughout 2021 including adherence of the program to state statute and coordination of certification and clearing processes to provide community standards for medical transport and competencies beyond state requirements. Providing medical direction and oversight of quality assurance programming.

## Vice President/Regional Operations Coordinator, Emergency Medicine Professionals

*Volusia/Flagler Counties, Florida (5/17-12/21)*

Regional Operations Coordinator specifically works with the Emergency Medicine Professionals Executive Committee and Board of Directors to support corporate operations and development as well as corporate management and Emergency Department/Hospital throughput. The Regional Operations Coordinator serves to provide high level communication to the AdventCare Health System Central Florida Region North Division Administrations as well as working on health care process improvement and care delivery innovation with AdventHealth Corporate Administration.

## Chief of Staff, Florida Hospital Flagler (Now AdventHealth Palm Coast)

*Palm Coast, Florida (1/16-12/18)*

Participating in expansion of capacity from 99 to 150 patients including observation unit following new construction, sole hospital in Flagler County, with thriving Interventional Cardiology program, Orthopedic Center of Excellence, Cancer Center, and Robotic Surgery program. Initiating improved hospital wide throughput utilizing LEAN methodologies. Rolling out hospital wide Just Culture education and responsible for ensuring medical staff compliance. Completed Bylaws revision. ***Awarded the "2016 Florida Hospital Mission Award" while serving as Chief of Staff.***

## Daytona International Speedway

*Daytona Beach, Florida (1/15-5/18)*

**Attending Physician** serving as "99" or trackside physician as well as providing physician services at the Infield Care Center for participants, crew members, employees, and fans. ***Provided pre-hospital care on scene and during transport for Kyle Busch post crash February 21, 2015.***

## Florida Hospital Flagler Emergency Department (Now AdventHealth Palm Coast)

*Palm Coast, Florida (1/16)*

**Assistant Medical Director,** Served in this role to help transition the new Medical Director into his position as well as launching two projects that had been in process for the past year: Emergency Department Improvement Team (ongoing LEAN team to continually address reduction of waste in ED processes) and introduction of Tele-Neurology including Stroke LEAN event.

## Florida Hospital Flagler Emergency Department (Now AdventHealth Palm Coast)

*Palm Coast, Florida (4/14-12/15)*

**Medical Director** 30+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Transitioned this new contract as an employee of **Emergency Medicine Professionals**. ***Decrease in LWBS from 14% to 1% with Press Ganey scores improved from 70th %tile to 90th %tile.***

## Bert Fish Medical Center Emergency Department (Now Advent Health New Smyrna)

*New Smyrna Beach, Florida (1/12-3/14)*

**Medical Director** 20+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**. BFMC ED awarded "***Innovation of the Year in Patient Care***" by the Florida Hospital Association in 2012 for implementation of multiple initiatives to improve patient focused care with an emphasis on quality and safety.

## Bert Fish Medical Center Emergency Department (Now AdventHealth New Smyrna)

*New Smyrna Beach, Florida (4/11-12/11)*

**Attending Physician** 20+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**.

## Florida Hospital Fish Memorial Emergency Department (Now AdventHealth Fish)

*Orange City, Florida (1/11-3/11)*

**Attending Physician** 30+ Bed ED with Cardiology, Pulmonology, Surgery, Gastroenterology, Orthopedic, Gyn, ENT, Psychiatry, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**. ***VOTED INTO PARTNERSHIP IN APRIL 2011 AFTER MINIMUM PREREQUISITE 18 MONTH PERIOD.***

## Florida Hospital DeLand Emergency Department (Now AdventHealth DeLand)

*DeLand, Florida (10/10-12/10)*

**Attending Physician** 25+ Bed ED with Cardiology, Surgery, Gastroenterology, Orthopedic, Ob/Gyn, Psychiatric, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**.

## Bert Fish Medical Center Emergency Department (Now AdventHealth New Smyrna)

*New Smyrna Beach, Florida (8/09-7/10)*

**Attending Physician** 20+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**.

## Carolina Emergency Medicine Physician Association, Partner, Director ED Operations

*Greenville, South Carolina (7/05-6/07 and 1/08-6/10)*

**Attending Physician** rotating in four facilities of the Greenville Hospital System.
**Greenville Memorial Hospital** (*Greenville*): Level I Trauma Center with 90,000 ED visits annually. 50+ Bed ED including Critical Care, Intermediate Care, Pediatric, Cardiac Care, and Fast Track Areas.
**Allen Bennett Memorial Hospital** (*Greer*): 30,000 ED visits annually in this 25+ Bed ED with Ob/Gyn, Cardiology, Orthopedic, Gastroenterology, and General Surgery specialty service availability on site.
**Hillcrest Memorial Hospital** (*Simpsonville*): 25,000 ED visits annually in this 20+ Bed ED with Orthopedic and General Surgery specialty service availability on site.
**North Greenville Hospital** (*Travelers Rest*): 10,000 ED visits annually in this 10+ Bed ED with no specialty services on site.
***VOTED INTO PARTNERSHIP IN 2007 AFTER MINIMUM PREREQUISITE 2 YEAR PERIOD.***
**DIRECTOR OF ED OPERATIONS-** Including patient experience, Press Ganey orientation and ongoing coaching of physicians, all patient complaints/concerns, facilitating transitions of care.
**MEDICAL DIRECTOR, GREENVILLE MEMORIAL HOSPITAL BEHAVIORAL ANNEX-** Provided clinical policy oversight, process improvement, and coordination with hospital employed Advanced Practice Clinicians for care of patients awaiting placement at inpatient psychiatric facilities.

## Bert Fish Medical Center Emergency Department (Now AdventHealth New Smyrna)

*New Smyrna Beach, Florida (1/07-2/08)*

**Attending Physician** 20+ Bed ED with Cardiology, Surgery, Gastroenterology, Orthopedic, Gynecology, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**.

### Stuart F. Meyer Hospice House

*Palm Coast, Florida (8/07-12/07)*

**Associate Medical Director** 8 Bed inpatient Hospice unit providing patient care and facilitating the Interdisciplinary Team involving administration, nursing and patient care staff, social workers, and clergy. Responsible for developing plans of care for terminally ill patients facing imminent expiration, as well as providing inpatient care for those enrolled in the Home Hospice program requiring symptom management or respite care.

### Florida Hospital Flagler Emergency Department (Now AdventHealth Palm Coast)

*Palm Coast, Florida (5/07-11/07)*

**Attending Physician** Level II Facility with 50,000 visits annually. 20+ Bed ED with Cardiology, Surgery, Gastroenterology, Orthopedic, Gynecology, Pediatric, and Nephrology specialty service availability on site.

### Advocate Christ Medical Center, Emergency Department

*Oak Lawn, Illinois (6/02-6/05)*

**Resident Physician** in Level I Trauma Center with 82,000 ED visits annually. 50+ Bed ED including Critical Care, General Care, Pediatric, Cardiac Care, and Fast Track Areas. Rotations outside of the Emergency Department include Ultrasound, MICU, PICU, Trauma Surgery, General Surgery, Pediatrics, Orthopedics, Obstetrics/Gynecology, Oral Surgery, EMS, and Radiology.

### Henry Ford Health System, Center for Clinical Effectiveness

*Detroit, Michigan (10/97-6/98)*

**Administrative Assistant** and **Data Analyst** working on several outcomes-based research projects and grant applications (including NIH). Worked under the Director of Cardiovascular Informatics to coordinate computer programmers and outside consultants to develop a new computer-based cardiovascular information system for electronic charting in the hospital/clinic as well as formation of a queryable database.

### St. Joseph Mercy Health System, McPherson Hospital, Emergency Department

*Ann Arbor/Howell, Michigan (8/96-10/97)*

**Unit Clerk** in the Emergency Department coordinating inter-departmental services and patient care including hospitalizations and transfers to outlying facilities.

## LICENSURE

| | |
|---|---|
| **State of Florida** | April 11, 2007 - present |
| **State of South Carolina** | March 4, 2005 - present |
| **State of Illinois** | June 24, 2002 – July 31, 2005 |

## CERTIFICATIONS

**Healthcare Leadership, Administration, and Management Subspecialty Board Eligible**
Exam Completed November 19, 2024 (results pending)
**EMS Initial Subspecialty Board Certification November 19, 2021**
**Emergency Medicine Board Recertification January 1, 2018**
**Emergency Medicine ConCert Exam** Pass September 15, 2016

**ACEP Directors Academy Graduate**

| | |
|---|---|
| Phase I | November 2011 |
| Phase II | May 2012 |
| Phase III | November 2012 |
| Phase IV | August 2015 |

**FCEP Leadership Academy** June 2012 - July 2013

**Emergency Medicine Initial Board Certification December 6, 2007**

| | | | |
|---|---|---|---|
| Written Examination | Pass | November 8, 2006 | 10 |
| Oral Examination | Pass | October 22, 2007 | |

**Diplomate of the National Board of Medical Examiners**

| | | |
|---|---|---|
| USMLE Step 1 | Pass | May 26, 2000 |
| USMLE Step 2 | Pass | July 2, 2001 |
| USMLE Step 3 | Pass | April 14, 2004 |

**PROFESSIONAL ACTIVITIES**

**Vice President of Membership, American College of Emergency Physicians**, 2024-present
**BOD Liaison to the EMRA BOD**, American College of Emergency Physicians, 2024-present
**Secretary/Treasurer, American College of Emergency Physicians**, 2023-2024
**Board of Directors, American College of Emergency Physicians**, 2022-present
**Executive Committee, American College of Emergency Physicians**, 2023-present
**Nominating Committee, American College of Emergency Physicians**, 2023-present
**ACEP Liaison to the American College of Surgeons Committee on Trauma**, 2023-present
**Liaison to the ACEP EMS and Disaster Medicine Committees & Sections,** 2022-present
**Liaison to the ACEP Emergency Department Accreditation Board of Governors**, 2023-present
**Executive Director Search Firm Selection Committee, American College of Emergency Physicians**, 2024
**ACEP BOD Liaison to ACEP Council Reference Committee B**, 2024
**Liaison to the ACEP Finance Committee**, 2023-2024
**Liaison to the ACEP Health Information Technology Committees & Sections**, 2022-2023
**AdventHealth Artificial Advisory Council**, 2022-present
**AdventHealth Epic Steering Committee**, 2022-present
**AdventHealth Corporate Clinical Informatics Governance Committee**, 2022-present
**AdventHealth Best Practices Committee**, 2022-present
**AdventHealth Best Practices Subcommittee**, 2022-present
**AdventHealth Evidence Based Medicine Order Set Review Committee**, 2022-present
**AdventHealth Epic Provider Enhancement Request Committee**, 2022-present
**AdventHealth Corporate CMO Consortium**, 2021-present
**AdventHealth Legal, Risk, and Compliance Advisory Committee**, 2022-present
**AdventHealth Population Health Advisory Committee**, 2022-present
**AdventHealth Referral Governance Committee**, 2022-present

**AdventHealth Radiology Stewardship Committee**, 2022-present
**AdventHealth Clinical Excellence Steering Committee**, 2023-present
**Liaison to the AdventHealth Oncology Institute**, 2023-present
**Liaison to the AdventHealth Medical Oncology Council**, 2023-present
**Liaison to the AdventHealth Radiation Oncology Council**, 2023-present
**Liaison to the AdventHealth Heart, Lung, and Vascular Institute**, 2023-present
**Liaison to the AdventHealth Cardiology and Pediatric Cardiology Council**, 2023-present
**Advisor, AdventHealth Emergency Medicine Council**, 2022-present
**Advisor, AdventHealth Behavioral Health Council**, 2022-present
**Advisor, AdventHealth Care Management Council**, 2022-present
**Vice President, Emergency Medicine Professionals,** 2017-2021
**Executive Committee Member, Emergency Medicine Professionals,** 2011-2021
**Board of Directors, Emergency Medicine Professionals,** 2011-2021
**Partner/Shareholder, Emergency Medicine Professionals,** 2010-2021
**President, Florida College of Emergency Physicians,** 2019-2021
Served Two Consecutive Terms (1 of 3 people to have done so over 50 years)
Completed Executive Search/Transitioned CEO and Organizational Restructure
Revised Bylaws
Established Women in Medicine Committee
Established Florida EM Physician Owned Corporation Consortium
**President-Elect, Florida College of Emergency Physicians,** 2018-2019
**Vice President, Florida College of Emergency Physicians,** 2017-2018
**Treasurer, Florida College of Emergency Physicians,** 2016-2017
**Bylaws Task Force, Florida College of Emergency Physicians** 2020
**Executive Committee**, **Florida College of Emergency Physicians,** 2016-2022
**Finance Committee**, **Florida College of Emergency Physicians,** 2016-2021
**Board of Directors**, **Florida College of Emergency Physicians,** 2013-2022
**Flagler Technical College EMT Advisory Board of Directors**, 2018-present
**AdventHealth Corporate Emergency Department Reimagine Design Group**, 2021-2023
**AdventHealth Central Florida Division Clinically Integrated Network Board of Managers**, 2021-present
**AdventHealth Corporate Transitions of Care Steering Committee**, 2020-present
**AdventHealth Corporate Transitions of Care Clinical Workstream Committee**, 2020-present
**AdventHealth Corporate Change Coalition Steering Committee**, 2021-2023
**AdventHealth Corporate Cross Clinical Advisory Council**, 2020-2022
**Co-Chair, AdventHealth Cross Clinical Advisory Council Emergency Medicine Rapid Decision Group**, 2020-2022
**Co-Chair AdventHealth ED/Imaging Subject Matter Expert Working Group**, 2020-2022
**AdventHealth Corporate Formulary & Therapeutics Critical Care and Emergency Medicine Clinical Advisory Committee**, 2020-present
**AdventHealth Corporate Care Management Steering Committee**, 2021-present
**AdventHealth Corporate Epic Advanced Care Planning Working Group,** 2020-present

**AdventHealth Corporate Epic Opioid Working Group**, 2020-present
**AdventHealth Corporate COVID-19 Vaccination Planning Taskforce**, 2020-2022
**AdventHealth Corporate COVID-19 Open Door Task Force, Emergency Medicine**, 2020
**AdventHealth Corporate Clinical Response to COVID-19 Contributing Author, Emergency Medicine,** 2020
**AdventHealth Central Florida Division COVID-19 Workstream Task Force**, 2020-2022
**Co-Chair, AdventHealth Corporate ED Clinical Reliability Council,** 2019-2023
**AdventHealth Corporate Protecting Access to Medicare Act (PAMA) / Radiology Appropriate Use Criteria (AUC) Clinical Advisory Task Force**, 2020-2023
**AdventHealth Corporate PAMA/CDSM Committee,** 2019-present
**AdventHealth Central Florida Division Cardiovascular Institute Heart Failure Steering Committee**, 2021-present
**Co-Chair, AdventHealth Central Florida Division North Region ED Governance Council,** 2019-2021
**Co-Chair, AdventHealth Central Florida Division North Region ED/Hospitalist Governance Council,** 2018-2021
**AdventHealth Central Florida Division North Physician Champion Orthopedics**, 2020-2021
**AdventHealth Central Florida Division North Physician Champion Neurosciences**, 2020-2021
**AdventHealth Central Florida Division North Readmissions Committee,** 2018-2021
**AdventHealth Central Florida Division North Region Transfer Committee,** 2018-2021
**AdventHealth Central Florida Division North Opioid Stewardship Committee,** 2018-2021
**AdventHealth Central Florida Division North Region ED/Radiology Council,** 2017-2021
**AdventHealth Central Florida Division North Region CHF Committee,** 2017-2021
**AdventHealth Central Florida Division North Region Stroke Committee,** 2017-2021
**AdventHealth Central Florida Division North Region Pediatric Quality Committee,** 2017-2021
**Flagler County Open Arm Recovery Services (OARS) Committee**, 2020-present
**Chief Medical Officer, WaterSafe (501C3)**, 2019-present
**Executive Committee Member, WaterSafe (501C3)**, 2019-present
**Board of Directors, WaterSafe (501C3)**, 2019-present
**Co-Founder, WaterSafe**, 2016-present
**ED Throughput Council, AdventHealth Daytona Beach**, 2017-2021
**ED Throughput Council, AdventHealth Fish Memorial**, 2017-2021
**ED Throughput Council, AdventHealth Deland**, 2017-2021
**ED Throughput Council, AdventHealth Palm Coast**, 2014-present
**ED Throughput Council, AdventHealth New Smyrna Beach**, 2012-2014, 2017-2021
**Board of Directors,** Florida Hospital Flagler 1/16-12/18
**Chief of Staff**, Florida Hospital Flagler 1/16-12/18
Revised Bylaws
**EMPros Physician Leader Representative to the Emergency Department Practice Management Association (EDPMA)**, 2018-2021

**Councillor,** American College of Emergency Physicians, 2013-2022
**Council Steering Committee,** 2020-2022, American College of Emergency Physicians
**Candidate Forum Subcommittee of the Council Steering Committee**, 2021, American College of Emergency Physicians
**Annual Meeting Subcommittee of the Council Steering Committee**, 2021, American College of Emergency Physicians
**Chair, Council Reference Committee B 2018**, American College of Emergency Physicians
**Council Reference Committee B 2015**, American College of Emergency Physicians
**Quality&Patient Safety Committee**, 2020-2023, American College of Emergency Physicians
**Measure Lifecycle Subcommittee of the Quality & Patient Safety Committee**, 2020-2023, American College of Emergency Physicians
**Reimbursement Committee**, 2019-2022, American College of Emergency Physicians
**Chair, Reimbursement Committee Working Group 1**, 2021-present, American College of Emergency Physicians
**Surprise Medical Billing (SMB)/Independent Dispute Resolution (IDR) Implementation Joint Task Force**, 2021, American College of Emergency Physicians and Emergency Department Practice Management Association
**Emergency Medicine Practice Committee,** 2017-2022 American College of Emergency Physicians
**Best Practices for Incidental Findings in the Emergency Department National Working Group**, 2021-2022, Selected representative of the ACEP Emergency Practice Committee for this Joint Venture Project with the American College of Radiology
**Chair, Policy Statement Supporting Safer Working Conditions for Emergency Care Workers Subcommittee of the Emergency Medicine Practice Committee**, 2020-2021, American College of Emergency Physicians
**Award Selection Subcommittee of the EM Practice Committee**, 2021, American College of Emergency Physicians
**Disaster Preparedness Joint Subcommittee of the EM Practice Committee and the Disaster Management Section**, 2021, American College of Emergency Physicians
**Chair, EM Subspecialty Board Certification Subcommittee of the Emergency Medicine Practice Committee**, 2019-2020, American College of Emergency Physicians
**Disaster Preparation Standards Related to Personal Protection Equipment in the ED, Subcommittee of the EM Practice Committee**, 2021, American College of Emergency Physicians
**EMS Committee,** 2017-present, American College of Emergency Physicians
**Democratic Group Practice Section**, 2016- present, American College of Emergency Physicians
**Emergency Medical Services-Prehospital Care Section**, 2016-present, American College of Emergency Physicians
**Freestanding Emergency Centers Section**, 2016-present, American College of Emergency Physicians
**Well Being Committee,** 2016-2017, American College of Emergency Physicians
**Women in Emergency Medicine Committee**, Florida College of Emergency Physicians,

2019-2021
**Florida EM Physician Owned Corporation Consortium**, Florida College of Emergency Physicians, 2019-2021
**Government Affairs Committee**, Florida College of Emergency Physicians, 2013-2022
**Medical Economics Committee**, Florida College of Emergency Physicians, 2013-2022
**Pediatrics Committee**, Florida College of Emergency Physicians, 2013-2022
**EMS Committee**, Florida College of Emergency Physicians, 2013-2022
**Chair, American Heart Association Go Red for Women Luncheon,** 2018
**Readmissions Stakeholder Summit Panelist,** 2017, Florida Hospital Association
**Florida Office of Insurance Regulation and Insurance Consumer Advocate,** Emergency Medical Transportation Work Group, 2016-2017
**Faculty/Panel Moderator**, FCEP Emergency Medicine Payment Reform Summit, 2017-2019
**AHS Florida Regional Strategic Physician Leadership Development Program,** 2013-2014
**Baker Act Interagency Committee**, 2012-2016 Volusia and Flagler Counties
**Physician Representative**, 2013 Rand Corporation Study US Value of Emergency Medicine
**Chief of Staff Elect**, Florida Hospital Flagler 2015
**Interim Chair Department of Medicine**, Florida Hospital Flagler 2015
**Vice Chief of Staff**, Florida Hospital Flagler 2014
**Hospital/Physician Strategy Committee**, 2014-2016, Florida Hospital Flagler
**Medical Executive Committee Member**, 2014-2019, Florida Hospital Flagler
**Medical Director,** 2014-2016, Florida Hospital Flagler Emergency Department
**Performance Improvement Committee**, 2014-2019, Florida Hospital Flagler
**Peer Review Committee**, 2014-2019, Florida Hospital Flagler
**Biomedical Ethics Committee**, 2014-2019, Florida Hospital Flagler
**Patient Safety Committee**, 2014-2019, Florida Hospital Flagler
**Medical Records and Utilization Review Committee**, 2014-2018, Florida Hospital Flagler
**Emergency Management Committee**, 2014-2018, Florida Hospital Flagler
**Readmissions Committee**, 2014-2018, Florida Hospital Flagler
**Care Transitions Committee**, 2014-2018, Florida Hospital Flagler
**Cardiology Committee**, 2016-2018, Florida Hospital Flagler
**Stroke Committee**, 2014-present, Florida Hospital Flagler
**Critical Care Committee**, 2016-2018, Florida Hospital Flagler
**Pharmacy and Therapeutics Committee**, 2016-2018, Florida Hospital Flagler
**Community Relations Committee**, 2014-2018, Florida Hospital Flagler
**Medical Executive Committee Member**, 2013, Bert Fish Medical Center
**Chair, Peer Review Committee**, 2013, Bert Fish Medical Center
**Medical Director**, 2011-2014, Bert Fish Medical Center Emergency Department
**Physician Director**, 2010-2014, Stroke Program, Bert Fish Medical Center
**Expert Witness,** 2010-2020, Abbason & Associates contracted with Florida DOH
**Judge,** Florida College of Emergency Physicians Annual Case Presentation Competition
**Judge,** Florida College of Emergency Physicians Annual Simulation Wars Competition
**Director of Emergency Department Operations**, Carolina Emergency Medicine
**Associate Director**, Greenville Memorial Hospital Emergency Department Behavioral Annex

(Psychiatric care holding facility within ED for patients awaiting inpatient psychiatric placement.)
**Candidate Selection Committee Member**, Carolina Emergency Medicine, 2005-2009
**Board of Directors**, Carolina Emergency Medicine Physicians Association, 2007-2009
**Member**, Advocate Christ Emergency Medicine Department Journal Club, 2002-2005
**Mentor**, Advocate Christ Emergency Medicine Residency Mentorship Program, 2003-2005
**Member**, Advocate Christ Emergency Medicine Residency Selection Committee, 2003-2005

## PROFESSIONAL ORGANIZATIONS

**Fellow** of the American College of Emergency Physicians
**Fellow** of the American Academy of Emergency Medicine
**Founding Fellow** of the American College of Healthcare Trustees
**Member** of the American College of Health Care Executives
**Member** of the American College of Health Care Executives Physician Forum
**Member** of the National Association of EMS Physicians
**Member** of the Florida College of Emergency Physicians
**Member** of the Florida Association of EMS Medical Directors
**Member** of the American Medical Association
**Member** of the Florida Medical Association

## AWARDS

**ACEP Speaker's Award for Outstanding Service**, 2021-2023
**AdventHealth Information Technology Clairvoyant Award**, 2022
**ACEP Speaker's Award for Outstanding Service**, 2019-2021
**Humanitarian of the Year**, AdventHealth Palm Coast Foundation, 2019
**ACEP President's Award for Outstanding Service,** 2018-2019
**Physician of the Quarter**, Florida Hospital Flagler, 2017
**"Top Doctor" Award**, Daytona Beach News Journal, 2016
**Mission Leadership Award,** Florida Hospital Flagler, 2016
**Dedication to Community Service Award**, WaterSafe 2016
**Health Professional of the Year,** Flagler County 2015

## PUBLICATIONS

Christopher L. Moore, MD, Andrew Baskin, MD, Anna Marie Change, MD, MSCE, Dickson Cheung, MD, MBA, MPH, Melissa A. Davis, MD, MBA, Baruch S. Fertel, MD, MPA, Kristen Hans, RN, MS, Stella K. Kang, MD, MSc, David M. Larson, MD, Ryan K. Lee, MD, MBA, **Kristin B. McCabe-Kline, MD**, Angela M. Mills, MD, Gregory N. Nicola, MD, Lauren P. Nicola, MD. **White Paper: Best Practices in the Communication and Management of Actionable Incidental Findings in Emergency Department Imaging**. Journal of the American Col-

lege of Radiology. Volume 20, Issue 4, p422-430, April 2023. Published online March 13, 2023, DOI: https://doi.org/10.1016/j.jacr.2023.01.001

**Dr. Kristin McCabe-Kline, MD. FCEP President's Last Message: FCEP's 50th Anniversary Reflections.** *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 27, Number 6, Summer 2021 issue, page 6.

**Dr. Kristin McCabe-Kline, MD. FCEP President's Message: Emergency Medicine Workforce: Emergency Medicine is an Essential Voice in the House of Medicine.** *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 27, Number 5, Spring 2021 issue, page 6.

**Dr. Kristin McCabe-Kline, MD. FCEP President's Message: Beyond the Pandemic: Stop Surviving and Start Thriving.** *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 27, Number 4, Winter 2021 issue, page 6.

**Dr. Kristin McCabe-Kline, MD. FCEP President's Message: Rise Up.** *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 27, Number 2, Summer 2020 issue, pages 6-7.

**Dr. Kristin McCabe-Kline. Emerging from COVID-19 crisis calls for coming together.** Daytona Beach News-Journal May 3, 2020.

**Kristin McCabe-Kline: In COVID-19 pandemic, It's time to get to work 'doing right'.** *floridapolitics.com* April 30, 2020.

**Kristin McCabe-Kline, MD. FCEP President's Message: Finding Peace in the Emergency Department.** *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 26, Number 4, Winter 2020 issue, page 6.

**Kristin McCabe-Kline, MD. FCEP President's Message: Strategic Goal Updates.** *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 26, Number 3, Fall 2019 issue, pages 4-5.

**Dr. Kristin McCabe-Kline and Dr. Charles Duva. PHYSICIANS: Medical billing law is rebounding on Volusia, Flagler emergency medical staff.** Daytona Beach News-Journal August 21, 2019.

**Kristin McCabe-Kline, M.D. Tackling Florida's Opioid Crisis Requires Clinical Collaboration.** *Tampa Bay Times*. May 2, 2019.

**Kristin McCabe-Kline. Communication Across the Continuum of Care: Emergency Department information exchange (EDie).** *EMPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 25, Number 2, Summer 2018 issue, page 19.

**Kristin McCabe-Kline. Resilience in the Emergency Department.** *EMPulse*. Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 23, Number 4, Winter 2016-2017 issue, pages 24-25.

**Kristin McCabe, M.D. Don't Tear Safety Net.** *Daytona Beach News-Journal*. Community Voices, March 2, 2016.

**Kristin McCabe-Kline. End Game in the Emergency Department: The Tip of the Spear.** *EMPulse*. Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 18, Number 2, Spring 2013 issue, pages 14-15.

**Kristin B. McCabe**. **Fix-It-Man.** *Preach: Enlivening the Pastoral Art*. Copyright © World Library Publications, A division of J.S. Paluch Company, Inc., Schiller Park, IL. March-April 2005 issue. (This was a commissioned work linking the practice of Emergency Medicine with pastoral avocations for the "Intersections" feature column.)

Shalin S. Shah, Glenn F. Tokarski, James K. McCord, Nabil E. Khoury, **Kristin B. McCabe**, Robert J. Morlock, Husam Noor, Peter A. McCullough. **Acute Coronary Syndromes in the Emergency Room: Impact of an Emergency Department Cardiac Clinical Decision Unit on a Population of Patients with Episodic Chest Discomfort.** *Supplement to Journal of the American College of Cardiology*, February 2000. Volume 35. Supplement A, page 380. Abstract 1127-138.

**PRESENTATIONS**

**What to Do: Before Day 1 of a New Contract.** May 2023
American College of Emergency Physicians Indy Class. Dallas, Texas.

**Negotiating Employee Contracts.** August 2022
American College of Emergency Physicians Indy Class. Dallas, Texas.

**New Contract Change Management.** August 2022
American College of Emergency Physicians Indy Class. Dallas, Texas.

**One Voice for Volusia.** December 2020
Volusia County Florida, Virtual Event.

**Flagler Cares Coalition: Opioid Use Disorders.** November 2020
Flagler County Florida, Virtual Event.

**Emergency Medicine Vision 2030.** October 2020
AdventHealth Corporate Clinical Excellence Conference, Altamonte Springs, Florida.

**Protecting Access to Medicare Act / Appropriate Use Criteria.** October 2020
AdventHealth Central Florida Division North Region CMO Roundtable. Virtual Event.
AdventHealth Central Florida Division North Region CEO Roundtable. Virtual Event.

**Regional AdventHealth Opioid Initiatives Presentation.** September 2020
Leadership Daytona Class XL Program /Daytona Regional Chamber of Commerce, Virtual Event.

**Preparing for the Next Pandemic: Information Flow.** September 2020
American College of Emergency Physicians Webinar Series, Virtual Event.

**Florida Emergency Medicine Town Hall.** August 2020
Symposium by the Sea, Florida College of Emergency Physicians Conference, Virtual Event.

**Statewide Effort to Prepare for the COVID-19 Surge in Florida.** April 2020
FMDA Quality Advocacy Coalition Stakeholders Virtual Meeting.

**Opioid Epidemic Impact and Solutions.** August 2019
Keeping Hope: Overdose Awareness & Remembrance Day, Daytona Beach, Florida.

**Florida Emergency Medicine Town Hall.** August 2019
Symposium by the Sea, Florida College of Emergency Physicians Annual Conference, Boca Raton, Florida.

**Fearless and Focused.** February 2019
Flagler Professional Women's Council Luncheon Presentation, Palm Coast, Florida.

**Emergency Medicine Innovators Summit Panelist Moderator.** February 2019
FCEP Conference, Emergency Medicine Learning and Resource Center, Orlando, Florida.

**Statewide Effort to Avoid Hospital Readmissions Panelist.** October 2018
FMDA Quality Advocacy Coalition Stakeholders Workshop, Orlando, Florida.

**Emergency Medicine Payment Reform Summit Panelist Moderator.** February 2018
FCEP Conference, Emergency Medicine Learning and Resource Center, Orlando, Florida.

**EMS Wellness: Where are we?** December 2017
FCEP/Emergency Medicine Learning Resource Center Webinar.

**Emergency Medicine Innovators Summit Panelist Moderator.** February 2017
FCEP Conference, Emergency Medicine Learning and Resource Center, Orlando, Florida.

**Work Life Balance.** September 2016
FCEP Life after Residency Conference Faculty, Gainesville, Florida.

**Optimizing Transitioning of Patients from the Emergency Department.** April 2014
Flagler County Emergency Nurses Association Meeting, Palm Coast, Florida.

**Pre-Hospital Education for Stroke Alert and STEMI Alert.** December 2013
Volusia County EMS and Fire/Rescue CE, BFMC, New Smyrna Beach, Florida.

**Juggling Personal and Professional Life.** September 2013
FCEP Life after Residency Conference Faculty, Orlando, Florida.

**Trauma in Pregnancy Case Presentation and Follow-Up.** April 2004
Joint ACMC Trauma Surgery/Emergency Department Conference, Oak Lawn, Illinois**.**

**Pediatric Head Trauma.** November 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

**Pulmonary Embolism Case Presentation and Follow-Up.** July 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

**Testicular Cancer Case Presentation and Follow-Up.** July 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

**Caring for Caregivers.** May 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

## PROFESSIONAL REFERENCES

Available Upon Request.

## PERSONAL ACTIVITIES

**Member, Santa Maria del Mar Catholic Church**
**Member, Father Lopez Catholic High School Parent Teacher Organization**
**Member, Father Lopez Catholic High School Greenwave Athletic Association**
**Certified Judge and Coach, USA Artistic Swimming Association**
**Sustaining Member, Junior League of Daytona Beach, Florida**

**Former Member, Junior League of Greenville, South Carolina**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

## Bing S. Pao, MD, FACEP

***Question #1:*** **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

The most important asset I bring to the ACEP Board is experience. I have spent over thirty years leading and participating in a variety of medical organizations. Since serving as President of the California Emergency Medicine Residents' Association, I have remained deeply engaged in advocacy. My work with organizations such as the California Medical Association and the American Medical Association has broadened my perspective, sharpened my decision-making skills, and enhanced my ability to understand complex issues from multiple viewpoints.

As the senior director of a physician-owned democratic partnership with no outside equity ownership or debt, I possess a deep understanding of emergency medicine financing and practice management. I understand how reimbursement directly impacts physician compensation, group sustainability and patient access to care. I regularly negotiate with health insurance companies and have successfully challenged unfair payment practices through advocacy and litigation. My reimbursement expertise will continue to help ACEP advocate effectively for fair payment nationwide.

I have demonstrated leadership by serving on multiple boards, chairing numerous committees, and being appointed to several task forces at the county, state, and national levels. As Chair of the Emergency Department Practice Management Association (EDPMA) during the COVID-19 pandemic, I met with the Deputy Secretary of Health and Human Services to successfully advocate for provider relief funds. During the passage of the No Surprises Act, I met with congressional offices to support a balanced solution to surprise billing. I will bring these leadership skills to advocate on behalf of ACEP members.

I possess a broad and deep knowledge of healthcare policy that will inform strategic advocacy efforts. I have experience drafting model legislation, developing policy, and testifying before legislative committees and regulatory bodies on behalf of emergency physicians. I was even invited by a health plan association to testify on how emergency physicians were left unpaid when financial responsibility was delegated to insolvent managed care groups. As a result, health plans began reversing this practice.

I excel at building coalitions to amplify ACEP's advocacy efforts. For example, I organized a coalition that successfully reversed the Kansas Medicaid policy that reduced emergency services payments and led efforts to prevent the VA from denying emergency visit claims. As Chair of the EDPMA political action committee, I understand how to bridge the gap between physicians and lawmakers to advance policy. My public policy work has been recognized at both state and national levels.

***Question #2:*** **What is your biggest concern about serving on the Board of Directors?**

My biggest concern is whether ACEP will be able to effectively address the issues that matter most to frontline emergency physicians. We must improve working conditions for emergency physicians. ACEP must ensure that emergency physicians have autonomy in clinical decision-making, scheduling, staffing, and supervision of mid-level providers. Emergency physicians also deserve job security and fair compensation.

ACEP must establish enforceable standards for emergency departments that ensure adequate resources for safe, high-quality care. Why should emergency departments be allowed to operate without sufficient staff? Airlines cannot fly without a full crew. Why is patient boarding tolerated when planes can't sit on the tarmac for more than 3–4 hours? Boarding poses a far greater risk to safety, yet there's little public outrage.

I am concerned that ACEP's voice is not resonating with the public, policymakers, or decision-makers. Should ACEP rethink its advocacy approach? Can we leverage a new administration to build relationships with those willing to listen? Failure only occurs when we stop trying. As the saying goes, "Insanity is doing the same thing over and over and expecting different results." I will lead ACEP to explore bold, new strategies to improve conditions for emergency physicians.

***Question #3:*** **What are the two most pressing issues facing members and how would you address them?**

The two most pressing issues facing ACEP members are:
1. Improving working conditions for emergency physicians to enhance physician wellness
2. Ensuring the financial sustainability of emergency medicine

Improving working conditions includes creating safer workplaces, reducing boarding, eliminating redundant administrative tasks, increasing autonomy, and ensuring sufficient resources.

To address workplace safety, I will urge ACEP to:
- Advocate for a national reporting system on ED workplace violence
- Promote effective hospital protocols and training to prevent violence
- Support legislation increasing penalties for assaulting healthcare workers

To address boarding and overcrowding, I will insist that ACEP:
- Advocate for CMS to require solutions to boarding as a condition of Medicare/Medicaid participation
- Push for financial incentives akin to hospital core measures
- Leverage ACEP's accreditation program to encourage hospitals to implement evidence-based boarding solutions

Regarding administrative burdens, I support ACEP's adoption of technologies, including AI, to streamline workflows and improve quality of care. The ACEP Artificial Intelligence Committee should play a leading role in policy development. AI tools must be implemented with safeguards to ensure fairness, protect privacy, and maintain physician oversight. I will also advocate for reduced regulatory requirements that contribute to physician burnout.

Emergency physicians deserve autonomy in decisions affecting patient care and practice management, including staffing, billing, and supervision. ACEP should provide resources for emergency physicians pursuing due process, unionization, or independent practice formation. I will continue to support legislative efforts to secure due process rights nationwide.

To ensure adequate emergency department resources, I will advocate for national standards regarding:
- Required equipment for emergency procedures and care
- Adequate staffing
- Responsive specialty support
- Timely access to radiology, pharmacy, social work, and case management

The second pressing issue is the financial sustainability of emergency medicine. ACEP's RAND study confirms declining reimbursement from both commercial and government payers. This is compounded by the growing number of payment denials and a disproportionate amount of uncompensated care.

I have the expertise to help ACEP secure funding for emergency care and address payment erosion. I have successfully supported litigation, regulatory reform, and legislation to protect emergency physician compensation. I will bring this experience to the Board to continue fighting for the financial viability of our specialty.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Bing S. Pao, MD, FACEP

***Contact Information***

Enter your mailing address here: POB 5000 PMB 205, Rancho Santa Fe, CA 92067
***Phone:*** 858-922-9165
***E-Mail:*** bingshihpao@gmail.com

***Current and Past Professional Position(s)***

Pinnacle Emergency Physicians - employee
Acute Care Specialists – independent contractor
Vituity – General Partner and Senior Director of Provider Relations
Assistant Clinical Professor, University of California at San Diego
Clinical Faculty, University of California at Riverside

***Education (include internships and residency information)***

Bachelor of Science in Biology, University of North Carolina at Chapel Hill, Graduated December 31st, 1987
Doctor of Medicine, Duke University, Graduated May 17, 1992
Internal Medicine Internship, University of Colorado Health Science Center, Completed June 2, 1993
Emergency Medicine Residency, University of California San Diego, Completed June 1, 1996

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

ABEM Certified November 20, 1998, Recertified January 1, 2009 & January 1, 2019

***Professional Societies***

American College of Emergency Physicians
California Chapter of the American College of Emergency Physicians
California Medical Association
San Diego County Medical Society
American Medical Association
Emergency Department Practice Management Association

***National ACEP Activities – List your most significant accomplishments***

ACEP Alternative Payment Model Task Force
ACEP Group Ownership Task Force
ACEP Accreditation Task Force
ACEP Balance Billing Task Force
ACEP Council Delegate & Reference Committee Member
ACEP Reimbursement Committee
ACEP Steering Committee

***ACEP Chapter Activities – List your most significant accomplishments***

California Chapter of the American College of Emergency Physicians, Chair Reimbursement Committee
California Chapter of the American College of Emergency Physicians, Government Affairs Committee

California Chapter of the American College of Emergency Physicians, Board of Directors
California Chapter American College of Emergency Physicians Distinguished Service Award
California Chapter American College of Emergency Physicians House of Medicine Award
California Chapter American College of Emergency Physicians Special Recognition Award

***Practice Profile***

***Total hours devoted to emergency medicine practice per year:*** **2000** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **40** % Research **0** % Teaching **5** % Administration **55** %

Other: _____ %

***Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)***

I currently work for Vituity, a national multi-specialty/hospital physician partnership. Clinically, I work in the emergency department at Moreno Valley Hospital in California.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Senior Director of Provider Relations, Vituity

***Expert Witness Experience***

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert N/A Cases** **Plaintiff Expert N/A Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Bing S. Pao, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Vituity

Address: 2100 Powell Street Suite 400

Emeryville, CA 94608

Position Held: Senior Director of Provider Relations

Type of Organization: Physician Partnership

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Emergency Department Practice Management Association

Address: 1660 International Drive Suite 600

McLean, VA 22102

Type of Organization: Trade Association

Leadership Position: Past Chairman of the Board, Board Member and Chair of the State Regulatory and Insurance Committee.

Term of Service: 2015-Current

Organization: California Medical Association

Address: 1201 K Street, suite #800

Sacramento, CA 95814

Type of Organization: Professional Medical Society

Leadership Position: Past Chair - Hospital Based Practice Forum, Delegate, Member of Committee on Medical Services

Term of Service: 2009-Present

Organization: San Diego County Medical Society

Address: 8690 Aero Drive, Suite 115-220

San Diego, CA 92123

Type of Organization: Professional Medical Society

Leadership Position: Board of Directors & Finance Committee

Term of Service: 2021-Present

Organization: American Medical Association

Address: 330 N. Wabash Ave., Suite 39300

Chicago, IL 60611-5885

Type of Organization: Professional Medical Association

Leadership Position: Alternate Delegate

Term of Service: 2021-Present

Organization: California Chapter of the American College of Emergency Physicians

Address: 1121 L Steet, Suite 401

Sacramento, CA 95814

Type of Organization: Professional Medical Society

Leadership Position: Past Board Member and Chair of the Reimbursement Committee

Term of Service: 2009-2012

Organization: California Emergency Medicine Residency Association

Address: 1121 L Steet, Suite 401

Sacramento, CA 95814

Type of Organization: Professional Medical Association

Leadership Position: Past President, Secretary/Treasurer

Term of Service: 1994-1996

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Bing Pao** Date May 22, 2025

CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

ACEP DEMOCRATIC GROUP PRACTICE SECTION

Dear Colleagues:

We are pleased to give our enthusiastic endorsement to Bing Pao, MD, FACEP for ACEP Board of Directors and strongly urges your support of his candidacy.

Dr. Pao's career demonstrates his steadfast commitment to improve the practice of emergency medicine.

Dr. Pao is a past board member of the California Chapter and has served the Chapter with incredible enthusiasm and dedication in a variety of leadership roles since he served as CalEMRA President in 1995-96. Through his numerous accomplishments, many years of service, and diversity of clinical experience, Dr. Pao will bring a broad and knowledgeable perspective to the ACEP Board. Dr. Pao's expertise and ability to combat exploitative behavior by insurance companies are needed on the ACEP Board of Directors.

Dr. Pao is a tireless advocate for emergency physicians, with several decades of commitment at every level of organized medicine. In addition to being a past board member of the California Chapter and past Co-Chair of the Chapter's Reimbursement Committee, Dr. Pao is a past board member of his local medical society, a delegate to the California Medical Association (CMA) House of Delegates, and the Chair of the CMA Hospital Based Practice Forum.

At the Chapter, group, and national level, Dr. Pao has been a passionate advocate for emergency physicians receiving fair compensation. His advocacy on behalf of our members has led him to testify before legislators in support of fair payment. He is a sought-after billing and reimbursement expert, serving on the CMA MACRA Task Force, and the College's Alternative Payment Model Task Force and Group Ownership Task Force. He has served as Chair of the Emergency Department Practice Management Association (EDPMA), Chair of the EDPMA Political Action Committee, and Senior Director of Provider Relations for Vituity.

We have witnessed Dr. Pao's ability to digest the complicated minutia of reimbursement and billing and relentlessly advocate on behalf of the average emergency physician.

Dr. Pao's dedication to emergency medicine and unique reimbursement skill set is exactly what we need on the ACEP Board of Directors as insurance companies continue to exploit front line emergency physicians. The California Chapter is extremely proud to endorse and respectfully requests your support of Dr. Bing Pao for the ACEP Board of Directors.

Respectfully,

JORGE FERNANDEZ, MD, FACEP
California Chapter President (2024-25)

CHRIS ROSS, MD, FACEP
Democratic Group Practice Section Chair

**California Chapter, American College of Emergency Physicians**
555 Capitol Mall, Suite 555 | Sacramento, CA 95814
(916) 325-5455 Phone | (916) 325-5459 Fax
info@californiaacep.org E-Mail | www.californiaacep.org

# Bing S. Pao, MD, FACEP

Emergency medicine is at a turning point. Each day, we face intensifying clinical demands, dwindling autonomy, declining reimbursement, and growing moral injury from working in overcrowded, understaffed, and under-resourced emergency departments. I've lived this reality. I know what it takes to transform our environment—so emergency physicians can thrive, not just survive.

It's time we take back control—of our working conditions, our profession, and our future. ACEP must lead by supporting:

- Democratic, physician-owned practice models,
- Unionization where appropriate, and
- Legislative and regulatory action that protects our autonomy and prioritizes patient care.

Fair payment is foundational. Without it, we cannot attract or retain board-certified emergency physicians. The RAND study confirms what we already know: our reimbursement is declining while our value remains unmatched. ACEP must:

- Champion Medicare reform, including inflation-adjusted payments.
- Advocate for Medicaid rates that reflect the true cost of care.
- Empower physicians to negotiate fair commercial contracts.
- Hold insurers accountable for abusive denials and downcoding.

The integrity of our healthcare system is at stake. ACEP must be a bold voice for:

- Increased funding for medical research and graduate education.
- Evidence-based health policy.
- Ensuring timely access to emergency care.

We must also invest in ACEP's future. To grow our membership, we must market the full value of ACEP – our advocacy, education, and professional community – with targeted outreach, especially to younger and early-career physicians. That means telling our story better and listening more intently. By acting on feedback from emerging leaders, ACEP can tailor offerings, enhance communication, and strengthen engagement for the next generation.

**What do I bring to the ACEP Board?**

As a senior director in a national, physician-owned partnership, I bring practical, frontline experience in emergency medicine finance, reimbursement, and payer negotiations. I've gone toe-to-toe with insurers – resolving disputes, negotiating contracts, and winning litigation. I know how to defend our value, and I'll bring that fight to ACEP.

I also bring decades of leadership experience at every level – county, state, and national. I've chaired boards, task forces, and committees. I served as President of the California Emergency Medicine Residents' Association, led the Emergency Department Practice Management Association, and advocated as an officer of Physicians for Fair Coverage.

As an advocate, I've crafted policy, led a political action committee, and unified diverse stakeholders to protect our profession and improve emergency care. ACEP recognized my work with the Colin C. Rorrie, Jr., Award for Excellence in Public Policy.

I'm ready to serve – and to elevate the voice of emergency physicians nationwide. I ask for your support and your vote.

**Vote Bing Pao, MD, FACEP – experienced leadership, proven advocacy, committed to you.**

# Vote for Bing Pao, MD, FACEP

## for ACEP Board of Directors



**Trusted Leadership. Proven Advocacy. A Voice for Emergency Physicians.**

## Seasoned Healthcare Leader

### Effective Advocacy Skills

- Awarded ACEP Colin Rorrie Jr. Award for Excellence in Healthcare Policy.
- Led legislative, regulatory and policy wins through ACEP, CMA and AMA.
- Experience in developing strategic goals and tactics for advocacy.
- Chair EDPMA Political Action Committee.

### Expertise in Emergency Medicine Financing and Practice Management

- Senior Director for Vituity, a democratic physician-owned partnership.
- Extensive knowledge of physician reimbursement and practice management.
- Medical Staff Executive Committee experience.

### Proven Leadership Experience

- Board roles: San Diego Medical Society, California ACEP, EDPMA, PFC.
- Former President, California EMRA.
- Chair, EDPMA Board.

## Vision for ACEP

### Improving the Emergency Physician Work Environment and Preventing Moral Injury

- Address workload, staffing, and autonomy.
- Support democratic physician-led models.
- Advance legislative and regulatory reforms.

### Ensuring Fair Payment

- Push for inflation-adjusted Medicare rates.
- Enable fair insurer negotiations.
- Back legal action against unfair payers.

### Increasing ACEP Membership

- Targeted outreach to show ACEP's value.
- Engage younger members for feedback.
- Continuously improve offerings and communication.

**Vote for Bing Pao for ACEP Board of Directors**

Endorsed by the California Chapter of the American College of Emergency Physicians

LinkedIn Page

# Bing S. Pao

858-922-9165 | bingshihpao@gmail.com | LinkedIn

## Profile

Dedicated and seasoned Emergency Physician offering experience in collaborating with others to solve problems. Ability to build effective working relationships with internal and external members to accomplish organizational goals. Track record of success delivering desired results in fast-paced, dynamic environments. Achieved success functioning as liaison between administrators, staff members, external agencies, and other key stakeholders. Excellent political, analytical, and communication skills with high attention to detail. Proven history of strengthening compliance, improving processes, elevating performance, negotiating, resolving disputes and providing excellent customer service. A skilled communicator with the vision and insight necessary to be able to create and provide strategic decisions.

## Professional Experience

**Pinnacle Emergency Physicians • Forest Park, GA • 1996 – 1999**

**Vituity • Emeryville, CA • 1999 – Present**

**Acute Care Specialists • Encinitas, CA • 2000 – 2001**

**Flight Physician, Life Flight San Diego**

**Reviewer, Journal of Emergency Medicine**

**Reviewer, Western Journal of Emergency Medicine**

## *Appointments*

- Scientific Advisory Board, Stemedica Cell Technologies, Inc.
- Assistant Clinical Professor, Department of Emergency Medicine, University of California, San Diego
- Clinical Faculty, University of California Riverside
- Residency Coordinator, Palomar Hospital
- Billing and Reimbursement Director, Vituity, Palomar-Pomerado Hospital
- Assistant Medical Director, Palomar Hospital Emergency Department
- Medical Staff Executive Committee, Palomar Hospital
- Senior Director of Provider Relations, Vituity

## *Organizations & Societies*

- ACEP Councilor & Fellow
- ACEP Reimbursement Committee
- ACEP Steering Committee
- ACEP Accreditation, Alternative Payment Model & Group Ownership Task Force
- AMA Alternate Delegate, 2021-present

- CAL/ACEP Board of Directors, 2009-2012
- CAL/ACEP Membership Committee
- CAL/ACEP Reimbursement Committee Co-Chair
- CAL/EMRA President, 1995-1996
- CAL/EMRA Secretary/Treasurer, 1994-1995
- California Medical Association, Chair Hospital Based Practice Forum
- California Medical Association, Delegate Hospital Based Physicians Forum
- California Medical Association Organized Medical Staff Section
- California Medical Association MACRA and Medicare Task Force
- Disaster Medical Assistance Team
- Emergency Department Practice Management Association (EDPMA) Board of Directors & Chair
- Emergency Department Practice Management Association State Regulatory and Insurance Committee Chair
- Physicians for Fair Coverage, Treasurer & Board of Directors
- Public Health Service Externship Program
- San Diego County Medical Society Board of Directors

## *Education & Certifications*

**EMERGENCY MEDICINE RESIDENCY,** UNIVERSITY OF CALIFORNIA, SAN DIEGO

**INTERNAL MEDICINE INTERNSHIP,** UNIVERSITY OF COLORADO HEALTH SCIENCE CENTER, BOULDER, CO

**MEDICAL SCHOOL,** DUKE UNIVERSITY SCHOOL OF MEDICINE, DURHAM, NC

**BACHELOR OF SCIENCE IN BIOLOGY,** UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, CHAPEL HILL, NC

BOARD CERTIFIED IN EMERGENCY MEDICINE

ADVANCED TRAUMA LIFE SUPPORT

ADVANCED CARDIAC LIFE SUPPORT

PEDIATRIC ADVANCED LIFE SUPPORT

CERTIFIED MEDICAL INSURANCE SPECIALIST

CERTIFIED MEDICAL CODER

## *Honors*

- Phi Beta Kappa, University of North Carolina at Chapel Hill
- Graduated with Highest Distinction, University of North Carolina at Chapel Hill
- AED Premedical Honors Society
- SAEM Medical Student Award
- Mercy Air Resident of the Year
- San Diego Magazine “Top Doc” Award 2005, 2006
- Palomar-Pomerado Quality Champion Award, CMS Core Measures, Pneumonia, 2007

- Volunteer Hospital Association Physician Champion Award, 2009
- CAL/ACEP Special Recognition Award
- CAL/ACEP Chapter Service Award
- CAL/ACEP House of Medicine Award
- CEP America 2012 Distinguished Service Award
- Emergency Department Practice Management Association Committee Task Force Service Award
- Emergency Department Practice Management Association Leadership Service Award

## *Publications*


- Pao B, Hayden S. Cerebral gas embolism resulting from inhalation of pressurized helium. Annals of Emergency Medicine. 1996, 28, 3: 363-366.
- Cerebral Gas Embolism From Pressurized Helium Inhalation. Presented at the Undersea and Hyperbaric Medical Society Scientific Meeting, 1994.
- Pao B, Pelvic inflammatory disease, The 5 Minute Emergency Medicine Consult, Baltimore: Lippincott, Williams & Wilkins, 1999:832-833.
- Pao B, Screening, Brief Intervention, and Referral for Treatment (SBIRT) in the Emergency Department, Lifeline. September 2011: 11.
- Pao B, How to Deal with Problem Payers, Lifeline. December 2010: 6-9.
- Pao B, Is this the End of Section 1011, Lifeline. September 2009: 11.
- Pao B, Payer Audits. Lifeline. January 2013: 8-12.
- Pao B, Riner M, and Chan T. Impact of the Balance Billing ban on California Emergency Providers. Western Journal of Emergency Medicine. 2014, 15(4): 518-522.
- Pao BS, Chan TC. Patient Cost Share for Emergency Physician Services During the COVID-19 Pandemic. J Emerg Med. 2022 Sep;63(3):420-425.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

# Council Officer Candidates

Scientific Assembly

SALT LAKE CITY 25

# 2025 Council Officer Candidates

## Speaker



**Michael J. McCrea, MD, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

## Vice-Speaker



**Kurtis A. Mayz, JD, MD, MBA, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



**Larisa M. Traill, MD, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



**Aine Yore, MD, FACEP**

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

## Michael J. McCrea, MD, FACEP

***Question #1:*** **What qualities do you possess to be effective in this role?**

I hope that these past two years as your Vice Speaker I have lived up to the charge for which I was elected: to serve our Council, represent the Council to the Board of Directors, and be a resource for all members who wish to make a difference in our specialty. My leadership experiences at the chapter and College level prepared me to serve the Council and believe I have served you faithfully these past two years. As a prior committee chair and chapter president, I am known for efficiency while facilitating debate. Perhaps the most important quality I would bring to being Speaker is that I am approachable and always willing to listen, even if we disagree on an issue. I have helped members and sections craft and author successful resolutions. Now having seen it from the council officer's side, I have an even better perspective to serve our members going forward.

***Question #2:*** **How do you balance free and open debate versus meeting efficiency?**

Balancing debate while running an efficient meeting is perhaps the most important duty of the presiding officer.

As your current Council Vice Speaker, a two-term chapter president, and former chair of multiple committees and task forces, I am known for fostering an environment in which all voices have the chance to be heard while staying on schedule. Although it may seem counterintuitive, it is by ensuring balanced debate that the Speaker maintains control of the agenda and presides over an efficient meeting. Maintaining the equilibrium of the principle of majority rule versus the rights of the minority or any member to speak is at the forefront of my mind while at the podium monitoring debate. For example, if only those in support of a resolution have spoken, it is the Speaker's duty to actively inquire if there are any who wish to speak in opposition. If not, further testimony supporting the resolution may not be needed and the assembly can proceed directly to a vote and efficiently move on to the next item of business. Similarly, if balanced testimony from both sides of the issue has been heard, while it may be appropriate to proceed to a vote, the Speaker should sense the desire from the Council to hear additional testimony. I gained this experience with parliamentary procedure firsthand these past two years as your Vice Speaker from working with our Speaker, Council parliamentarian, and ACEP staff. This service has provided me with the knowledge and expertise to facilitate balanced and efficient debate as your next Council Speaker.

***Question #3*****: What would improve the councillor experience and Council operations?**

Having served these past two years as Vice Speaker, I have experienced firsthand the "sausage making" that goes into planning Council and helping our Speaker and staff run our meeting. I truly believe our two days together are about as efficient as they can be without adding additional time or, gasp, adding a third day to Council. I believe it is through more robust use of asynchronous testimony before we gather that will significantly improve Council operations and efficiency. I feel that if individuals or a component body author a resolution, it should be required to submit sponsor testimony when asynchronous testimony opens. We have all had the experience reading a resolution and wondering "I wonder what led to this resolution?" Last year I reached out to many authors asking for them to submit testimony for exactly this reason. Additionally, many chapters have a chapter "caucus" prior to Council to review resolutions. I always appreciate seeing chapters weigh in, even if it's only "support" or "oppose" without any additional testimony. By greatly expanding the amount of asynchronous testimony submitted, the Council Officers could better plan reference committee agendas to plan for more time for live testimony on more complex or controversial resolutions.

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)***

Attending Physician, residency core faculty
*Mercy Emergency Care Services, Team Health*
October 2014 – Present
*Lucas County Emergency Physicians, Inc., Premier Physician Services*
September 2009 – October 2014

*Emergency Professionals of Ohio, Inc, TeamHealth*
Staff physician July 2018 – 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

*Emergency Medicine Physicians of Guernsey County, Ltd.*
Staff Physician, September 2006 – December 2006

***Education (include internships and residency information)***

THE Ohio State University Medical Center
Emergency Medicine Residency 2004 – 2007

Medical College of Ohio at Toledo
M.D. 2000 – 2004

Ohio Wesleyan University
B.A. Biochemistry 1996 – 2000

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***
American Board of Emergency Medicine
Initial certification 6/27/2008
Recertified 2017, valid through 12/31/2028

***Professional Societies***

American College of Emergency Physicians
Ohio Chapter ACEP
American Medical Association
Ohio State Medical Association
American Institute of Parliamentarians

***National ACEP Activities – List your most significant accomplishments***

**College**
Finance Committee, 2023 – present
Educational Meetings Committee, 2021 – 2023
Task Force on Supply Chain and PPE, 2020
Bylaws Committee, 2015 – 2024
-Chair 2021 – 2023
-Vice-Chair 2020 – 2021
State Legislative and Regulatory Committee, 2012 – 2019
-Subcommittee Chair, EM Practice, 2016 – 2019
ACEP Teaching Fellowship alumnus, 2010-11

**Council**
Vice Speaker, 2023 – 2025
Council Reference Committee A, Chair, 2021
Task Force on Council Size, Chair, 2019
Council Horizon Meritorious Service Award recipient, 2020
Council Steering Committee, 2016 – 2017
Council Horizon Award recipient, 2014
Council Tellers, Election, and Credentials Committee, 2013 – 2016
Council Reference Committee, 2012

***ACEP Chapter Activities – List your most significant accomplishments***

Ohio Chapter President, 2015 - 2016, 2016 - 2017
Ohio Chapter Immediate Past President, 2017 – 2018
Ohio Chapter President Elect, 2013 – 2014, 2014 - 2015
Ohio Chapter Secretary, 2011 – 2012, 2012 – 2013
Ohio Chapter Board of Directors, 2011 – present
Midwest Medical Student Symposium, chair, 2015 – present
Councillor, 2011 – 2023
Alternate Councillor, 2010
Oral Board Review Course, Course Co-Director, 2012 – 2017
Emergency Medicine Review Course, faculty, 2011 – 2020

***Practice Profile***
***Total hours devoted to emergency medicine practice per year:*** **1920** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***
Direct Patient Care **70** % Research **<1** % Teaching **30** % Administration **0** %
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 serving as a core faculty Bon Secour Mercy Health - St. Vincent Medical Center Emergency Medicine Residency

Moonlight at a single coverage rural ED within Mercy Health system, Mercy Tiffin Hospital.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Simulation Director, TeamHealth, Northeast 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. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert 0 Cases Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Michael J. McCrea, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

2. Employer: Mercy Emergency Care Services, Inc. Team Health

Address: 2213 Cherry St

Toledo, OH 43608

Position Held: Attending physician, residency core faculty

Type of Organization: Employee model

Employer: Emergency Professionals of Ohio, Inc, Team Health

Address: 7123 Pearl Rd

Middleburg Heights, OH 44130

Position Held: Part time staff physician

Type of Organization: Independent contractor model

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Ohio Chapter ACEP

Address: 5980 Venture Dr, Suite B

Dublin, OH 43017

Type of Organization: Professional medical association

Leadership Position: President, President-elect, Secretary, Immediate Past President

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

Leadership Position: President, Vice President, Immediate Past President

Duration on the Board: 2017 – 2023

Organization: University of Toledo College of Medicine Alumni Affiliate

Address: 2801 W Bancroft St, MS 301

Toledo, OH 43606

Type of Organization: Alumni board for MCO/UT medical school graduates

Leadership Position: President, President-elect, Immediate Past President

Duration on the Board: 2014 - 2021

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: Simulation director for TeamHealth, northeast group. Develop and teach simulation courses and write simulation cases for TeamHealth physicians and non-physician providers.

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:



7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Michael James McCrea, MD** Date 5/31/2025

Ohio ACEP
American College of Emergency Physicians
Advocacy | Education | Leadership

July 23, 2025

Councillors
ACEP 2025 Scientific Assembly
Salt Lake City, Utah

Dear Councillors,

The Board of Directors of the Ohio Chapter, American College of Emergency Physicians, enthusiastically endorses our friend and colleague, **Michael J. McCrea, MD, FACEP for ACEP Council Speaker**.

The Ohio Chapter has greatly benefited from Dr. McCrea's outstanding leadership and unwavering dedication to our chapter since 2010. He was awarded, by Ohio ACEP, the 2017 *Bill Hall Award for Service*, the chapter's highest honor for service with distinction. He has served on our Board of Directors since 2011 and served the chapter as President for two terms from 2015 – 2017. He has also actively participated in key chapter committees including our Education and Government Affairs Committee. He is also the Chair of our Bylaws Committee and has served as an invaluable resource in this role. His leadership is also appreciated with our Midwest Medical Student Symposium. While extremely active with the chapter's educational programs as a contributing faculty member for courses and textbooks, his ability to testify and speak to legislators has also been of great value to the chapter. He is a compelling and powerful advocate for his profession. In fact, the chapter awarded him with the 2019 *Emergency Physician Advocacy Award* to celebrate his leadership in advocacy efforts. Dr. McCrea has also represented the Chapter as a Councillor annually since 2011, after a year as an Alternate Councillor with the Ohio ACEP Leadership Development Academy. In 2022 he served as the chapter's council delegation leader.

Dr. McCrea has consistently demonstrated an unwavering commitment to both Emergency Medicine and the College. He has shared without hesitation his expertise on committees of the College, including the Educational Meeting Planning Committee, the Bylaws Committee (Chair) and the State Legislative-Regulatory Committee. His leadership in the College has been recognized by appointments to the Council Reference Committee; Tellers, Election, and Credentials Committee; and Council Steering Committee. His dedication and impact at Council were further acknowledged in 2020 when he received the Council Meritorious Service Award, and again in 2023 when he was elected Council Vice-Speaker by his peers. A skillful listener, communicator, and leader, he has demonstrated at every turn his commitment to the cause and mission of emergency medicine and is well prepared to serve as Council Speaker.

**The Ohio Chapter ACEP is pleased to support Michael J. McCrea, MD, FACEP for election as ACEP Council Speaker.**

Sincerely,



Dr. Christina Campana
President, Ohio ACEP

**President**
Christina Campana, DO, FACEP

**President-Elect**
RJ Sontag, MD, FACEP

**Treasurer**
Dan C. Breece, DO, CPE, FACEP

**Secretary**
Laurel Barr, MD, FACEP

**Immediate Past President**
Joseph Tagliaferro, DO, FACEP

**Executive Director**
Holly Dorr, MBA, CAE, CMP

**5980 Venture Dr., Suite B, Dublin, OH 43017**
**Phone: (614) 792-6506**

# Michael J. McCrea, MD, FACEP

July 2025

Fellow councillors, colleagues, and friends,

These past two years serving as your vice speaker has provided the most rewarding experiences of my professional life. Along with our esteemed speaker, to represent the Council to the Board of Directors, to "be in the room where it happens," has been exhilarating. It is quite satisfying to see the journey of a resolution adopted by Council to become College objectives that then ultimately leads to policy statements or advocacy.

As the speaker's designee to the Finance Committee, I have seen firsthand that the College does not have unlimited resources nor staff time. Tough decisions must often be made while executing our fiduciary responsibility as leaders in the College. We must find the balance of the new ideas and proposals from each year's adopted resolutions with the ongoing work of the College.

I continue to believe that year-round engagement by our councillors will lead to the best use of our brief two days together each fall at Council. We need mechanisms to share potential resolutions prior to the deadline. Asking authors to work with the Council officers before the deadline to develop their ideas into strong resolutions should be the norm, not the exception. We must continue to use asynchronous testimony, especially from authors and co-sponsors. Additionally, since many chapters and sections caucus prior to Council to review resolutions, I would ask that after those meetings chapters and sections provide asynchronous testimony, even if it is simply "support" or "oppose."

Finally, perhaps it's the panoramic view from the speaker's podium, but despite the heated debate on difficult resolutions, at the end of the day, despite our many differences, I still believe that far more unites us than divides us as emergency physicians.

I would be honored to continue to serve our members, our College, and our Council, for another two years as your next speaker.

Yours in service,

Michael

# MICHAEL MCCREA, MD, FACEP
# FOR COUNCIL SPEAKER



## PRINCIPLES & VALUES

***Leverage technology for year-round member engagement***

***Facilitate quality Resolution and policy development***

***Represent your voice to the ACEP Board of Directors***

## SERVICE TO ACEP

### ACEP & Council

- Vice Speaker
- Bylaws Committee Chair
- Council Steering Committee
- Reference Committee Chair
- Council Meritorious Service Award
- Tellers, Credentials & Elections Committee
- Task Force on Council Size Chair
- Council Horizon Award
- Educational Meetings Planning Committee
- State Legislative and Regulatory Committee

### Ohio Chapter ACEP

- Chapter Council Delegation Leader
- Two-Term Chapter President
- Midwest Medical Student Symposium Chair
- Chapter Bylaws Committee Chair
- Championed HB 7 “I’m Sorry” Law
- Bill Hall Award for Service
- Advocacy Award

**2020**

- Vice Speaker
- Bylaws Committee Chair
- Task Force on Council Size
- Ohio ACEP Bill Hall Award For Service
- Council Steering Committee

**2015**

- Council Horizon Award
- Tellers, Election, & Credentials Committee
- Ohio ACEP Board of Directors

**2010**

- Ohio ACEP Council Delegation Leader
- Reference Committee Chair
- Council Meritorious Service Award
- Ohio ACEP Advocacy Award
- Midwest Medical Student Symposium
- Two-term Ohio ACEP Chapter President
- Reference Committee
- Councillor
- Alternate Councillor

# Michael James McCrea, MD, FACEP, FAAEM

13100 Five Point Rd
Perrysburg, OH 43551
(614)-975-5370 (cell)
mmccrea2@gmail.com

---

**EDUCATION:**

*THE Ohio State University Medical Center*
- Columbus, OH
- Emergency Medicine Residency
  July 2004 – June 2007

*Medical College of Ohio at Toledo*
- Toledo, OH
- Doctor of Medicine
  August 2000 – June 2004

*Ohio Wesleyan University*
- Delaware, OH
- Bachelor of Arts in Biochemistry, minor in History
- Phi Beta Kappa
- *Magna cum laude*
  August 1996 – May 2000

**PROFESSIONAL EXPERIENCE:**

*Mercy St. Vincent Emergency Medicine Residency*
- Curriculum Director
  September 2021 - Present
- Associate Program Director
  January 2020 – September 2021
- Assistant Program Director
  May 2012 – December 2019
- Simulation Director
  September 2009 – June 2018
- Core Faculty
  September 2009 - Present

*Mercy Emergency Care Services, Team Health*
- Attending Physician
  October 2014 - Present

*Lucas County Emergency Physicians, Inc., Premier Physician Services*
- Attending Physician
  September 2009 – October 2014

*Wood County Emergency Physicians, Inc., Premier Physician Services*
- Medical Director
  March 2013 – June 2014

*Mid-Ohio Emergency Physicians, LLP*
- Staff Physician

August 2009 – May 2010

*Richland County Emergency Physicians, Inc., Premier Health Care Services*

- Assistant Medical Director
  Staff Physician
  December 2008 – August 2009

*Emergency Medicine Physicians of Richland County, Ltd.*

- Staff Physician
  November 2006 – December 2008
- Quality Director
  July 2008 – December 2008

*Emergency Medicine Physicians of Guernsey County, Ltd.*

- Staff Physician
  September 2006 – December 2006

**LICENSURE AND CERTIFICATIONS:**

- American Board of Emergency Medicine
  June 2008 Initial Certification, recertified 2018
- State Medical Board of Ohio
  May 2006, renewed June 2020
- Drug Enforcement Agency
  May 2006, renewed January 2018
- Advanced Cardiac Life Support (ACLS), expires 2022, instructor
- Pediatric Advanced Life Support (PALS), expires 2022, instructor
- Advanced Trauma Life Support (ATLS), initial 2004

**LEADERSHIP EXPERIENCE:**

*American College of Emergency Physicians*

- ACEP Council Vice Speaker
  October 2023 – Present
- ACEP Leadership and Advocacy Conference Planning Group
  January 2024 – Present
- ACEP Finance Committee
  October 2023 – Present
- ACEP Educational Meeting Planning Committee
  October 2021 – Present
  ACEP23 track chair health policy, airway/anesthesia/analgesia
  ACEP22 track chair health policy
- ACEP Task Force on Supply Chain
  April 2020 – August 2020, member
- ACEP Task Force on Council Size
  January 2019-October 2019, Task Force Chair
- ACEP Bylaws Committee
  Chair 2021-2023
  Vice Chair 2020-2021
  Member 2015 - Present

- ACEP Council Steering Committee
  Member 2016-17
- ACEP State Legislative/Regulatory Committee
  Member 2012-2020
  Subcommittee Chair, EM Practice, 2016-2019
  Objective leader 2013-2014, 2014-2015, 2015-2016, 2019-2020
- ACEP Council Reference Committee
  Committee Chair 2021, Boston
  Committee Member 2012, Denver
- ACEP Council Tellers, Election, and Credentials Committee
  Member 2013-2016

*Ohio Chapter of American College of Emergency Physicians*

- Chair, Bylaws Committee
  2019 – Present
- Chair, Midwest Medical Student Symposium
  2015 – Present
- Chapter Immediate Past President
  2017 – 2018
- Chapter President
  2015-2016, 2016-2017
- Chapter President-elect
  2013-2014, 2014-2015
- Chapter Secretary
  2011-2012, 2012-2013
- Board of Directors
  2011- Present
- Councilor
  2011- Present
- Leadership Development Academy
  2011-12
- Chapter Government Affairs Committee member
  2010 – 2024
- Chapter Education Committee member
  2020 – 2024, Board Liaison
  2010 – 2020, Member
- Alternate Councilor
  2010

*Mercy St. Vincent Medical Center - Toledo, OH*

- Graduate Medical Education Committee
  Member, 2018 - 2021
- Code Blue Committee
  Chair, 2017 - 2021

*MedCentral Hospital - Mansfield, OH*

- ICU Committee member

2009
- Trauma Committee member
  2009

*The Ohio State University Medical Center*
- Resident's Advisory Council
  2004 – 2007
  - Co-Chair 2006 – 2007
  - Emergency Medicine Residency Representative, 2006 – 2007
- Graduate Medical Education Committee, Resident Representative
  2006 – 2007

*Medical College of Ohio*
- School of Medicine Curriculum Committee
  2001 – 2004
- School of Medicine Year III and IV Curriculum Subcommittee
  2002 – 2004
- School of Medicine Year I and II Curriculum Subcommittee
  2000 – 2002

**PROFESSIONAL MEMBERSHIPS:**

- American College of Emergency Physicians (ACEP)
- Ohio Chapter American College of Emergency Physicians (Ohio ACEP)
- Emergency Medicine Resident's Association (EMRA)
- American Academy of Emergency Medicine (AAEM)
- Council of Residency Directors (CORD)
- American Medical Association (AMA)
- Ohio State Medical Association (OSMA)

**RESEARCH EXPERIENCE AND SCHOLARLY ACTIVITIES:**

*Mercy St Vincent's Medical Center*
- Scholarly Publications and Presentations
  - Posadny, C, Keel, C, Douglas, T, Watz, M, Aouad, A, **McCrea, M**. Syphilis is Serious: Case Report of Tertiary Syphilis. Post Presentation, Mercy Health Research Day, May 2024

  - Plewa, M, Ledrick, D, Jenkins, K, Orqvist, A, **McCrea, M**. Can USMLE and COMLEX-USA Scores Predict At-Risk Emergency Medicine Residents' Performance on In-Training Examinations? *Cureus*. 2024;16(4):e58684. PMID: 38651085

  - Murali, S, Davis, C, **McCrea, M,** Plewa, M. Orbital Compartment Syndrome: Pearls and Pitfalls for the Emergency Physician. *J Am Coll Emerg Physicians Open*. 2021 Mar 6;2(2):e12372. PMID: 33733246

- Curriculum Director for Emergency Medicine Residency
  April 2016 – Present
  - Oversaw complete curriculum overhaul for residency didactics

- Director of Simulation Education for Emergency Medicine Residency, September 2009 – June 2018
  - Have implemented a curriculum to assess core competency in ACLS and PALS for Emergency Medicine Residents

  - **McCrea, MJ**, Orqvist, AM, Burgard, K. Assessment of Advanced Cardiac Life Support and Pediatric Advanced Life Support Competency by Emergency Medicine Residents Using a Simulation Based Curriculum. Poster presentation, Midwest Regional SAEM Meeting, October 2012.

  - **McCrea, MJ.** Assessment of Advanced Cardiac Life Support and by Emergency Medicine Residents Using a Simulation Based Curriculum. Poster presentation, ACEP Research Forum, October 2011.

  - **McCrea, MJ**. *Ann Emerg Med*. 2011;**58**:S335.

  - Developed a comprehensive high-fidelity simulation case library to assess Milestones for our Emergency Medicine Residency

*Ohio ACEP*

- Chapter author for Carol Rivers' Preparing for the Written Board Exam in Emergency Medicine, 11th Ed (released January 2024)
- Chapter author for Carol Rivers' Preparing for the Written Board Exam in Emergency Medicine, 8th Ed (released January 2017)
- Chapter author for Carol Rivers' Preparing for the Oral Board Exam in Emergency Medicine, 11th Ed (released January 2016)
- Chapter author for Carol Rivers' Preparing for the Written Board Exam in Emergency Medicine, 7th Ed (released January 2014)
- Chapter author for Carol Rivers' Preparing for the Oral Board Exam in Emergency Medicine, 10th Ed (released January 2013)
- Article reviewer for Ohio ACEP 2011 LLSA Express

*The Ohio State University Medical Center*

- Scholarly Project and Quality Improvement Project
  - Diagnostic Accuracy and Appropriate Antibiotic Treatment of Pelvic Inflammatory Disease and Cervicitis by Emergency Physicians

*Medical College of Ohio*

- Research Fellowship at Medical College of Ohio Family Practice Center, in Toledo, OH
  Summer 2001

**TEACHING EXPERIENCE:**

*Michigan College of Emergency Physicians*

- Winter Symposium, faculty lecture, "Hyperemesis: Gravid and Grass," January 2024
- Winter Symposium, faculty lecture, "You Swallowed What?" January 2024

- Winter Symposium, faculty lecture, "Wide World of Tachycadias," January 2023
- Winter Symposium, faculty lecture, "Bradycardais," January 2023
- Winter Symposium, faculty lecture, "Themes and Variations of M&M," January 2022
- Winter Symposium, faculty lecture, "The Day I Almost Quit," January 2021

*All Ohio EM Conference*
- Faculty lecture, "The Day I Almost Quit," January 2020
- Faculty panelist, "Airway Emergencies," January 2019

*American College of Emergency Physicians*
- ACEP Teaching Fellowship, completed March 2011
- Project selected for Poster Presentation at 2011 ACEP Research Forum

*Ohio Chapter of American College of Emergency Physicians*
- Ohio ACEP Resident Connect, "My Worst Birthday Ever: The Day I Got Sued," August 2021
- Emergency Medicine Board Review Course – Faculty
  September 2011 - 2020
- Oral Board Review Course
  Course Co-Director
  April 2012 – 2017
  Faculty examiner
  April 2010 – September 2017

*The Ohio State University Medical Center*
- Teaching resident for monthly procedure labs for fourth-year medical students rotating on Emergency Medicine Clerkship
- Teaching resident for ultrasound skills lab for fourth-year medical students enrolled in Emergency Ultrasound Honors Elective

**VOLUNTEER AND COMMUNITY SERVICE**

*Douglas A. Rund Emergency Medicine Alumni Society*
- Co-founder of alumni society for graduates of The Ohio State University Emergency Medicine Residency to plan continuing education, social, community service, and life-long learning events.
- Immediate Past President
  September 2021 - 2023
- President
  October 2019 – September 2021
- Vice-president
  September 2017 – October 2019
- Board of Governors
  September 2017 - 2023

*University of Toledo College of Medicine Alumni Affiliate*
- Board Past-President

May 2020 – May 2021
- Board President
  May 2018 – May 2020
- Scholarship Committee Chair
  Spring 2015 – 2022
- Board of Trustees
  2013 - 2022

**HONORS AND AWARDS:**

*Ohio Chapter American College of Emergency Physicians*
- Emergency Physician Advocacy Award, 2019
- Bill Hall Award for Service, 2017, the Chapter's highest award

*American College of Emergency Physicians*
- ACEP Council Meritorious Service Award, 2020
- ACEP Council Horizon Award, 2014

*Premier Physician Services*
- Newcomer Medical Director of the Year, 2013

*Mercy St. Vincent Medical Center*
- Best Case Report Poster Presentation, Mercy Health Research Day, May 2024
- Best Poster Presentation, Midwest Regional SAEM Regional October 2012
- Attending of the Year, Emergency Medicine Residency, 2011-2012

*The Ohio State University Medical Center*
- Resident Research Award, 2007

**REFERENCES:** Available upon request

**PERSONAL INFOMRATION:** Married to wife Pamela in 2000
Son Mitchell born 2004, daughter Abigail born 2006
Hobbies and Interests: golf, competitive powerlifting, college football, lighthouses, LEGO, JRR Tolkien, Game of Thrones, Star Wars, and GO BUCKS!

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

## Kurtis A. Mayz, JD, MD. MBA, RP, FACEP

***Question #1:*** **What qualities do you possess to be effective in this role?**

My training and experience as a lawyer, parliamentarian, and department chair has developed many skills that are useful as an effective vice speaker and presiding officer.

As an attorney, I understand my role as skilled advocate and strong voice for my client well. I am a good listener and an effective communicator. I can understand varied concerns and arguments, synthesize and distill information, and communicate it in a way which mediates disagreements. I know how to work to find common ground and ensure that the written language reflects the agreement. This will help guide my ability to hear and understand the voice of the Council, represent Council before the board and translate that to actions that speak and results that last. I know how to manage time effectively, keep meetings or hearings on schedule and organize the flow of information and evidence. I am able to maintain composed and make sound and decisive judgements even when faced with challenging or tense situations.

As a registered parliamentarian, I have a solid working knowledge of the rules and procedures that help facilitate smooth and effective meetings, and a strong sense of impartiality and fairness which allows me to be unbiased and treat all participants equally. This ensures that everyone has a chance to be heard, and their rights are protected. I am trained in maintaining decorum in a respectful and orderly environment which ensures that discussions remain relevant and focused and makes effective use of members' time. I am calm and deliberate.

As an organizational leader, I can set a clear vision for the future and articulate it to others. I can motivate and inspire others, fostering a positive working environment. I develop, mentor, and empower others to realize their potential. I am a relationship builder, which leads to the trust, respect, and open communication needed from a good vice speaker. I am a problem solver and have a strong sense of adaptability and resilience. I can delegate effectively. I am experienced at thinking strategically and considering the long-term implications of decisions.

Lastly, I have integrity, believe in accountability, and am teachable. I am honest and transparent and have a willingness to learn and adapt to new information. I am passionate about the work of the Council and dedicated to the mission of the college. I will advocate strongly on behalf of the Council and work with the board to achieve our mutual goal, to promote the highest quality of emergency care and to serve as the leading advocate for emergency physicians, their patients, and the public.

***Question #2:*** **How do you balance free and open debate versus meeting efficiency?**

The first key to balancing free and open debate and meeting efficiency is realizing that not all debate has to occur on the Council floor, and effectively using processes which allow us to discuss issues before the Council meeting even begins.

Encouraging the use of asynchronous testimony is instrumental in the success of the meeting and we should continue to develop this process further. Creation of Council workgroups on "hot button" issues could help facilitate resolution development and help limit the sometimes-duplicative nature of resolutions. In doing so, we create a more contemplative environment where ideas can be more thoroughly vetted and refined prior to the Council meeting, with the goal of a more streamlined and efficient meeting. This process also assists smaller chapters and sections with limited representation in ensuring that their voices can be heard in a way that is sometimes more challenging in the traditional reference committee process.

Before the Council meeting, structuring the agenda so there is sufficient time for the anticipated business is key. Preparation before the Council, including having a strong working knowledge of the resolutions to be discussed and a sense of the areas of contention which might be addressed, can prepare the presiding officer to efficiently handle the debate.

During the Council meeting, the presiding officer must create a safe environment that encourages open dialogue and balanced participation, while keeping the council on task. Knowledge of parliamentary procedure, maintaining impartiality, and collaboration with the parliamentarian also guides the efficiency of this process. For example, more effective use of the consent agenda and education on its use could help with meeting efficiency. As a registered parliamentarian I can facilitate this. As the presiding officer, I will help guide discussions through active listening and the ability to summarize and clarify points which will move the discussion forward. I will guide councillors to remain professional, respectful, and factual in their discussions.

Lastly, the presiding officer must recognize when everything that needs to be said has been said, even if not everyone has had an opportunity to say it and help guide the Council to that same conclusion. Affirming that many good points have been heard and asking if there are any new points can help guide the debate to a close. The ultimate goal being that the Council feels that its collective voice is heard and that councillors have a worthwhile experience in the process.

***Question #3*: What would improve the councillor experience and Council operations?**

Although the "main event" is the in-person Council meeting, the operational aspect of Council and the councillor experience is a year-long process. My goals are to help the Council feel informed and vested in the work of the council and its officers year-round and engage more members in the process.

As Vice Speaker, I will work with the Speaker to keep the Council informed of current events and work with chapter leaders to help disseminate the work of the Council by both providing regular written updates on the work of the Council and attending chapter meetings as requested. I will continue to make robust use of the engagED Council forum to share Council work and seek input as needed.

I will work with the Speaker to develop the "Council Corner," a segment in ACEP Now that educates members on the Council process and highlights the ongoing work of the Council in a way that demonstrates how that work benefits the membership. This may inspire other members to become engaged in the process. I would also consider having Council social media accounts to be able to provide highlights and updates in real time. This creates the added benefit of providing an external face of the Council which spotlights its important work to other stakeholders and collaborators as well as the community at large. Strategically communicating the work of the Council through social media and other media outlets can also help the College in its advocacy efforts.

Council and Council meeting procedure education would help enhance the efficiency of meetings. We have a significant number of new councillors each year. Historically we have relied on new councillor orientation to introduce the Council and its procedures. This year, for the first time, "ACEP Council 101," an on-demand orientation is offered. As the Council work becomes longer in scope and timeline, I would work to expand this project to provide accessible basic online modules or optional live online opportunities to learn about the Council process and parliamentary procedure. We should also have a resolution development committee that could formally serve to review and provide feedback on resolution ideas and resolutions in development.

At the Council meeting, efficiency is paramount, and we need alternate ways of disseminating information to the Council and the membership, so we are ready to work when the gavel hits. I would advocate for limiting the number of in-person speeches in favor of increasing the use of on-demand formats. While I believe that it is important for the candidates and ACEP leadership to have live interaction with the Council, I also believe that we can continue to be more selective in our other presentations. Although it may seem counter-intuitive, by limiting some presentations to pre-recorded online formats, I'm convinced we can get more voices and messages heard. Some issues are urgent and need live debate. Others may not be.

Council decorum is also important. Creating an environment that ensures all councillors can feel comfortable expressing their viewpoints without retribution is key. This takes a collaborative effort from Council leadership and individual delegations and councillors.

Finally, it is important that we continue to leverage technology to ensure a smooth meeting process. We need to ensure that the meeting space is equipped with adequate wi-fi capability that can support our growing numbers. We need to ensure that the technology that we use for amendment submission and the voting process is user friendly and free of error. We need to discuss whether, when, and how remote options for meeting attendance and voting should be offered. Our collective portfolio of online and technological services needs to ensure that we can effectively keep councillors up to date and actively engaged in the process before, during, and after the meeting. Once again, the key is that every voice is heard.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Kurtis A. Mayz, JD, MD. MBA. RP, FACEP

***Contact Information***

420 E Archer St. Apt 405, Tulsa, OK 74120
***Phone:*** 914-420-7927
***E-Mail:*** drmayzesq@gmail.com

***Current and Past Professional Position(s)***

CURRENT POSITION

Chairman Pediatric Emergency Medicine
Medical Director Pediatric Emergency Center
Saint Francis Hospital, Tulsa, OK

PREVIOUS

Emergency Medicine Physician
Heart of Mary Hospital, Urbana, IL

Firefighter (Traveling Physician)
United States Acute Care Solutions

Emergency Medicine Physician
Presence Saint Joseph Medical Center, Joliet, IL

Associate Director and Vice Chairman-Department of Emergency Medicine
Presence Saint Joseph Medical Center, Joliet, Illinois

Interim Medical Director and Chairman- Department of Emergency Medicine
Presence Saint Joseph Medical Center, Joliet, Illinois

Assistant Director-Department of Emergency Medicine
Presence Saint Joseph Medical Center, Joliet, Illinois

Attending Physician- United States Acute Care Solutions (USACS)
Genesys Regional Medical Center, Grand Blanc, Michigan

***Education (include internships and residency information)***

**Education**

Masters of Business Administration: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois

Medical Doctor: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois

Juris Doctor: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois

BA: Political Science; BA: Biology
Certificate in Lobbying: Center for Congressional and Presidential Studies
The American University, Washington, DC

**Post Graduate Training**

Pediatric Emergency Medicine Fellowship
University of Michigan Health System, Ann Arbor, Michigan

Chief Resident, Emergency Medicine, Patient Safety and Quality Improvement
Stony Brook University Medical Center, Stony Brook, New York

Emergency Medicine Resident
Stony Brook University Medical Center, Stony Brook, New York

**MD: 2011**

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

American Board of Emergency Medicine-Pediatric Emergency Medicine (2019)
American Board of Emergency Medicine (2016)

***Professional Societies***

American Institute of Parliamentarians
National Association of Parliamentarians
American College of Emergency Physicians
Emergency Medicine Resident Association
Oklahoma College of Emergency Physicians
American Academy of Emergency Medicine
American Academy of Pediatrics
American College of Legal Medicine
American Bar Association
American Health Lawyers Association
American Medical Association
American College of Healthcare Executives
American Association for Physician Leadership

***National ACEP Activities – List your most significant accomplishments***

ACEP Teaching Faculty- Medical-Legal (2016-Present)

Council:
Vice Speaker Candidate (21,23)
Steering Committee Member (20-21)
Reference Committee Chair (24)
Reference Committee Member (19, 20, 22)
Tellers and Credentials Committee Member (20-23)
Special Task Force on Council Elections (19)
Councillor (OK/IL): (17-Present)

Committees:
Pediatric Emergency Medicine
Medical Legal
Bylaws

***ACEP Chapter Activities – List your most significant accomplishments***

President- Oklahoma College of Emergency Physicians
Board of Directors: Oklahoma College of Emergency Physicians
Bylaws Committee Chair: Oklahoma College of Emergency Physicians
Councillor: Oklahoma College of Emergency Physicians
Councillor: Illinois College of Emergency Physicians

***Practice Profile***

***Total hours devoted to emergency medicine practice per year:*** **1680** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **50** % Research ____ % Teaching **10** % Administration **40** %

Other: _____ ____%

***Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)***

I am the Chairman of Pediatric Emergency Medicine and Medical Director of the Pediatric Emergency Center at the Children's Hospital at Saint Francis in Tulsa, Oklahoma. The hospital is one of 6 sites in the Saint Francis Health System and is one of two Children's Hospitals in the state of Oklahoma. We are a referral hospital for the state and surrounding region with multiple subspecialties and operate as a level 1 trauma center although not currently designated by ACS. We play host to 6 different residency programs in Emergency Medicine, Pediatrics, and Family Medicine.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Chairman of Pediatric Emergency Medicine
Medical Director Pediatric Emergency Center

***Expert Witness Experience***

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert** **2** **Cases** **Plaintiff Expert** **Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Kurtis A. Mayz, JD, MD. MBA. RP, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: United States Acute Care Solutions

Address: 4535 Dressler Road, NW

Canton, OH 44718

Position Held: Chairman Pediatric Emergency Medicine
Medical Director Pediatric Emergency Center

Type of Organization: Saint Francis Hospital, Tulsa, OK

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Oklahoma College of Emergency Physicians

Address:

Type of Organization:

Leadership Position: Board Member and President

Term of Service: July 2022- Present (President 2024- Present)

Organization: Oklahoma State Association of Parliamentarians

Address: 213 S Main St

Independence MO 64050

Type of Organization:

Leadership Position: Board Member

Term of Service: 2023- Present

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: Stock owner United States Acute Care Solutions

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☒ If YES, Please Describe: Mother, tele ICU nurse Westchester Medical Center, Valhalla, NY

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ N/A
☒ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Kurtis A Mayz** Date 5/16/25

Oklahoma College of
EMERGENCY
PHYSICIANS

July 20, 2025

ACEP Councillors,

It is with great enthusiasm and honor that the Oklahoma College of Emergency Physicians endorses Dr. Kurtis A Mayz JD, MD, MBA, RP, FAAP, FCLM, FAAEM, FACEP, for Vice-Speaker of the ACEP Council.

Dr. Mayz came to Oklahoma from Illinois in 2021, where he was extraordinarily active in ACEP/ICEP, to take over as chairman of the pediatric emergency department at Saint Francis Hospital in Tulsa, our state's largest emergency department.

Although his education, training, and work experience have carried him far and wide across the country, we are blessed and fortunate to have him join us here in Oklahoma. While his CV speaks for itself, he immediately impressed us with his clinical acumen, his willingness to help contribute to, and lead our state ACEP chapter and with his wit and wisdom. In short order, he was elected to the OCEP Board of Directors, served as one of our councillors and, as an active ACEP bylaws committee member, took over as Chair of our own bylaws committee, where he effectively brought our bylaws into compliance and functionality.

In 2024, Dr Mayz was elected president of OCEP. As president, he has continued to demonstrate leadership excellence. He has met with all residency programs in the state and encouraged ACEP and chapter membership helping us to obtain an additional councillor seat this year. He has led our advocacy efforts including working to revive our PAC. He is currently working to establish a collaborative leadership development program.

As a Council member, Dr Mayz has served on the steering committee, tellers and credentials committee, and reference committee which he has also chaired. He has served on ACEP committees including the pediatric emergency medicine, medical-legal, and bylaws committees. Dr Mayz also serves as ACEP teaching faculty, and is an active ABEM oral board examiner.

As chairman of a department, Dr Mayz understands what it means to lead a team of physicians. As a former traveling physician, Dr. Mayz's clinical practice has taken him to several states across the country working in many different practice environments in

BOARD OF DIRECTORS
President
Kurtis A Mayz
JD, MD, MBA, FACEP
Vice-President
Cecilia Guthrie
MD, FACEP
Treasurer
Derek Martinez
DO
BOARD
Aimee R. Blagovich
DO, FACEP
Jeff Goodloe
MD, FACEP
Laura Janneck
MD, MPH, FACEP
James R. Kennedye
MD, RPH, FACEP
McKenzi Ormsbee
DO

Oklahoma College of
EMERGENCY
PHYSICIANS

both pediatric and general emergency medicine departments. This experience has given him a broad view of the practice of emergency medicine across the country in a way that allows him to understand the issues facing our members from a more global perspective. As a lawyer, Dr. Mayz has trained to be an effective advocate and leader. As a registered parliamentarian, he has a strong working knowledge of the rules and procedures that govern effective meetings.

A true servant leader and educator, Dr Mayz's business and legal backgrounds are unique assets among EM physician leaders, and they have thus far paid dividends for our chapter organization and the other organizations he serves. Dr Mayz is a beloved member of our chapter, enjoyed for his energetic spirit and whit, appreciated for his candor and even-keeled nature, and respected for his knowledge and expertise.

Dr Mayz is as articulate, devoted, energetic, wise and qualified an individual as you will ever meet and will unquestionably make an exceptional ACEP Vice Speaker. His diverse training and practice experience make him uniquely qualified to serve as an effective Vice Speaker, leader, and advocate for our Council. It is without a doubt that he will bring these skills and experience to the office of Vice Speaker in a way that will exceptionally advance the goals of the Council and the College.

The Oklahoma College of Emergency Physicians unequivocally endorses Dr. Kurtis A. Mayz for Vice-Speaker of the Council of the American College of Emergency Physicians and looks forward to his years of dedicated service.

Yours Very Sincerely and Respectfully,

CCGuthrie MD

Cecilia Guthrie, MD, FACEP
OCEP Vice President

BOARD OF DIRECTORS
President
Kurtis A Mayz
Vice-President
Cecilia Guthrie
Treasurer
Derek Martinez
BOARD
Aimee R. Blagovich
Jeff Goodloe
Laura Janneck
James R. Kennedye
McKenzi Ormsbee

# Kurtis A. Mayz, JD, MD. MBA. RP, FACEP

Fellow Councillors,

Thank you for your efforts to advance emergency medicine, and your invaluable service to the College as Councillors. I am humbled by the opportunity to seek your vote and serve as Vice Speaker as we work to move the College forward.

My efforts as your next Vice Speaker, are simply summarized, **"ACEP Physicians, your voice heard."** I view our organization as a family united by the common goals of "promoting the highest quality of emergency care," and being "the leading advocate for emergency physicians, their patients, and the public."

As an organization, as I look at our "house," physician members serve as the foundation above which all else rests. Without them the organization would not exist. ACEP operates on a daily basis under the covering of its Board of Directors and administrative staff. As the voice of chapters and sections, the Council serves as the representative pillars between the physician and the organization. As Vice Speaker and your advocate when Council is not in session, my vision is to improve:

**Accountability:** I will hold the Board accountable to the will of the Council. I will sometimes partner with the Board in accomplishing the goals of the College and at other times act as the loyal opposition to ensure that the voice of the Council is heard and followed.

**Collaboration:** In these challenging times, now more than ever we need to understand that there will be issues that we will not agree on. While these are important issues that need discussion, it is important that we discuss these issues internally rather than creating division externally. Moreover, we need to focus on issues on which we can find common ground. This process should not be one that is initiated on the Council floor. I will work to create collaborative work groups to discuss these issues in an effort to create common ground as well as reduce redundancy.

**Engagement:** Council work extends beyond the Council meeting. With many new Councillors annually, it's important to ensure that we keep the Council engaged and informed throughout the year and ensure the appropriate resources and training to ensure effective participation in the Council. In addition, we must continue to demonstrate the importance of Council service and develop qualified leaders to carry out the business of the Council. I will work to continue to improve communication within the Council and work with individual Chapters and Sections to create opportunities for leadership development.

**Process:** The pandemic era taught us that we must continue to keep pace with the changing flow of information and be nimble in the way we conduct business. I will work to improve processes by leveraging technology and resources to create an effective environment to conduct Council business.

As a first generation Venezuelan-American I recognize the importance of leadership development and inclusive excellence. I am the product of leadership that believed in me as a resident physician and continued to encourage me and provide opportunities for me to engage in the College. Ultimately this led to the opportunity to lead. We need to continue to work towards a leadership that is as diverse as our membership and our patients. We need to create and foster opportunities for leadership development amongst our diverse group of members. I will work to create opportunities to develop Council leaders that embody this goal.

As Vice Speaker I will listen as effectively as I speak, guide as effectively as I lead, and encourage as effectively as I advocate. Thank you for this opportunity to serve you, as I work to ensure ***your voice is heard***.

Respectfully,

Kurtis

ELECT MAYZ
VICE SPEAKER



*ELECT*

# KURTIS A MAYZ

**JD,MD,MBA, RP, FACEP**

## A C E P
## V I C E  S P E A K E R

*"I will listen as effectively as I speak, guide as effectively as I lead, and encourage as effectively as I advocate."*

**EVERY VOICE HEARD**

# VISION

Physican members are the foundation of our organization, without which it would not exist. ACEP operates on a day to day basis under the covering of its Board of Directors and administrative staff. As the voice of chapters and sections, the Council serves as the representative pillars between the physician and the organization. As Vice Speaker and a leader of the Council, your advocate when Council is not in session, I will work with the Speaker to:

- Hold the Board **ACCOUNTABLE** to the will of the Council
- Foster **COLLABORATION** through workgroups and a more longitudinal Council workflow throughout the year
- Encourage **ENGAGEMENT** by working with chapters and sections to improve communication and leadership development, and demonstrate the importance of Council service.
- Improve **PROCESSES** by leveraging technology and resources to create an efficient and effective environment to conduct Council business and improve Councillor experience.



# EXPERIENCE

## ACEP

- Educational Faculty- Medical Legal and Risk Management
- Bylaws, Medical-Legal, and Pediatric Emergency Medicine Committees
- Oklahoma Chapter: President, Board of Directors, Parliamentarian, Bylaws Committee Chair

## Council

- Steering, Reference, and Tellers Committees
- Chair- Reference Committee and Steering sub-comittee on Council Meeting
- Member- Special task force on elections

## Clinical

- Board Certified in Emergency and Pediatric Emergency Medicine
- Chairman of Pediatric Emergency Medicine and Medical Director of Pediatric Emergency Center, Saint Francis Children's Hospital, Tulsa, Oklahoma
- Former Traveling Physician- 10 states, academic, non-academic, urban, suburban, and rural settings, has a broad understanding of what it is like to practice EM across the country
- Telemedicine physician

## Professional

- Registered Parliamentarian-National Association of Parliamentarians, experience with parliamentary procedure and meeting facilitation.
- Certified Parliamentarian Candidate- American Institute of Parliamentarians
- Member- American College of Parliamentary Lawyers
- Attorney- Trained as an advocate, able to see issues from multiple different perspectives, anticipate arguments, frame the narrative, and defend/advocate for positions that are not his own. Trained to understand the client's needs and develop the strategy that best meets those needs.
- MBA concentration in healthcare and human resources- leadership skill in healthcare administration and organizational management.

*Actions that speak.*
*Results that last.*

## Proudly Endorsed By

Oklahoma College of EMERGENCY PHYSICIANS

# Kurtis A Mayz, JD, MD, MBA, RP, FAAP, FCLM, FAAEM, FACEP

420 E Archer St
Apt 405
Tulsa, OK 74120
drmayzesq@gmail.com
914-420-7927



## Education

| | |
|---|---|
| 08/2008-05/2011 | Masters of Business Administration: Medical Scholars Program<br>University of Illinois, Champaign-Urbana, Illinois |
| 08/2006-05/2011 | Medical Doctor: Medical Scholars Program<br>University of Illinois, Champaign-Urbana, Illinois |
| 08/2004-12/2006 | Juris Doctor: Medical Scholars Program<br>University of Illinois, Champaign-Urbana, Illinois |
| 08/2000-05/2004 | BA: Political Science; BA: Biology<br>Certificate in Lobbying: Center for Congressional and Presidential Studies<br>The American University, Washington, DC |

## Post Graduate Training

| | |
|---|---|
| 07/2014-06/2016 | Pediatric Emergency Medicine Fellowship<br>University of Michigan Health System, Ann Arbor, Michigan |
| 07/2013-06/2014 | Chief Resident, Emergency Medicine, Patient Safety and Quality Improvement<br>Stony Brook University Medical Center, Stony Brook, New York |
| 07/2011-06/2014 | Emergency Medicine Resident<br>Stony Brook University Medical Center, Stony Brook, New York |

## Post Graduate Certifications

| | |
|---|---|
| 11/2022 | Registered Parliamentarian-National Association of Parliamentarians |
| 09/2014-04/2016 | GME Scholars Program: Healthcare Administration Certificate<br>University of Michigan Health System, Ann Arbor, Michigan |
| 2013 | ACEP Emergency Department Director's Academy: Phase 1<br>American College of Emergency Physicians, Dallas, TX |
| 08/2004-05/2006 | Graduate Teaching Certificate |

University of Illinois, Champaign-Urbana, Illinois

## Board Certifications

2019 American Board of Emergency Medicine-Pediatric Emergency Medicine

2016 American Board of Emergency Medicine

## Medical Licensure

California
Connecticut
Florida
Illinois
Maryland
Michigan
Ohio
Oklahoma
New York
Pennsylvania

## Legal Licensure

2008-Present New York State Bar

2007-Present New Jersey State Bar

2007-Present Federal District Court of New Jersey Bar

## **Notary**

2024-Present Notary Public: State of Oklahoma

2005-Present Notary Public: State of New York

## Certifications

2011-Present Advanced Cardiac Life Support (ACLS)

2011- Present Advanced Trauma Life Support (ATLS)

2011-Present Pediatric Advanced Life Support (PALS)

2014 Neonatal Resuscitation Program (NRP)

2013 Difficult Airway Course

## Work Experience-Medical

| | |
|---|---|
| 12/2021-Present | Chairman Pediatric Emergency Medicine<br>Medical Director Pediatric Emergency Center<br>Saint Francis Hospital, Tulsa, OK |
| 11/2018- Present | Emergency Medicine Physician<br>Heart of Mary Hospital, Urbana, IL |
| 1/2017-12/2021 | Firefighter (Traveling Physician)<br>United States Acute Care Solutions |
| 11/2017-09/2018 | Emergency Medicine Physician<br>CEP America<br>Presence Saint Joseph Medical Center, Joliet, IL |
| 9/2017-10/2017 | Associate Director and Vice Chairman-Department of Emergency Medicine<br>United States Acute Care Solutions (USACS)<br>Presence Saint Joseph Medical Center, Joliet, Illinois |
| 5/2017-8/2017 | Interim Medical Director and Chairman- Department of Emergency Medicine<br>United States Acute Care Solutions (USACS)<br>Presence Saint Joseph Medical Center, Joliet, Illinois |
| 7/2016-4/2017 | Assistant Director-Department of Emergency Medicine<br>United States Acute Care Solutions (USACS)<br>Presence Saint Joseph Medical Center, Joliet, Illinois |
| 11/2014-6/2016 | Attending Physician- United States Acute Care Solutions (USACS)<br>Genesys Regional Medical Center, Grand Blanc, Michigan |

## Work Experience-Legal

| | |
|---|---|
| 2/2020-Present | Medical Legal Mayz Consulting, LLC<br>Tulsa, OK |
| 5/2005-8/2005 | Law Intern-Hon. William K Nelson<br>New York State Supreme Court, New City, New York |

## Research Interests

1. Risk Management and Medical Legal Review
2. Patient Safety and Quality Improvement
3. Operations

## Committee Appointments

***National***

| | |
|---|---|
| 2024 | ACEP Council Reference Committee (Chairman)<br>American College of Emergency Physicians, Dallas, TX |
| 2022 | ACEP Council Reference Committee<br>American College of Emergency Physicians, Dallas, TX |
| 2020-21 | ACEP Council Steering Committee<br>American College of Emergency Physicians, Dallas, TX |
| 2020-2023 | ACEP Council Tellers and Credentials Committee<br>American College of Emergency Physicians, Dallas, TX |
| 2019-20 | ACEP Council Reference Committee<br>American College of Emergency Physicians, Dallas, TX |
| 2020 | Risk-Underwriting Committee<br>United States Acute Care Solutions, Canton, OH |
| 2019-Present | Bylaws Committee<br>American College of Emergency Physicians, Dallas, TX |
| 2017-Present | Claims Committee<br>United States Acute Care Solutions |
| 2016-Present | Risk Management Committee<br>United States Acute Care Solutions, Canton, OH |
| 2015-Present | Medical Legal Committee<br>Sub-committee Chair: Criminal vs Civil Testimony for ED Physicians (2016)<br>American College of Emergency Physicians, Dallas, TX |
| 2016-2020 | Political Action Committee: Board of Directors<br>United States Acute Care Solutions, Canton, OH |
| 2014-2018 | Pediatric Emergency Medicine Committee<br>American College of Emergency Physicians, Dallas, TX |
| 2012-2014 | Health Policy Committee<br>Emergency Medicine Residents Association, Dallas, TX |

***State***

| | |
|---|---|
| 2024-Present | President<br>Oklahoma College of Emergency Physicians |

| | |
|---|---|
| 2022- Present | Board of Directors/Councillor<br>Oklahoma College of Emergency Physicians |
| 2017-2021 | Councillor/Alternate Councillor<br>Illinois College of Emergency Physicians |

***Local***

| | |
|---|---|
| 2015-2016 | Medical Legal Review Committee<br>University of Michigan Health System, Ann Arbor, MI |
| 2013-2014 | Hospital Quality Assurance Review Committee<br>Stony Brook University Medical Center, Stony Brook, NY |
| 2013-2014 | Emergency Medicine Quality Improvement Committee<br>Stony Brook University Medical Center, Stony Brook, NY |
| 2012-2014 | Hospital Patient Safety Committee<br>Stony Brook University Medical Center, Stony Brook, NY |
| 2011-2014 | Graduate Medical Education Committee<br>Stony Brook University Medical Center, Stony Brook, NY |
| 2009-2011 | Progress and Promotions Committee<br>University of Illinois, Champaign-Urbana, Illinois |
| 2004-2011 | Medical Scholars Program Advisory Committee<br>University of Illinois, Champaign-Urbana, Illinois |

## Honors and Awards

| | |
|---|---|
| 2019 | Finalist: Firefighter-Physician of the Year<br>United States Acute Care Solutions |
| 2015 | Emeriquiz Best Case Discussant<br>American Academy of Pediatrics Annual Meeting |
| 2013 | Emergency Department Directors Academy Scholarship<br>Emergency Medicine Residents Association, Dallas, TX |
| 2012 | Leadership and Advocacy Scholarship<br>Emergency Medicine Residents Association, Dallas, TX |
| 2009 | Beta Gamma Sigma Business Honor Society<br>University of Illinois, Champaign-Urbana, Illinois |
| 2008 | NSHMBA Foundation Scholar |

| | |
|---|---|
| | National Society of Hispanic MBAs, Irving, TX |
| 2006-2010 | List of Teachers Rated as Excellent (9 semesters)<br>University of Illinois, Champaign-Urbana, Illinois |
| 2004 | Land of Lincoln Legal Scholarship<br>University of Illinois, Champaign-Urbana, Illinois |

## Professional Societies

| | |
|---|---|
| 2014-Present | American College of Emergency Physicians |
| 2008-Present | Emergency Medicine Resident Association<br>American College of Emergency Physicians |
| 2008-Present | American Academy of Pediatrics |
| 2008-Present | American College of Legal Medicine |
| 2004-Present | American Bar Association |
| 2004-Present | American Health Lawyers Association |
| 2004-Present | American Medical Association |
| 2011-2016 | Society for Academic Emergency Medicine |

## Community and Professional Service

| | |
|---|---|
| 2023-Present | Board Member<br>Oklahoma State Association of Parliamentarians |
| 2022-Present | Oral Boards Examiner<br>American Board of Emergency Medicine |
| 2021-2022 | Mock Oral Boards Examiner<br>Illinois College of Emergency Medicine |
| 2016-Present | Litigation Stress Support Team: United States Acute Care Solutions |
| 2012-Present | Leadership and Advocacy- Legislative Advocacy<br>American College of Emergency Medicine |
| 2007-Present | Competition Judge: Moot Court, Client Counseling, Negotiations<br>University of Illinois College of Law, Champaign-Urbana Illinois |
| 1999-Present | American Red Cross |

Health and Safety Instructor and Instructor trainer: Lifeguarding, CPR, Water Safety Instruction

1998-2015 New York State First Responder & Emergency Medical Technician
Spring Hill Community Ambulance
W.P. Faist Volunteer Ambulance (1st Lt-training officer '00-'03)

## Teaching

**University Courses**

2014 Medical Emergencies: *Instructor*
Stony Brook University, Stony Brook, NY

2009-2010 Business Ethics: *Teaching Assistant*
University of Illinois, Champaign-Urbana, Illinois

2007-2010 Anatomy: *Lab Instructor*
University of Illinois, Champaign-Urbana, Illinois

2004-2006 Introduction to Molecular and Cellular Biology: *Lab Instructor*
University of Illinois, Champaign-Urbana, Illinois

**Other Courses**

2016-2019 American Heart Association: BLS, ACLS, PALS,
Presence Saint Joseph Medical Center, Joliet, IL

2014-2016 American Heart Association: BLS, ACLS, PALS,
University of Michigan Health Systems Simulation Center, Ann Arbor, MI

2013-2014 Difficult Airway Course: EMS
Difficult Airway Course Northeast, Stony Brook, NY

2012-2014 American Heart Association: BLS, PALS
Stony Brook University Medical Center, Stony Brook, NY

**Clinical Teaching**

2014-2016 Pediatric Emergency Medicine Fellow
University of Michigan Health System, Ann Arbor, MI
Bedside teaching and supervision of Emergency Medicine, Pediatric, Family Medicine, and Psychiatry residents and 3rd and 4th year medical students in the pediatric Emergency Department

Pediatric Observed Structured Clinical Education (OSCE) Facilitator in twice-yearly teaching module for Emergency Medicine residents

Pediatric procedure lab Instructor for annual hands-on teaching of pediatric emergency procedures to Emergency Medicine residents

2011-2014 Clinical Assistant Instructor of Emergency Medicine
Stony Brook University Medical Center, Stony Brook, NY
Bedside teaching and supervision of emergency medicine interns, internal medicine, ob/gyn, family medicine residents, and 3rd and 4th year medical students in the emergency department setting

## Lectures and Presentations

**National**

9/2024 *Little Plaintiffs, Big Lawsuits*
ACEP23: ACEP National Conference, Philadelphia, PA

9/2024 *Sign Here, See You In Court*
ACEP23: ACEP National Conference, Philadelphia, PA

9/2024 *Medical Legal Risk in Psychiatric Emergencies*
ACEP22: ACEP National Conference, Boston, MA

10/2023 *Little Plaintiffs, Big Lawsuits*
ACEP23: ACEP National Conference, Philadelphia, PA

10/2023 *Sign Here, See You In Court*
ACEP23: ACEP National Conference, Philadelphia, PA

10/2023 *Top 5 Medical Legal Risks in 5 Minutes or Less*
ACEP23: ACEP National Conference, Philadelphia, PA

9/2022 *Little Plaintiffs, Big Lawsuits*
ACEP22: ACEP National Conference, Boston, MA

9/2022 *Liability Concerns & Controversies Working with Non-Physician Providers*
ACEP22: ACEP National Conference, Boston, MA

9/2022 *Medical Legal Risk in Psychiatric Emergencies*
ACEP22: ACEP National Conference, Boston, MA

4/2022 *Private Equity in Emergency Medicine*
ACEP Leadership and Advocacy Conference, Washington, DC

10/2021 *Little Plaintiffs, Big Lawsuits*
ACEP21: ACEP National Conference, Boston, MA

| | |
|---|---|
| 10/2021 | *Liability Concerns & Controversies Working with Non-Physician Providers*<br>ACEP21: ACEP National Conference, Boston, MA |
| 10/2021 | *Top 5 Legal Risks in 5 minutes or Less*<br>ACEP21: ACEP National Conference, Boston, MA |
| 10/2020 | *Little Plaintiffs, Big Lawsuits*<br>ACEP20: ACEP National Conference, Dallas, TX (virtual) |
| 10/2019 | *Double Jeopardy: Risk in Psychiatry*<br>ACEP19: ACEP National Conference, Denver, CO |
| 10/2019 | *Smile: You're on Candid Camera: Invasions of Privacy in the ED*<br>ACEP19: ACEP National Conference, Denver, CO |
| 10/2018 | *Double Jeopardy: Risk in Cardiology*<br>ACEP18: ACEP National Conference, San Diego, CA |
| 10/2018 | *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*<br>ACEP18: ACEP National Conference, San Diego, CA |
| 10/2017 | *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*<br>ACEP17: ACEP National Conference, Washington, DC |
| 10/2015 | *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*<br>ACEP15: ACEP National Conference, Boston, MA |
| 10/2015 | *16 year old Male with Altered Mental Status*<br>Discussant: *And that's when I thought I had died*<br>Emergiquiz: 2015 American Academy of Pediatrics, Washington, DC |

**State/Local**

| | |
|---|---|
| 3/2025 | *Little Plaintiffs, Big Lawsuits (Invited)*<br>Emerald Coast ACEP Summer Symposium |
| 9/2023 | *Little People, Big Hurts: Pediatric Emergency Medicine Trauma (Invited)*<br>Emerald Coast ACEP Summer Symposium |
| 3/2025 | *Little Plaintiffs, Big Lawsuits*<br>*Comanche County Residency Lecture*<br>Lawton, OK |
| 2/2025 | *Little Plaintiffs, Big Lawsuits*<br>*Virginia ACEP Scientific Assembly* |

06/2024 *Sign Here, See You in Court (invited speaker)*
Oklahoma Emergency Medicine Review Conference
Tulsa, OK

09/2023 *Little People, Big Hurts: Pediatric Emergency Medicine Trauma*
Saint Francis Hospital Trauma Symposium (Invited)
Tulsa, OK

7/2023 *Little Plaintiffs, Big Lawsuits*
*Michigan ACEP Scientific Assembly*

7/2023 *Top 5 Medical Legal Risks in 5 Minutes or Less*
*Michigan ACEP Scientific Assembly*

06/2023 *Medical Legal Risk in Emergency Medicine*
Oklahoma Emergency Medicine Review Conference
Tulsa, OK

05/2022 *Top 5 Legal Risks in 5 minutes or Less*
Oklahoma Emergency Medicine Residencies Conference
Tulsa, OK

11/2020 *Medical Legal Considerations for the Pediatric Emergency Medicine Physician*
Pediatric Emergency Medicine Fellowship
University of Michigan, Ann Arbor, MI

10/2020 *3-2-1 Contract*
Emergency Medicine Residency
Pennsylvania State University at Hershey

2/2016 *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*
Genesys Emergency Medicine Residency Program, Grand Blanc, MI

04/2010 Pre Hospital Pediatric Emergency Care
04/2009, 11/2009 Rockland County Fire Training Center, Pomona, NY
04/2008, 10/2008

**Intramural**

Emergency Medicine Residency Core Lectures
10/2015 *Evaluation of Pediatric Limp*
*10/2015* *Journal Club: Pediatric Resuscitation and Therapeutic Hypothermia*
11/2013 *Pediatric Trauma*
05/2013 *Bariatric Surgery Complications*
01/2013 *Pediatric Rashes*
06/2012 *Emergency Department Employment Contracts*
01/2012 *Crystal Arthropathies*

Pediatric Emergency Medicine Core Lectures
03/2015 *Medical-Legal: Basics of Testifying*
02/2015 *Pediatric Head Trauma*

Pediatric Emergency Medicine Ethics Conferences
08/2015 *Parental Refusal of Medical Treatment*
03/2015 *Minors and Medical Decision Making*

Pediatric Emergency Medicine and Critical Care Medicine Joint Lectures
03/2016 *Initial sepsis management in the Emergency Department and Pediatric Intensive Care Unit*
06/2015 *Acetaminophen Toxicity*

Pediatric Emergency Medicine Case Conference
02/2016 *8 y/o male with shortness of breath*
03/2015 *16 y/o with altered mental status*

Pediatric Emergency Medicine Board Review
09/2015 *Board review questions*

Pediatric Emergency Medicine Simulation
03/2016 *15 y/o in a motor vehicle collision*
06/2015 *3 y/o with iron toxicity*

## Research

**Extramural Presentations**

**Mayz KA, Sroufe N, Kelker H, Cranford J, Goldfarb A**: *Implementation of a Whiteboard Communication tool in the Pediatric Emergency Department and its Impact on Communication* Lecture Presentation. National Pediatric Emergency Medicine Fellows Conference, Charlotte, NC March 2015

**Intramural Presentations**

**Mayz KA, , Kelker H, Cranford J, Pham K, Goldfarb A, Sroufe N**: *Implementation of a Whiteboard Communication tool in a Pediatric Emergency Department: A Quality Improvement Initiative Shows Improved Communication and Parent Satisfaction.*
William Barsan Research Day, University of Michigan, Ann Arbor, MI April 2016

**Mayz KA, Johnson S:** *Emergency Department Attending and Resident Attitudes towards Quality Improvement and Patient Safety.* Lecture Presentation. Stony Brook Emergency Medicine Research Symposium. Stony Brook, NY June 2014

**Quality Improvement Projects**

2016 *Pediatric Resident Trauma Simulation Video*
University of Michigan Health Systems, Ann Arbor, MI
Creation of a "model" trauma simulation video as a training module to enhance the ability of pediatric residents to effectively run a trauma resuscitation

2013-2014 *Patient Safety Reporting System workgroup*
Stony Brook University Medical Center, Ann Arbor, MI
Workgroup study to redesign or purchase new patient safety reporting system with the goal of creating ease of use and enhancing employee reporting

2013-2014 *Emergency Department Workflow Study Committee Member*
Stony Brook University Medical Center, Stony Brook, NY
Workflow study looking at provider location and patient flow in emergency department. Implementation of teaming concept, relocation of provider workstations, and reordering of patient rooms

2013-2014 *Root Cause Analysis: Central Line Guidewire Retention*
Stony Brook University Medical Center, Stony Brook, NY
Root cause analysis for sentinel event of retained guidewire and subsequent implementation of new two person verification and documentation system for central line placement

2013 *Anticoagulation Order Set Review workgroup*
Stony Brook University Medical Center, Stony Brook, NY
Worked on revising anticoagulation order set to make it more streamlined and user friendly as well as less error prone

## Bibliography

Publications

**Declan A, Dietrich A, Mayz KA** on behalf of the ACEP Pediatric Emergency Medicine Committee, *Why Pursue Pediatric Emergency Medicine?* EM Resident. December 2015.

Manuscripts

**Mayz KA, , Kelker H, Cranford J, Pham K, Goldfarb A, Sroufe N**: *Implementation of a Whiteboard Communication tool in a Pediatric Emergency Department: A Quality Improvement Initiative Shows Improved Communication and Caregiver Satisfaction.*

**Mayz KA** *Emergiquiz Case Report: Sleepy, Starving, and Sexual: A 16 year old male with Altered Mental Status.*

Abstracts

**Mayz KA, , Kelker H, Cranford J, Pham K, Goldfarb A, Sroufe N**: *Implementation of a Whiteboard Communication tool in a Pediatric Emergency Department: A Quality Improvement Initiative Shows Improved Communication and Parent Satisfaction.* Poster Presentation-Pediatric Academic Society Annual Meeting April 2016

## Languages

Norwegian (Intermediate)
Spanish (Intermediate)

## Biographical

Hobbies and Interests:

- Music: Piano and Singing
- Sports: Baseball, Swimming, Tennis
- Watching sports
- Foodie
- Travel/Beach

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

## Larisa May Traill, MD, FACEP

***Question #1:*** **What qualities do you possess to be effective in this role?**

With over 20 years of experience in the American College of Emergency Physicians (ACEP), I possess a unique set of qualities that equip me to serve as an effective Council Speaker. My extensive background, including 17 years as a Councillor or Alternate, has afforded me an in depth understanding of the Council's operations and the critical issues facing our members.

I have spent 17 years on the Bylaws Committee, including three as Chair, a role that provided me with invaluable insights into the governance and procedural frameworks that guide our organization. My experience in this area also ensures that I am well-equipped to address complex procedural matters, helping to foster clarity and transparency within our discussions. In addition to my work on the Bylaws Committee, I have also served three terms on Reference Committee A, including two as Chair. This experience honed my skills in leading discussions, managing debates, and ensuring that all voices are heard: I understand the importance of balancing diverse viewpoints while maintaining a focus on constructive dialogue. My leadership in this capacity has taught me how to navigate contentious issues effectively, bringing parties together to find common ground.

I have served on the Council Steering Committee, including as Chair of the Bylaws Subcommittee and my involvement on Tellers have further strengthened my organizational skills and my ability to guide meetings efficiently. I know how to create a structured agenda that promotes orderly discussion and encourages participation from all Council members. These experiences have instilled in me the importance of time management and respect for everyone's input, which are crucial qualities for an effective Council Speaker.

My years of experience on the State Legislation Committee, coupled with my service on Ethics and Education Meetings Subcommittee, have provided me with a well-rounded perspective, essential for addressing the multifaceted challenges we face in emergency medicine today. With experience in academic, community, and critical access emergency departments, I am currently employed by a non-profit health system, which has further deepened my understanding of the operational realities our members encounter, allowing me to advocate for policies that truly reflect our speciality's needs.

In conclusion, my extensive experience within ACEP, along with my leadership roles and deep commitment to our mission, position me as a capable and effective Council Speaker. I am dedicated to fostering an inclusive environment where all members feel heard and valued, ensuring that our Council can make informed decisions that advance our profession and improve patient care.

***Question #2:*** **How do you balance free and open debate versus meeting efficiency?**

Effective communication and collaboration are essential for productive Council meetings. I would promote inclusivity and an enriched dialogue by not only leveraging the existing debate structure but also enhancing asynchronous testimony to allow for greater debate prior to Council. Doing so will allow our in-person time to remain focused and efficient.

- Optimize Asynchronous Testimony: I would increase flexibility by allowing members to submit video statements, both asynchronously and during reference committees. This would not only accommodate those who cannot attend in person due to unforeseen circumstances, such as inclement weather or personal commitments, but also those who are unable to attend multiple concurrent reference committees. I would further optimize asynchronous debate by creating discussion groups. These forums would provide a platform for in-depth exploration of "hot topics," leading to more informed debates in the larger Council.

- Fostering Collaboration on Resolutions: Collaboration is key to effective governance. To facilitate this, we should identify similar resolutions in advance, allowing authors the opportunity to consolidate similar proposals.

- Leverage Consent Agenda and a Structured Debate Format: Continue to fully utilize a consent agenda for non-controversial items, allowing more time for contentious issues that require deeper discussion. Respecting members' time, by move promptly to a vote when it becomes evident that further discussion will not change opinions. By summarizing and clarifying key points during discussions, we can gauge the room's sentiment and adjust our approach as necessary. I would also explore increasing the number of reference committees and consider live-streaming and recording meetings, to enhance transparency and accessibility, enabling all members to stay informed and engaged.

- Soliciting Feedback for Continuous Improvement: To ensure that our meetings are effective and inclusive, we must solicit feedback from members regularly. Understanding whether members feel their voices were heard and if we achieved a balance between debate and efficiency is vital for continuous improvement.

In conclusion, enhancing our Council meetings requires a strategic approach that prioritizes collaboration, inclusivity, and efficiency. By leveraging asynchronous testimony, continuing to utilize a consent agenda, and fostering open dialogue through structured debate formats, we can create a Council environment that values diverse viewpoints and encourages productive discussions. Regular feedback and optimization of meeting formats will ensure that we remain responsive to the needs of our members, ultimately leading to more effective governance.

***Question #3*: What would improve the Councillor experience and Council operations?**

Improving the operations and overall experience of the Council is crucial for fostering member engagement, enhancing productivity, and ensuring that diverse viewpoints are heard. To achieve these goals, a multifaceted approach focused on communication, member involvement, and the use of technology is essential.

First and foremost, continuing to enhance communication within the Council is vital. Leveraging digital platforms and dedicated online forums to facilitate real-time discussions and updates among Council members. I would explore a dedicated Council mobile app which would allow members to stay connected, share insights, and engage in meaningful dialogue outside of formal meetings. Regular brief updates summarizing key discussions can keep members informed and engaged, fostering community and shared purpose.

In addition to improving communication, it is imperative to focus on member engagement. Establishing anonymous feedback mechanisms can encourage Council members to voice their opinions and suggestions regarding Council operations. This feedback would be regularly reviewed to demonstrate responsiveness and adaptability. Furthermore, actively reaching out to underrepresented groups and creating inclusive spaces for discussion will ensure a wide array of perspectives and enhance the richness of Council deliberations.

Orientation programs are also crucial for improving Council operations. A relevant and accessible orientation for new Council members to familiarize them with ACEP's structure, processes, and current initiatives, will empower them to contribute more effectively. Additionally, offering workshops on parliamentary procedure, effective communication, and leadership skills will strengthen members' confidence and enhance overall Council functionality.

Finally, leveraging technology can significantly enhance Council operations. Embracing virtual meetings and hybrid models allows for broader participation, accommodating members who may not be able to attend in person.

In conclusion, by enhancing communication, fostering member engagement, providing orientation, and utilizing technology, ACEP can significantly improve Council operations and member experience. Creating an environment of open dialogue, inclusivity, and structured engagement will not only enhance the effectiveness of the Council but also strengthen ACEP's mission to advocate for emergency physicians and the patients they serve.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Larisa May Traill, MD, FACEP

***Contact Information***

2280 Ivy Hill Drive
Commerce Township, MI 48382

***Phone:*** 347-426-6610
***E-Mail:*** larisa.traill@gmail.com

***Current and Past Professional Position(s)***

Current:
Regional Medical Director, Emergency Department McLaren Greater Lansing & McLaren Grand Ledge, McLaren Medical Group. Clinical Assistant Professor, Michigan State University, College of Human Medicine, Department of Emergency Medicine

Most recent previous:
Vice Chair, Emergency Department, MyMichigan Health (University of Michigan Health System), Alma & Mt Pleasant, Greater Midland Emergency Physicians (GMEP)
Director of Quality, Safety and Compliance, GMEP

***Education (include internships and residency information)***

Hons. BSc, Biology & Latin, University of Toronto, Victoria College, Toronto, Ontario, Canada
Emergency Medicine Residency, Detroit Medical Center/Wayne State University, Detroit, MI
St. George's University, School of Medicine (SGUSOM), Doctor of Medicine, 2005

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

American Board of Emergency Medicine, 2009, recertification 2019

***Professional Societies***

American College of Emergency Physicians Fellow
Michigan College of Emergency Physicians, Past-President
American Academy of Emergency Medicine, Fellow
Great Lake Chapter Division, American Academy of Emergency Medicine
College of Physicians & Surgeons of Ontario
Michigan State Medical Society
Oakland County Medical Society
American Medical Association
Michigan State Volunteer Registry, Office of Public Health Preparedness
Iota Epsilon Alpha (IEA) International Honor Medical Society, SGUSOM

***National ACEP Activities – List your most significant accomplishments***

***Committees, Sections, and EMRA*:**

| | |
|---|---|
| ***Awards Committee*,** American Academy of Women Emergency Physicians (AAWEP) | 02/2024-present |
| ***Committee Member, Educational Meetings Subcommittee*** | 09/2023-09/2024 |
| ***Committee Member, Ethics Committee*** | 09/2022-09/2024 |
| ***Chair, Bylaws Committee*** | 09/2018-09/2021 |
| ***Committee Member***, Bylaws Committee | 09/2010-present |

| | |
|---|---|
| ***Committee Member***, State Legislative and Regulatory Committee | 2013-2017 & 2021-present |
| ***Subcommittee Chair***, Telemedicine Objective, State Legislative and Regulatory Committee | 2015-2016 |
| ***Section Member***, AAWEP | 2015-present |
| ***Section Membe***r, Locum Tenens Section | 2018-2019 |
| **EMRA *Alumni Member*** | 2021-present |

***Council:***

| | |
|---|---|
| ***Tellers, Elections, and Credentialling Committee*** | 09/2024 |
| ***Chair, Council Reference Committee A "Governance & Membership"*** | 09/2024 |
| ***Council Steering Committee*** | 09/2020-9/2022 |
| ***Chair, Steering Committee, Bylaws and Council Standing Rules Subcommittee*** | 09/2021-09/2022 |
| ***Chair, Council Reference Committee A "Governance & Membership"*** | 08/2019 |
| ***Councilor***, ACEP Council, MCEP Chapter | 2011-present |
| ***Alternate Councillor***, ACEP Council, MCEP Chapter | 2009 & 2010 |

***ACEP Chapter Activities – List your most significant accomplishments***

**Michigan College of Emergency Physicians:**

***Leadership:***

| | |
|---|---|
| **Leadership Development Program, *Director*** | 07/2024-present |
| **Leadership Development Program*, Taskforce*** | 07/2021-02/2024 |
| **Michigan Emergency Medicine Foundation *Chair, Board of Trustees*** | 07/2017-07/2018 |
| **Michigan Emergency Medicine Foundation *Immediate Past Chair, Board of Trustees,*** | 07/2018-07/2019 |
| **Michigan Emergency Medicine Foundation *Member, Board of Trustees,*** | 07/2017-present |
| ***Chair, Physician Wellbeing Task Force*** | 01/2018-01/2019 |
| ***Immediate Past President*** | 08/2017-07/2018 |
| ***President*** | 07/2016-07/2017 |
| ***President-Elect*** | 07/2015-07/2016 |
| ***Board Member*** | 07/2012-07/2018 |

***Committee & Mentorship:***

| | |
|---|---|
| ***Resolution Writing Committee*** | 03/2023-present |
| ***Education Committee*** | 07/2009-present |
| ***Legislative Committee*** | 07/2013-07/2015<br>07/2018-present |
| ***Executive Director Search Committee*** | 03/2022-7/2022 |
| ***Executive Committee*** | 07/2013-07/2018 |
| ***Chair, Education Committee*** | 05/2013-07/2018 |
| ***Committee Member, Quality Committee*** | 09/2016-09/2018 |
| ***Editor*, *MCEP Newsletter,* "*News & Views*"** | 01/2010-06/2013 |
| ***Resident Mentor,*** MCEP Membership Committee | 2011-2012 |

***Practice Profile***

***Total hours devoted to emergency medicine practice per year:*** **1680** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **50** % Research **0** % Teaching **0** % Administration **50** %

Other: _____ ____%

***Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)***

Direct employed by nonprofit healthcare organization, McLaren Medical Group/McLaren Health Care. Multi-hospital group. My employment is at a community teaching ED and a freestanding ED.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Regional Medical Director, Emergency Department McLaren Greater Lansing & McLaren Grand Ledge, McLaren Medical Group. Clinical Assistant Professor, Michigan State University, College of Human Medicine, Department of Emergency Medicine

***Expert Witness Experience***

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert 0 Cases** **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Larisa May Traill, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: McLaren Medical Group

Address: G-3235 Beecher Road

Flint, MI 48532

Position Held: Regional Medical Director, Emergency Department, McLaren Greater Lansing & McLaren Grand Ledge

Type of Organization: Nonprofit

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Michigan College of Emergency Physicians

Address: 6647 W St. Joseph Hwy

Lansing, MI 48917

Type of Organization: Nonprofit

Leadership Position: Past President (2016-2017)
Board member (2012-2018)
Co-Director, Leadership Development Program (2023-present)
Education Committee Member (Chair 2013-2018), Legislative Committee Member, Resolution Writing Committee, Executive Director Search Committee, Executive Committee, Quality Committee, Newsletter Editor

Term of Service: 2009-present

Organization: Michigan Emergency Medicine Foundation

Address: 6647 W St. Joseph Hwy

Lansing, MI 48917

Type of Organization: Nonprofit

Leadership Position: Member, Board of Trustees (Chair, 2017-2018)

Term of Service: 07/2017-present

Organization: American Academy of Emergency Medicine

Address: 555 East Wells Street, Suite 1100

Milwaukee, WI 53202-3800

Type of Organization: Nonprofit

Leadership Position: *Great Lakes Chapter Division (GLAAEM)* Member
*GLAAEM Board of Directors*, MI State Representative

Term of Service: 2020-present

Organization: American Board of Emergency Medicine

Address: 3000 Coolidge Road

East Lansing, MI 48823

Type of Organization: Nonprofit

Leadership Position: Oral Board Examiner & Certifying Exam Case Developer

Term of Service: 2017-present

Organization: Organization for Space Medicine, Engineering and Design

Address: info@osmed.org

Type of Organization: Nonprofit

Leadership Position: Bylaws Consultant, Rules & Regulations Committee

Term of Service: 2023-2024

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Larisa May Traill, MD, FACEP** Date 6/4/2025

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**
Therese Mead, DO, FACEP

**PRESIDENT-ELECT**
Michael Gratson, MD, MHSA, FACEP

**TREASURER**
Luke Saski, MD, FACEP

**SECRETARY**
Andrew Taylor, DO, FACEP

**IMMEDIATE PAST PRESIDENT**
Michael Fill, DO, FACEP

**BOARD OF DIRECTORS**
Abigail Brackney, MD, FACEP
Pamela Coffey, MD, FACEP
Bram Dolcourt, MD, FACEP
Michael Doyle, DO
Antony Hsu, MD, FACEP
Zachary Jarou, MD, MBA
Jeffrey McGowan, DO, FACEP
Diane Paratore, DO, FACEP
Ryan Reece, MD, NRP, FACEP
Brittany Garza, DO (candidate member)

**EXECUTIVE DIRECTOR**
Christy K. Snitgen

www.mcep.org

*52nd Michigan EM Assembly*
*July 27-30, 2025*
*Grand Hotel*

Dear Councillors:

It is with great pleasure that the Michigan College of Emergency Physicians (MCEP) and the ACEP American Association of Women Emergency Physicians (AAWEP) Section endorse Larisa M. Traill, MD, FACEP for the office of ACEP Council Vice Speaker.

Dr. Traill served with distinction as a member of MCEP's Board of Directors for six years. During her 2016-17 term as MCEP President, she worked tirelessly to shepherd the College through the sudden illness and passing of MCEP's beloved Executive Director, Diane Kay Bollman, taking on additional leadership duties during this turbulent time. She continues to serve an invaluable member of the Michigan College, remaining active with State Legislative Committee, the Education Committee, which she chaired for six years, as well as serving as a Co-Director for MCEP's Leadership Development Program. In 2019, she was awarded one of the MCEP's highest honors, the Ronald L. Krome, MD Meritorious Service Award.

Dr. Traill possesses the necessary skills and experience to not only excel in the offices of Council Vice Speaker and Speaker, but also to represent the mission and values of the College. As a member of the Bylaws Committee for sixteen years, including three as Chair, she possesses an in-depth familiarity with ACEP's governing documents and principles and each Chapter's bylaws, as well as expertise in parliamentary procedure.

Dr. Traill also has extensive experience at the ACEP Council, with 16 years as a Councillor or Alternate for the MCEP delegation, and having served on the Council Steering Committee, the Tellers, Credentials, and Elections Committee, and twice as Chair of Council Reference Committee A, during which she demonstrated her ability to efficiently summarize testimony and facilitate a meeting that is efficient, congenial, and enjoyable.

Dr. Traill, in addition to her past and current service on four ACEP Committees, continues to participate in the AAWEP section, actively engaging and supporting female members to serve on MCEP and ACEP committees and in other leadership roles. She remains a staunch advocate for women physicians and the empowerment of women.

Additionally, Dr. Traill a Regional Medical Director for McLaren Medical Group, is the Emergency Department Director for McLaren Greater Lansing, a Level 3 Trauma Center, and McLaren Grand Ledge, a Freestanding Department. She is a Clinical Assistant Professor, at Michigan State University, College of Human Medicine, Department of Emergency Medicine, and core faculty at the new McLaren Greater Lansing Emergency Medicine Residency.

In conclusion, Dr. Traill demonstrates all the qualities and skills that represent the legacy of emergency medicine while fostering a vision for its future aiming to bring our specialty forward to new and greater heights. Her work, both in Michigan and at the national level, demonstrates that she would shine on the Council stage.

I would respectfully ask that you join our Chapter and the ACEP American Association of Women Emergency Physicians Section in supporting the nomination of Larisa Traill, MD, FACEP for the office of Council Vice Speaker of the American College of Emergency Physicians.

Regards,

Therese Mead, DO, FACEP
President, MCEP

Andrea Austin, MD, FACEP
Chair, ACEP AAWEP Section

ACEP AMERICAN ASSOCIATION OF Women EMERGENCY PHYSICIANS

# Larisa M. Traill, MD, FACEP

Dear ACEP Members,

I am honored to announce my candidacy for the position of ACEP Council Vice Speaker. With 20 years of dedicated experience in the College, including 16 years as a Councillor or Alternate, I am deeply committed to advancing our mission and ensuring that our voices are heard. My extensive background includes:

- 20 years of ACEP experience, with 16 years as a Councillor/Alternate.
- 16 years on the Bylaws Committee, including three as Chair.
- Twice Chaired Reference Committee A.
- 4 ACEP Committees
- 3 Council Committees
- Council Subcommittee Chair
- 4 ACEP Committees
- 2 ACEP Sections

These experiences have equipped me with a comprehensive understanding of our organization's structure, values, and the critical issues we face. They have also instilled in me a passion for fostering a collaborative environment where every member feels valued and empowered to contribute.

As your Vice Speaker, I will prioritize three core values:

- Efficiency & Consensus Building: In a profession as dynamic as emergency medicine, it is crucial that we streamline our processes to focus on what truly matters. We cannot tackle every issue at once, but by focusing on our mission, we can ensure that our discussions are productive and impactful. I will focus on reducing redundancy in discussions, ensuring that our meetings are efficient while still allowing for robust dialogue. I am committed to facilitating debates to help prioritize key issues and drive meaningful outcomes for our members and their patients. Conflict is one of the greatest catalysts for creative problem-solving and improved solutions. When managed constructively, oppositional debate can lead to a more thorough evaluation of ideas, increased member cohesion, and a greater sense of ownership over decisions.

- Collegiality & Inclusion: Every Councillor, whether new or seasoned, deserves the opportunity to share their perspectives and insights. I will work diligently to create an inclusive environment where every voice is heard. Leveraging virtual technology and online media platforms will be key to maximizing engagement and participation. Together, we can cultivate a Council where every member feels empowered to contribute.

- Trust & Integrity: In all our dealings, transparency, fairness, and respect must be our guiding principles. As Vice Speaker, I will uphold these values on the Council floor and at Board meetings, ensuring that every decision is made with the utmost integrity. Trust is fundamental to effective leadership, and I aspire to be your trusted partner in navigating the complexities of our organization and profession.

In conclusion, I will lead with purpose, passion, and professionalism. I humbly ask for your support as your next ACEP Council Vice Speaker. Together, we can shape the future of emergency medicine and create a lasting impact for our members and our patients.

Thank you for your consideration.

Sincerely,

Larisa Traill, MD, FACEP
ACEP Candidate for Council Vice Speaker

# Trust in TRAILL



## Your Next ACEP Council Vice Speaker

Larisa M. Traill, MD, FACEP


**Contact Information:**

larisa.traill@gmail.com
X @lm_traill
IG @larisatraill
Cell 347-426-6610


## Experience You Can Trust

16 years as MCEP Delegation Councillor/Alternate
Longest-serving ACEP Bylaws Committee Past Chair
Twice Chair of Reference Committee A
Service on multiple Council Committees and Subcommittees
Experience on four ACEP Committees and multiple Sections

## Vision for the Future

Consensus building and engagement
Commitment to collegiality and professional fulfilment
Solution-oriented approach
Proven follow-through on initiatives

## Leadership Highlights

Past President of the Michigan College of Emergency Physicians
Co-Director of the MCEP Leadership Development Program
Past Michigan EMF Chair
Regional Medical Director for Level 3 Trauma Center and a Freestanding ED
Clinical experience:
- Academic, community, critical access and freestanding
- Non-profit, locums, CMG, and democratic group practices
- Socialized healthcare

## Endorsements:

**"Larisa's proven commitment, leadership, and experience are just what the Council needs. She has the full support of AAWEP and MCEP!"**

ACEP AMERICAN ASSOCIATION OF Women EMERGENCY PHYSICIANS

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

## Core Values

Passion for Policy and Procedure: Unmatched dedication to the intricacies of bylaws and governance
Social Intelligence: Ability to moderate debate, maximize efficiency, and foster a spirit of collaboration
Trust and Integrity: A career rooted in community, collegiality, and dedicated to advancing the specialty

## Join Us in Supporting Larisa!

Together, we can enhance the ACEP Council with experience, vision, and trust.

Date of Preparation: January 2025

_____
Larisa M. Traill, MD, FACEP, FAAEM

**Larisa M. Traill, MD, FACEP, FAAEM**

---

**Home Address:**
2280 Ivy Hill Drive
Commerce Township, MI
48382-5122

**Telephone**:
347-426-6610 (C)
**Email**: larisa.traill@gmail.com

## Education:

**George Marasleion 16th Lykeion**, Athens, Greece

**Honors Bachelor of Science**, Biology & Latin — conferred 06/1999
University of Toronto (U of T)

**Doctor of Medicine** — conferred 06/2005
St. George's University School of Medicine (SGUSOM)

## Post-Doctoral Training:

**Emergency Medicine Residency**, Sinai-Grace Hospital — 07/2005-06/2008
Wayne State University (WSU) / Detroit Medical Center (DMC)

**Michigan College of Emergency Physicians (MCEP)** — 03/2009-12/2010
**Leadership Development Program,** Lansing, MI

**American College of Emergency Physicians** — 08/2009-03/2010
**(ACEP) Teaching Fellowship,** ACEP, Dallas, TX

## Board Certification:

American Board of Emergency Medicine (ABEM) — Expires: 12/31/2029

## Faculty Appointments:

Clinical Assistant Professor — 12/2017-present
Michigan State University, College of Human Medicine
Department of Emergency Medicine

Volunteer Clinical Assistant Professor of Emergency Medicine — 09/2016-09/2018
Indiana University, School of Medicine, Terre-Haute, IN

Clinical Assistant Professor — 06/2009-05/2015
Department of Emergency Medicine
WSU School of Medicine, Detroit, MI

## Hospital Appointments:

### *Fulltime:*

Regional Medical Director, Emergency Department — 03/2025-present
McLaren Greater Lansing & McLaren Grand Ledge
McLaren Medical Group

Vice Chair, Emergency Department, — 08/2024-02/2025
MyMichigan Medical Centers-Alma & Mount Pleasant
Michigan Medicine/University of Michigan Health System

Director of Quality, Safety and Compliance, — 09/2022-02/2025
Greater Midland Emergency Physician (GMEP)

Attending Physician, GMEP — 01/2017-02/2025
Emergency Department, MyMichigan Medical Centers
Alma & Mt Pleasant, MI
Michigan Medicine/University of Michigan Health System

Attending Physician, Emergency Department — 07/2008-05/2013
Medical Center Emergency Services, PC, Detroit, MI
DMC Sinai-Grace Hospital, Harper University Hospital,
And DMC Surgery Hospital

Attending Physician, Emergency Department — 05/2013-02/2015
Emergency Medicine Specialists, PC — (contract sold)
St John Providence Hospital, Macomb

***Locums***:

Attending Physician, Emergency Department — 01/2011-01/2024
Windsor Regional Hospital, Metropolitan Campus
Windsor, Ontario, Canada

Attending Physician — 11/2015-11/2018
Emergency Department, Mid-Michigan Medical Center-Alpena — (contract sold)
Michigan Medicine/University of Michigan
Alpena, MI

Attending Physician — 01/2017-01/2018
Emergency Department, Mercy Rockford Memorial Hospital
Rockford, IL

Attending Physician — 12/2014-12/2017
Emergency Department
Dickinson County Memorial Hospital
Iron Mountain, MI

ApolloMD Strike Team Physician — 09/2016-01/2017
Emergency Department, Moses Taylor Hospital
Scranton PA

ApolloMD Strike Team Physician — 05/2016-09/2016
Attending Physician, Emergency Department — (contract sold)
Union Hospital, Terre-Haute, IN

ApolloMD Strike Team Physician — 09/2015-01/2016
Attending Physician, Emergency Department — (contract sold)
MetroSouth Medical Center, Blue Island, IL

ApolloMD Strike Team Physician — 03/2015-07/2015
Attending Physician, Emergency Department
Aiken Regional Medical Center, Aiken, SC

## Professional Societes:

American College of Emergency Physicians (ACEP), Fellow
Michigan College of Emergency Physicians (MCEP), Past-President
American Academy of Emergency Medicine (AAEM), Fellow
Great Lake Chapter Division, American Academy of Emergency Medicine (GLAAEM)
College of Physicians & Surgeons of Ontario (CPSO)
Michigan State Medical Society (MSMS)
Oakland County Medical Society (OCMS)
American Medical Association (AMA)
Michigan State Volunteer Registry, Office of Public Health Preparedness
Iota Epsilon Alpha (IEA) International Honor Medical Society, SGUSOM
Kaplan Medical Honor Society

## Medical Licensure & Certifications:

| | |
|---|---|
| State of Michigan Board of Medicine Physician License | Expires: 11/14/2027 |
| State of Michigan Board of Pharmacy Controlled Substance License | Expires: 11/14/2027 |
| DEA Registration, Michigan | Expires: 11/30/2025 |
| Ontario Medical License, CPSO #946072 | Expires: 05/31/2025 |
| NIH Stroke Scale Certification | Completed 2007 |
| National Incident Management System (NIMS) Incident Command System (ICS) Certification (IS: 100, 200, 700) | Completed 2007 |

## Service & Awards:

### *Professional:*

**Greater Midland Emergency Physicians:**
***Director of Quality, Compliance, and Safety*** 10/2022-02/2025

**Wayne State University Pathologists' Assistant Program** 07/2022-present
***Advisory Board Member***

**ABEM: Oral Board Examiner** 07/2017-present
**Certifying Exam Case Developer** 01/2024-present

**MDHHS*:***
***Advisory Group Member, Statewide Psychiatric Bed Registry*** 07/2018-07/2024
Michigan Inpatient Admissions Discussion (MIPAD)
Michigan Department of Health and Human Services

**Organization for Space Medicine, Engineering, and Design:** 03/2024-present
Bylaws Consultant, Rules & Regulations Committee

**Michigan College of Emergency Physicians (MCEP):**

| | |
|---|---|
| **Leadership Development Program, *Director*** | 07/2024-present |
| **Leadership Development Program, *Taskforce*** | 07/2021-02/2024 |
| **Michigan Emergency Medicine Foundation** ***Chair, Board of Trustees*** | 07/2017-07/2018 |
| **Michigan Emergency Medicine Foundation** ***Immediate Past Chair, Board of Trustees,*** | 07/2018-07/2019 |
| **Michigan Emergency Medicine Foundation** ***Member, Board of Trustees,*** | 07/2017-present |
| ***Chair, Physician Wellbeing Task Force*** | 01/2018-01/2019 |
| ***Immediate Past President*** | 08/2017-07/2018 |
| ***President*** | 07/2016-07/2017 |
| ***President-Elect*** | 07/2015-07/2016 |
| ***Board Member*** | 07/2012-07/2018 |

***Committee & Mentorship:***

| | |
|---|---|
| ***Resolution Writing Committee*** | 03/2023-present |
| ***Education Committee*** | 07/2009-present |
| ***Legislative Committee*** | 07/2013-07/2015<br>07/2018-present |
| ***Executive Director Search Committee*** | 03/2022-7/2022 |
| ***Executive Committee*** | 07/2013-07/2018 |
| ***Chair, Education Committee*** | 05/2013-07/2018 |
| ***Committee Member, Quality Committee*** | 09/2016-09/2018 |
| ***Editor***, ***MCEP Newsletter, "News & Views"*** | 01/2010-06/2013 |
| ***Resident Mentor,*** MCEP Membership Committee | 2011-2012 |

***Awards:***

| | |
|---|---|
| **Ronald L. Krome, MD, Meritorious Service Award** | 07/2019 |

**American College of Emergency Physicians (ACEP):**

***Committees, Sections, and EMRA*:**

| | |
|---|---|
| ***Awards Committee*,** American Academy of Women Emergency Physicians (AAWEP) | 02/2024-present |
| ***Committee Member, Education Committee*** | 09/2023-present |
| ***Committee Member, Ethics Committee*** | 09/2022-present |
| ***Chair, Bylaws Committee*** | 09/2018-09/2021 |
| ***Committee Member***, Bylaws Committee | 09/2010-present |
| ***Committee Member***, State Legislative and Regulatory Committee | 2013-2017 &<br>2021-present |
| ***Subcommittee Chair***, Telemedicine Objective, State Legislative and Regulatory Committee | 2015-2016 |
| ***Section Member***, AAWEP | 2015-present |
| ***Section Membe***r, Locum Tenens Section | 2018-2019 |
| **EMRA *Alumni Member*** | 2021-present |

***Council:***

| | |
|---|---|
| ***Tellers, Elections, and Credentialling Committee*** | 09/2024 |
| ***Chair, Council Reference Committee A "Governance & Membership"*** | 09/2024 |
| ***Council Steering Committee*** | 09/2020-9/2022 |
| ***Chair, Steering Committee, Bylaws and Council Standing Rules Subcommittee*** | 09/2021-09/2022 |
| ***Chair, Council Reference Committee A "Governance & Membership"*** | 08/2019 |
| ***Councilor***, ACEP Council, MCEP Chapter | 2011-present |
| ***Alternate Councilor***, ACEP Council, MCEP Chapter | 2009 & 2010 |

| | |
|---|---|
| **AAEM**: ***Great Lakes Chapter Division (GLAAEM)*** Member | 2020-present |
| ***GLAAEM Board of Directors***, MI State Representative | 07/2021-present |

**Windsor Regional Hospital (Ontario, Canada): *Committee Member,*** 2017-2019
Planning Committee, "*City of Roses Annual Community Emergency Medicine Conference*"

## ***Expert Testimony:***

House Judiciary Committee Hearing 10/24/2013
HB 4354: *Access To Quality Emergency Care Act*
In Support, Bill Introduced by MCEP

House Health Policy Committee Hearing 05/24/2017
HB 4135, Opposed, Representing MCEP

## ***Teaching:***

***Clinical Educator*** 07/2009-05/2013
Medical Students and Emergency Medicine Residents
Emergency Medicine Residency, Department of Emergency Medicine

**Sinai-Grace Hospital, WSU/DMC** 05/2011
**Department of Emergency Medicine Grand Rounds:**
Lecture series: "Oncologic Emergencies" & "Oncologic Jeopardy

**Sinai-Grace Hospital, WSU/DMC,**
**Department of Emergency Medicine Grand Rounds:**
Lecture series: "Domestic Violence" 08/2007
Lecture: "Toxic Flora" 02/2006

**WSU School of Medicine & Department of Emergency Medicine:**
Instructor, Procedure Workshop for Medical Students 07/2006 & 07/2007

**Children's Hospital of Michigan, Emergency Medicine Grand Rounds:**
Case Presentation: "Chest Pain in a Pediatric Patient;
A Review of Hypertrophic Cardiomyopathy" 10/2005

**Clinical Instruction**
Volunteer Clinical Assistant Professor of Emergency Medicine 09/2016-09/2018
Indiana University, School of Medicine, Terre-Haute, IN

**ABEM Oral Board Review Seminars** 09/2011-05/2013
Emergency Medicine Residency Program,
WSU/DMC, Sinai-Grace Hospital

**ACEP Teaching Fellowship, Project & Presentation** 03/2010
"Oral Cases Are Fun!" ACEP, Dallas TX

**ACEP Teaching Fellowship, Microteaching Presentation** 08/2009
ACEP, Dallas TX

**Penn State College of Medicine** 10/2008
Faculty Instructor: Lytics In Practice:
Clinical Expertise for Emergency Medicine Residents,
Scholarship Program and Workshop

Mentorship: Dr. Rebecca Byrd 2009-2012
Dr. Brooke Frakes 2010-2012
Emergency Medicine Residency Program,
WSU/DMC, Sinai-Grace Hospital

Community Education

**DCT Aviation, Oakland County International Airport**
Annual Lecture & Seminar Director: "Aviation Medicine & CPR Training" 2013-2016

## Research & Publications:

Medical:

Bookman, K., Bissmeyer P., Denley B., Sauder, H., Traill, L., and Kluesner, N. (2023). 11/2023
Tips for Real-Time Information Sharing with Patients, *ACEP Now, 42*(11),12.

President's Column:
Traill, L.M., MCEP News & Views, Volume XXXVII, No. 2, p2. May/June 2017 06/2017

President's Column: "Advocacy: To Change What Is Into What Should Be" 04/2017
Traill, L.M., *MCEP News & Views*, Volume XXXVII, No. 2, p2. March/April 2017

President's Column: "Physician Wellness & Burnout" 02/2017
Traill, L.M., *MCEP News & Views*, Volume XXXVII, No.1, p2. January/February 2017

President's Column: "MCEP's 2017 Strategic Plan and Physician Wellness" 12/2016
Traill, L.M., *MCEP News & Views,* Volume XXXVI, No. 8, p2. November/December 2016

President's Column: "Farwell to the Dog Days of Summer" 10/2016
Traill, L.M., *MCEP News & Views*, Volume XXXVI, No. 7, p2. September/October 2016

Incoming President's Address: "A Scientific Assembly Recap and Looking Ahead" 08/2016
Traill, L.M., *MCEP News & Views*, Volume XXXVI, No. 6, p2. August 2016

"MCEP's 2012-2013 Strategic Plan: Where's the Value?" (Editorial) 03/2013
Traill, L.M., *MCEP News & Views*, Volume XXXIII, No. 2, p3. March 2013

"MCEP Kudos!" (Editorial) Traill, L.M., *MCEP News & Views* 11/2012
Volume XXXII, No. 9, p3. November 2012

*"*Emergency Medicine and HealthCare Reform: What Questions Do We Need To Ask" 10/2012
(Editorial) Traill, L.M., *MCEP News & Views*, Volume XXXII, No. 8, p3. October 2012

*"*10 Reasons Not to Miss the 2012 Scientific Assembly in Denver" (Editorial) 09/2012
Traill, L.M., *MCEP News & Views*, Volume XXXII, No. 7, p3. September 2012

*"*North American Medication Shortages: Should We Grow Our Own?" (Editorial) 05/2012
Traill, L.M., *MCEP News & Views*, Volume XXXII, No. 4, p3. May 2012

"Healthcare Reform and National Legislative Update" (Editorial) 04/2012
Traill, L.M., *MCEP News & Views*, Volume XXXII, No. 3, pp. 3-4. April 2012

*"*EMS Design in Japan and Tsunami Relief Efforts in Michigan" (Editorial) 05/2011
Traill, L.M., *MCEP News & Views*, Volume XXXI, No. 3, p5. May 2011

"Aviation and Patient Safety" (Editorial) 11/2010
Traill, L.M., *MCEP News & Views*, Volume XXX, No. 9, pp. 6-7. November 2010

"Medicinal Uses of Honey-A Historical Perspective" (Editorial) 09/2010
Traill L.M., *MCEP News & Views*. Volume XXX, No. 7, pp. 4-5. September 2010

"Leadership and Advocacy" (Editorial) 06/2010
Traill, L.M., *MCEP News & Views*. Volume XXX, No. 5, pp. 4-5. June2010

"Emergency Physician Burnout" (Editorial) 05/2010
Traill, L.M., *MCEP News & Views*. Volume XXX, No. 4, pp. 3-4. May 2010

"Community Service and the Emergency Department" (Editorial) 04/2010
Traill, L.M., *MCEP News & Views*. Volume XXX, No. 3, pp. 4-5. April 2010

*"*Epidural Abscess: When the MRI Counts*",* Traill, L.M. & Barton, M.A. 04/2010

American College of Emergency Physicians, *ACEP News, 'Focus On'*
*CME article*. Volume 29, No. 4, pp. 16-18. April 2010

"Acute Chest Syndrome: The Critical Cough", Traill, L.M. & Barton, M.A. 11/2008
American College of Emergency Physicians, *ACEP News, 'Focus On'*
*CME article*. Volume 27, No. 11, pp. 21-23. November 2008

*References Available Upon Request*

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# 2025 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

## Aine Yore, MD, FACEP

***Question #1:*** **What qualities do you possess to be effective in this role?**

I bring a deep respect for process. I believe that process matters — it is the framework that ensures fairness, transparency, and effectiveness. Good process is reliable and reproducible. It enables you to effectively express your vision and the values that animate you. That's what I want to preserve and enhance at Council.

The Council officers play a dual role in the College. There's the highly visible part we see each year: facilitating an organized, efficient, and engaging Council meeting. That requires poise, preparation, and the ability to manage a fast-moving, passionate conversation with fairness and clarity. But there's also a quieter, behind-the-scenes role—one that is no less critical.

The Speaker and Vice Speaker help plan the Council meeting, chair the Steering Committee, appoint members to Council committees, and play a key role in identifying and mentoring future leaders of the College.

Most importantly, they serve as the voice of the Council to the Board of Directors.

ACEP is and always has been a member-led organization. The work that you, the Councillors, do at this annual meeting is the foundation for the College's strategic direction. The values and vision you articulate—through testimony, debate, and democratic decision-making—give ACEP its compass. Without that, we are rudderless.

You are here as the elected representatives of our colleagues back home. And the Council officers are your representatives to the Board. They must be your advocates and hold the Board accountable to the direction this body sets and the principles that underly those decisions. I will work to ensure your voice is heard clearly. And when I am in the room with the Board, I will not be there to insert my personal views, but to center the conversation on the values and positions you—the Council—have established.

This is a role that demands humility, consistency, and clarity of purpose. I have spent more than a decade listening, learning, and helping this Council do its best work. I'm ready to serve—not to speak for myself, but to amplify your voice.

***Question #2:*** **How do you balance free and open debate versus meeting efficiency?**

Council brings together 436 of the best and brightest members of our profession to discuss the most challenging issues facing emergency medicine—a huge investment, and a precious opportunity. As a Council Officer, I will work to leverage this valuable resource to its fullest.

The best part of Council is the debate: big personalities with big ideas engaging in thoughtful, passionate exchanges. Sometimes there are sharply differing viewpoints, and other times, there is general agreement with nuanced dialogue on the optimal way to craft a policy. Usually, the presiding officer doesn't need to intervene. Council is largely self-regulating. Both Pro and Con positions are presented, and a dialogue follows. Eventually, a motion is made to close debate. As long as both sides have been fairly represented, that motion is in order—and the Council (not the presiding officer) decides whether to proceed. Only rarely must the chair overrule a premature motion if only one side has been heard.

The true challenge to efficiency? Emergency physicians' greatest strengths: we think on our feet, we solve problems, and we can't resist trying to improve things—even from the microphone. Thus appears the dreaded "friendly amendment" or "minor wordsmithing." The Chair must be firm in requiring that amendments follow standard procedures for submission. As Vice Speaker, I would ensure that expectation is clearly set and consistently upheld—for both fairness and efficiency.

The presiding officer must also navigate procedural complexities, as debate often wanders into the weeds of second-order amendments. Keeping testimony focused and on point is essential to sound decision-making. It takes a light touch to do this while respecting points of personal privilege, smiling through a few curmudgeonly declarations from Council elders, and helping the process feel not just efficient—but even a little fun.

Ultimately, this is about reading the room, respecting the process, and honoring the voices in it. After more than a decade attending Council, I look forward to serving in this role—to keep us continually thinking and moving forward, while ensuring every meaningful voice is heard.

***Question #3*: What would improve the councillor experience and Council operations?**

I believe that the Reference Committees are the true heart of Council. If we can improve the opportunities for Councillors to engage with these committees and further empower the committees to synthesize testimony into consensus, this can create space for the full Council to use its time to the best advantage in addressing the most complex and consequential issues it faces.

We've made real progress towards this end. We talk in tones of hushed awe at that one year when RefCom B got its entire slate on the consent agenda—with nothing extracted! But that's not always the case. In other years, nearly everything gets referred back to the full Council for debate.

Some extraction is inevitable. When a resolution resists consensus or sparks strong feelings, full Council debate is appropriate—and welcome. But other barriers to committee effectiveness can be addressed. I group these into three areas: Preparation, Participation, and Culture.

**Preparation**: Council can be overwhelming, especially for each years' new Councillors. Their orientation should be earlier and virtual, allowing new members to hit the ground running. The flood of materials Councillors receive could also be better paced and curated—highlighting documents most in need of advance review. Component bodies should be strongly encouraged to create processes to help their Council representatives, such as dividing up resolutions among their members for review, ensuring better-informed, more effective input.

**Participation**: Councillors can't be in all three rooms, and mic time is limited. Yet we have tools: asynchronous testimony, virtual testimony, and electronic amendment submission—all easier to use than ever, but underutilized. We should foster an expectation that these tools should serve as the *primary* mode of input. If in-person testimony is preferred, then we must expand the time allocated to reference committees.

**Culture**: The reference committees work hard, often late into the night. Committee members must weigh both the quantity of the testimony offered and also the relative strength of the arguments, assess tone and content, propose amendments, and recommend disposition. The more robust the preparation and participation, the more confidently they can craft a strong consent agenda. By fostering a stronger dialogue and greater participation in the committee process, we can build a shared understanding that—except in rare cases—the Council should view the consent agenda as conclusive.

This is the Council experience I love and will strive to lead: efficient, inclusive, and empowering—where every Councillor can fully participate and the Council itself can speak clearly.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE DATA SHEET

## Aine Yore, MD, FACEP

***Contact Information***

15350 162nd AVE NE, Woodinville WA 98072
***Phone:*** 425-870-7769
***E-Mail:*** aineyore@icloud.com

***Current and Past Professional Position(s)***

Physician, North Sound Emergency Medicine
Physician, Evergreen Emergency Services (past)
Physician, Puget Sound Physicians (past)

***Education (include internships and residency information)***

Northwestern University, BA 1993
Northwestern University, MD 1997
Johns Hopkins University School of Medicine, Residency in Emergency Medicine, 2000

***Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)***

ABEM 2001, 2011, 2021

***Professional Societies***

ACEP
WA-ACEP
WSMA – Board of Trustees

***National ACEP Activities – List your most significant accomplishments***

Councillor, 2012-2020, 2024
Alternate Councillor 2021-23
Steering Committee 2014-2016
Reference Committee A 2015, 2018, 2024
Reference Committee Chair 2015
Horizon Award 2015
Reimbursement Committee 2006-Present
State Legislative/Regulatory Committee 2019-2020
Communication/PR Committee 2018-2020
Finance Committee 2019-2020
Diversity, Inclusion, and Health Equity Committee 2022-Present
Social Media Delegate to ACEP-SA 2012-2019

***ACEP Chapter Activities – List your most significant accomplishments***

WA-ACEP:
President 2019-2020
Board of Directors 2010-2022
Legislative Affairs Chair 2009-2020
Guardian of Emergency Medicine Award 2021
Co-Founder and Director, WA-ACEP Political Action Committee

***Practice Profile***
***Total hours devoted to emergency medicine practice per year:*** **1500** Total Hours/Year

***Individual % breakdown the following areas of practice. Total = 100%.***

Direct Patient Care **85** % Research **0** % Teaching **0** % Administration **5** %
Other: **Organization work r/t ACEP, State Chapter State Medical Society** **10** %

***Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)***

Single site, physician-owned small group community-based practice.

***Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)***

Director and President for our physician practice. Claims Manager for malpractice purposes. Revenue Cycle Management chair, Human Resources Chair.

***Expert Witness Experience***
*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.*

**Defense Expert 0 Cases** **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

## Aine Yore, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: North Sound Emergency Medicine

Address: 15833 Mill Creek Blvd #12010

Mill Creek WA 98012

Position Held: Physician

Type of Organization: Physician Practice

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: North Sound Emergency Medicine

Address: 15833 Mill Creek Blvd #12010

Mill Creek WA 98012

Type of Organization: Physician Practice

Leadership Position: Board of Directors, President

Term of Service: 2003-2018

Organization: Pacific Northwest Emergency Physicians

Address: (no physical address, may be contacted by mail at the above address)

Type of Organization: LLC for captive malpractice insurance, collaboration with 6 regional EM groups

Leadership Position: Founder, President

Term of Service: 2009-2023

Organization: Emergency Medicine Professional Assurance Company

Address: 200 E Robinson St. Suite 1180,

Orlando, FL 32801

Type of Organization: Professional Liability Insurance Carrier

Leadership Position: Director

Term of Service: 2013-2025

Organization: Washington Chapter, American College of Emergency Physicians

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Washington State Chapter of the American College of Emergency Physicians

Leadership Position: Director, President

Term of Service: 2010-2022

Organization: Washington State Medical Association

Address: 1215 4th Ave., Suite 1901,

Seattle, WA 98161

Type of Organization: Washington State Chapter of the American Medical Association

Leadership Position: Trustee

Term of Service: 2018-2025

Organization: Providence General Foundation Everett

Address: 916 Pacific Avenue,

Everett, WA 98201

Type of Organization: Charitable fundraising organization for Providence Regional Medical Center Everett

Leadership Position: Director

Term of Service: 2004-2014

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE

☐ If YES, Please Describe: None, other than as a partner in our small group practice.

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

**Aine Yore, MD** Date May 9 2025

American College of Emergency Physicians®
WASHINGTON CHAPTER

**Board of Directors (2025-2026)**

**President**
Jessica Wall, MD, MPH, MSCE, FACEP

**President-Elect**
Sarah Hansen, MD

**Secretary/Treasurer**
Kevin Hodges, MD, FACEP

**Immediate Past President**
Joshua Frank, MD, FACEP

**Directors**
Rod Beaver, MD
Niels Beck, MD, FACEP
Annie Chipman, MD
Alyssa Dalton, MD
Anna McKeone, MD, FACEP
Amber Sabbatini, MD, MPH, FACEP
Ben Savitch, MD, JD, FACEP
Erika Schroeder, MD
Vasisht Srivanasan, MD, FACEP
Java Tunson, MD, FACEP
Gregory Lopez, MD, FACEP
David Markel, MD, FACEP

**Executive Director**
Ryan Byrd, CAE

WA-ACEP
4950 W. Royal Lane
Irving, TX 75063

Dear Councillors,

On behalf of the Washington Chapter of the American College of Emergency Physicians (WA-ACEP), we proudly endorse Dr. Aine Yore, MD., FACEP., for the ACEP Council Vice Speaker position. Dr. Yore has been an exceptional leader, advocate, physician, and colleague demonstrating unwavering dedication to emergency medicine and the ACEP mission.

Dr. Yore led a moderate-sized, dynamic democratic group in Washington State, working for over a decade in multiple roles from Practice Manager to President. Additionally, she co-founded, directed, and served as President of a unique collaborative venture between 6 independent groups. Currently, she continues to direct an emergency medicine insurance carrier. This extensive leadership experience and skill in many aspects of our profession has also been applied toward work with ACEP as well. She served as a Councilor for multiple terms, as a member of the Council Steering Committee, and as Chair of a Reference Committee. As Reference Committee Chair she navigated Council with extreme efficiency and great humor, demonstrating already the talent for this position.

She has contributed significantly to other critical ACEP committees, including Reimbursement, Legislative/Regulatory Affairs, Finance, and DEI. Her tenure as President of WA-ACEP and Board Member of the Washington State Medical Association further highlights her commitment to advancing emergency medicine at both state and national levels.

We need passionate advocates for emergency physicians, who thoroughly understand the relevant issues, to lead ACEP. Dr. Yore has already worked in depth on key issues such as balance billing, reimbursement, and health policy. Her ability to navigate complex legislative and regulatory landscapes makes her an ideal candidate to effectively represent and guide the ACEP Council. With her deep understanding of emergency medicine, strategic vision, proven commitment, quick wit, and ability to foster productive dialogue, we are confident that Dr. Yore will excel as ACEP Council Vice Speaker. We wholeheartedly support her candidacy and encourage the Council to do the same.

Thank you for your time and consideration. Please feel free to reach out to me and other WA-ACEP leadership should you require any additional information.

Sincerely,



Jessica Wall, MD, MPH, MSCE, FACEP
President, 2025 - 2026
Washington Chapter of the American College of Emergency Physicians (WA-ACEP)

# Aine Yore, MD, FACEP

WHAT ARE YOU PASSIONATE ABOUT?

Take a moment and ask yourself: What was it that motivated you to fly to Utah and sit in this chilly hotel ballroom for three days? What is it about serving on the Council that makes you give up a beautiful September weekend to be here?

Your answers will be as varied as our membership. But there's a common thread: **we care**. We hold values so important that we step away from our families, our work, and our lives to be here. Whether it's fighting for the ability to practice the best medicine we can, advocating for our residents and junior partners, or confronting the existential threats to our livelihoods posed by insurance companies and malpractice attorneys – something brings you here on this day, something you believe in enough to act on.

**That's why I'm asking for your vote for Vice Speaker.**

Because I care.

I care deeply about this Council and the work it does to shape our specialty, protect our patients, and chart the future of emergency medicine. I am passionate about helping you – our Councillors – effectively and democratically express your values in a way the Board can act on. And I am committed to ensuring that the leadership of this College remains accountable to the moral direction set by this body.

ACEP is, and must remain, a **membership-led organization**. The values held by our members – the issues you care about – must be the foundation for the College's activities. If we fail to understand what matters most to our members, we risk irrelevance.

This isn't theoretical. We know that younger emergency physicians have been drifting away from ACEP for years. We've worked hard to demonstrate the "value of membership," but we must do more than make our case—we must also **listen**. We need to ask, with humility and urgency: *What do our members value?* And then we must act on the answers.

If we fail to hear them, we will lose not only members – we will lose the next generation of emergency medicine leaders.

**This is what I'm passionate about.** And if you entrust me with the role of Vice Speaker, I promise to do everything I can to raise up your voices. I will work to ensure the moral purpose expressed by this Council is reflected in College policies and actions. I will strive to make the Council experience fair, efficient, and maybe even a little fun. And I will fight to ensure the voices and passions of our newest colleagues – our future leaders – are not just welcomed, but prioritized.



# Áine Yore, MD, FACEP

## Vice Speaker Candidate

### PROFILE

- Practicing Emergency Physician for 25 years
- Leader in single hospital democratic, independent EM practice
- WA State Chapter Past President
- Trustee, WA State Medical Association

### CONTACTS

aineyore@icloud.com
(425) 870-7769
Bluesky: @aineyoremd.bsky.social

15350 162nd AVE NE
Woodinville, WA 98072

### EDUCATION

Northwestern University Medical School Chicago, IL, 1997

Johns Hopkins Hospital Residency in Emergency Medicine, Baltimore, MD, 2000

### EXPERIENCE

**Political Advocacy and Health Policy**
State Legislative Chair for >10 years
State PAC Co-founder and director
Balance Billing task force, WA state

**Revenue Cycle Management**
ACEP Reimbursement Committee 19 years
Managed RCM and payer contracting for EM practice

**Medical Malpractice**
Self-Insurance/Captive management
Board member for insurance carrier
Claims Management

### SKILLS

- Communicator
- Innovative
- Passionate
- Collaborative
- Agile
- Detail-oriented
- Motivated

### AWARDS

**Horizon Award**
- ACEP Council

**Guardian of Emergency Medicine**
- Washington ACEP

## WHAT I BELIEVE

The values that our members hold must shape everything the College does. If we fail to hear and understand what Emergency Physicians value, we become irrelevant.





## MY PROMISE TO YOU

As Vice Speaker, I will work to:

- Create a Council experience that is efficient, fair, and maybe even a little fun
- Ensure that ACEP remains member-led and member-voiced
- Represent your voices and values at the Board of Directors when Council is not in session

## ENDORSED BY WASHINGTON CHAPTER

"Dr. Aine Yore has been an exceptional leader, advocate, and physician, demonstrating unwavering dedication to emergency medicine and the ACEP mission."

"With her strategic vision, deep understanding of emergency medicine, and ability to foster meaningful dialogue, we are confident she will excel as Council Vice Speaker."



# AINE YORE, M.D., F.A.C.E.P.

15350 - 162ND AVE NE
WOODINVILLE, WA 98072
425-870-7769
aineyore@icloud.com


## PROFESSIONAL EXPERIENCE

### EMERGENCY DEPARTMENT PHYSICIAN

| | |
|---|---|
| Providence Regional Medical Center Everett, Everett WA | July 2000-Present |
| Evergreen Hospital Medical Center, Kirkland, WA | 2013-2024 |
| Valley General Hospital, Monroe, WA | 2000-2013 |

### NORTH SOUND EMERGENCY MEDICINE

*Single-site, independent, democratic EM practice*

| | |
|---|---|
| Emergency Physician | 2000-Present |
| Practice Manager | 2003-2005 |
| President | 2006-2018 |

### PACIFIC NORTHWEST EMERGENCY PHYSICIANS

*Collaborative venture between 6 EM practices*

| | |
|---|---|
| Co-Founder/Director | 2009-2023 |
| President | 2012-2023 |

### EMERGENCY MEDICINE PROFESSIONAL ASSURANCE COMPANY

*Medical malpractice insurance carrier*

| | |
|---|---|
| Director | 2013-Present |
| Claims Committee 2013-2022 | |

### AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Council

| | |
|---|---|
| - Councilor | 2012-2020, 2024 |
| - Alternate Councilor | 2021-2023 |
| - Steering Committee | 2014-2016 |
| - Reference Committee | 2015, 2018, 2024 |
| - Chair, Reference Committee A | 2015 |
| - Horizon Award | 2016 |

Committees:

| | |
|---|---|
| - Reimbursement | 2006-Present |
| - State Legislative/Regulatory | 2017-2020 |
| - Communications/PR | 2017-2020 |
| - Finance | 2019-2020 |
| - DEI | 2022-Present |
| Scientific Assembly Social Media delegate | 2012-2019 |

### WASHINGTON STATE MEDICAL ASSOCIATION

| | |
|---|---|
| Member, Board of Trustees | 2018-Present |

Committees

- Legislative Advocacy
- DEI
- AI

**WASHINGTON CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS**

| | |
|---|---|
| President | 2019-2020 |
| Director | 2010-2022 |
| Legislative Affairs Chair | 2009-2020 |
| Guardian of Emergency Medicine Award | 2021 |

## TRAINING & EDUCATION

| | |
|---|---|
| Johns Hopkins University School of Medicine, Baltimore, MD | 1997-2000 |
| Residency in Emergency Medicine | |
| Northwestern University Medical School, Chicago, IL | 1993-1997 |
| Doctor of Medicine | |
| Northwestern University, Evanston, IL | 1990-1993 |
| Bachelor of Arts, Molecular Biology | |

## CERTIFICATIONS & LICENSURE

| | |
|---|---|
| Fellow of the American College of Emergency Physicians | 2004-Present |
| Diplomate, American Board of Emergency Medicine | 2001-Present |
| Physician and Surgeon, Washington State | 2000-Present |

## PROFESSIONAL INTERESTS

Balance Billing
Reimbursement and revenue cycle management
Health Policy
Medical Malpractice – claims management, risk management best practices, insurance company operations
Political Advocacy
Gender equity and reproductive rights
Social Media

## PERSONAL

Parent of four children, widowed
Private Pilot
Black belt and instructor, Shorin-Ryu Karate

# 2025 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

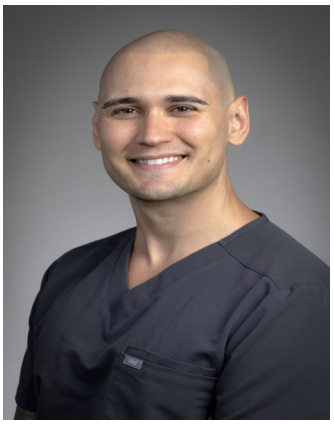


## *Council Meritorious Service Award*

Thom R. Mitchell, MD, FACEP

***Purpose:*** Presented to a member of the College who has served as a councillor for at least three years and who, in that capacity has made consistent contributions to the growth and maturation of the ACEP Council.

***Criteria:*** The nominee must be an active, life or honorary member of the College, and must have served as a councillor for at least three years. he nominee's contributions to the Council should include, but are not limited to, one or more of the following: Steering Committee membership; reference committee participation; participation on other Council committees; resolution development and debate; longevity as a councillor; or service as a Council officer.

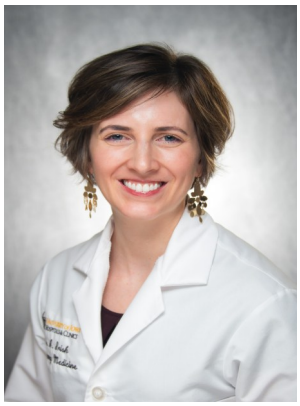


## *Council Horizon Award*

Joshua S. da Silva, DO, FACEP

***Purpose:*** Presented to an individual within the first five years of council service who demonstrates outstanding contributions and participation in Council activities. The award is given as needed, not necessarily annually.

***Criteria:*** The nominee should have made an outstanding contribution to the Council of important resolutions, significant contributions to Council discussions, etc.



## *Council Horizon Award*

Amanda K. Irish, MD, MPH, MS

***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.

# 2025 ACEP COUNCIL AWARDS




## *Council Teamwork Award*

AMA Emergency Medicine Section Council

**Purpose:** Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.

**Criteria:** Contributions to be recognized may include development of important resolutions, significant contributions to Council discussions, etc.



## *Council Curmudgeon Award*

David S. McClellan, MD, FACEP

**Purpose:** To recognize, in a lighthearted way, deserving Council participants that have contributed to the Annual meeting in a unique, eccentric, humorous, or cleverly astute manner.

***Criteria:*** The Curmudgeon Award will be presented to current or former Council participants (ie, Councillor or Alternate Councillor, President, Speaker, ACEP staff, etc.) that have embodied the essence of the description above.

# ACEP HONORS 2025 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

The 2025 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.



### *James D. Mills Outstanding Contribution to Emergency Medicine Award*

Marilyn J. Heine, 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*

Bing S. Pao, 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 award is named after Colin C. Rorrie, Jr., PhD, who served as ACEP's Executive Director from 1982 to 2003.

---



### *Judith E. Tintinalli Award for Outstanding Contribution in Education*

Scott D. Weingart, MD, FACEP

Presented to a member who has made a significant contribution to the educational aspects of emergency medicine.

---



### *John A. Rupke Legacy Award*

Stephen H. Anderson, 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.

## ACEP HONORS 2025 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



### *Pamela P. Bensen Trailblazer Award*

John F. McMaster, MD, FACEP

Presented to a current College member for seminal contributions over time to the growth of the College and to the specialty of emergency medicine. The award is named after Pamela P. Bensen, MD, a charter member of ACEP and the first woman resident in emergency medicine (1971).



### *Diane K. Bollman Chapter Advocate Award*

Jan Reisinger, MBA, CAE (posthumously)

Presented to a current or recent (within the past 12 months) ACEP chapter executive or chapter staff member who has made a significant contribution to advancing emergency care and the objectives of an ACEP chapter and the College. The award is named after Diane K. Bollman, who served as the executive director of the Michigan College of Emergency Physicians for 25 years and was an honorary member of ACEP.



### *Honorary Membership Award*

Janis Farnholtz Provinse, RN

Presented to individuals who have rendered outstanding service to the College or the medical profession.




### *Policy Pioneer Award*

Taylor S. Nichols, MD, FACEP

Presented to early- and mid-career members who have made outstanding contributions to the College's health policy and advocacy initiatives.



### *Council Meritorious Service Award*

Thom R. Mitchell, MD, FACEP

Presented to a member who has made consistent contributions to the growth and maturation of the ACEP Council.

## ACEP HONORS 2025 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



### *Award for Outstanding Contribution in Research*

Joseph P. Ornato, MD, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.



### *Award for Outstanding Contribution in EMS*

Robert Domeier, MD, FACEP

Presented to an individual who has made an outstanding contribution of national significance or application in Emergency Medical Services. The award is not limited to ACEP members.



### *Disaster Medical Sciences Award*

John L. Hick, MD, FACEP

Presented to an individual who has made outstanding contributions of national/ international significance or impact to the field of disaster medicine.



### *Community Emergency Medicine Excellence Award*

Derrick Oaxaca, MD

Presented to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.



### *Innovative Change in Practice Management Award*

Benjamin Bassin, MD, FACEP

Presented to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.

## ACEP HONORS 2025 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



### *Innovation & Excellence in Behavioral Health & Addiction Medicine Award*

Elizabeth M. McNamara, MD, FACEP

Presented to an individual who has made a significant contribution in advancing the emergency department care of patients with behavioral health and substance use disorder.



### *Public Health Trailblazer Award*

Jennifer Avegno, MD

Presented to an individual who has made a significant contribution in advancing public health care and injury prevention measures locally, statewide, or nationally.



### *Leon L. Haley, Jr. Award for Excellence in Diversity, Equity & Inclusion*

Lynne D. Richardson, MD, FACEP

In recognition of individuals who have significantly helped to advance diversity, inclusion, and health equity within their community, statewide, or nationally.



### *Lou Graff Award for Excellence in Observation Medicine*

Christopher Baugh, MD, MBA, FACEP

In recognition of emergency physicians who have made a significant contribution to the field of observation medicine within emergency medicine.

## ACEP HONORS 2025 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Penn Medicine
Emergency Medicine

### *EM Wellness Center of Excellence Award*

University of Pennsylvania Department of Emergency Medicine

Presented to an emergency medicine group, department, or clinical site that incorporates wellness and resilience on an institutional level and to use the information gathered in the nominations process to understand more about wellness best practices.

**OUR MISSION:** ACEP exists to support quality emergency medical care and to promote the interests of emegency physicians.

**OUR VISION:** ACEP is the home and community for career fulfillment and professional identity fpr every emergency physician.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

## OUR STRATEGIC GOALS AND OBJECTIVES:

**Career Fulfillment:** Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Develop and implement ongoing, two-way systems to identify the issues that hinder career satisfaction and meaningfully demonstrate to members that we hear them.
- Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.
- Focus resources, education and networks to assist members in identifying career opportunities and having career fulfillment across different professional interests or life stages.
- Remain diligent in addressing workforce solutions to ensure emergency physicians set the course for the future.

**Advocacy:** Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

- Expand and strengthen the role, approach and impact of state-level advocacy.
- Streamline and innovate our advocacy approach and content to better communicate the relevance, impact and accomplishments of advocacy efforts and empower members to advocate for themselves within their own workplaces, regardless of employment model.
- Identify, test and adopt new funding strategies to support advocacy programs.

**Practice Innovation:** Members work with ACEP to revolutionize the management of acute, unscheduled care.

- Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.
- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

**Member Engagement and Trust:** Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

- Build up the leadership pipeline within ACEP and throughout emergency medicine spheres of influence.
- Leverage personalization and opportunities for issue/interest-based participation to make a member's connection to ACEP more personally meaningful.
- Re-imagine the EMRA to ACEP pathway to retain more members upon residency completion.
- Develop recognition and rewards to redefine engagement.
- Measure and showcase the diversity and character of ACEP leaders and members.
- Enhance ACEP's brand positioning and communication strategies.

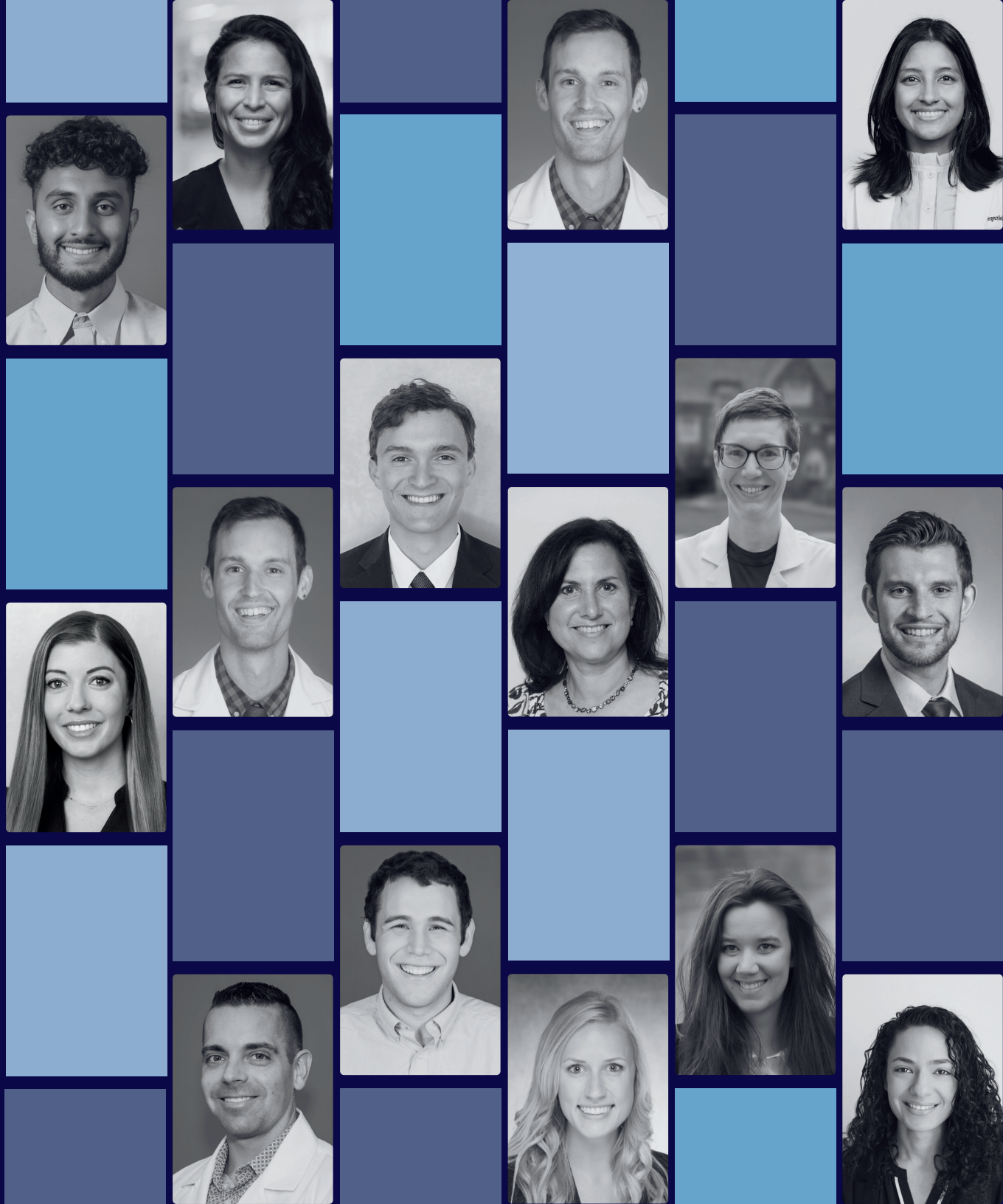
**Resources and Accountability:** ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

- Implement a systematic program evaluation process that considers new and on-going needs, return on investment/member value and ACEP's strategic plan.
- Invest in overhauling ACEP's digital infrastructure, processes and culture to modernize systems and improve the member and customer experience.
- Adopt effective project management techniques and data-driven decision-making processes.
- Re-examine membership and non-member models to fulfill our mission.
- Develop alternative or non-traditional revenue and in-kind sources and opportunities.
- Be more transparent and timelier in communicating College policies, processes, and initiatives.

EMF Emergency Medicine Foundation®
research → education → patient care

# NOW MORE THAN EVER, YOUR SUPPORT MATTERS TO THE FUTURE OF RESEARCH IN EMERGENCY MEDICINE.

# 2025 COUNCIL REPORT



**In 2025, EMF proudly announced a new milestone of nearly $22 million funded supporting more than 340 grant projects since 1972.**

## COUNCIL CHALLENGE IMPACT

366 Councillors and leaders at ACEP24 contributed more than $205,000 to EMF. ACEP Council is the largest and longest sustaining supporter of EMF, having contributed $3 million over 29 years.

## NEW 2025 GRANTS

The 2025 grant cycle is funding more than $500K to 14 grant projects across diverse topics including opioid treatment, pediatric burns, cardiology, EMS and education, reflecting a commitment to advancing emergency care through equity and innovation.

## UPCOMING RESEARCH PROPOSALS

EMF has released new RFPs for grant projects to begin July 2026. Visit EMF's website to learn more. Visit EMF's website to learn more about the grant priorities and due dates.

## 2025 GRANTEE WORKSHOP

The EMF/SAEMF Grantee Workshop was held in January 2025, providing EMF grantees with training and networking opportunities with that included emergency medicine research leaders.

Larisa Traill, MD, FACEP Luke Saski, MD, FACEP and Abigail Brackney, MD, FACEP at 2024 Council Challenge



EMF Grantee, Jonathan J. Oskvarek, MD, MBA at ACEP24 Research Showcase




EMF Trustee, Dr. Andrea Green, MD, FACEP and Dr. Kristin McCabe-Kline, MD, FACEP at EMF Reception



EMF Grantees at EMF reception at ACEP24



# 2025-2026 EMF RESEARCH AWARDEES



## EMF/EMRA RESIDENT RESEARCH GRANT

**Francesca Brancati, MD**
Duke University
*Evaluation of Bystander Interventions in Opioid-Associated Out-of-Hospital Cardiac Arrests in North Carolina*
$10,000



## PILOT RESEARCH GRANT

**Erin R Hanlin, MD, MPH**
Duke University
*Understanding the Barriers and Facilitators to the Delivery of Regional Evidence Based Pediatric Burn Care*
$92,523



## EMF/SAEMF MEDICAL STUDENT RESEARCH

**Max Higgins**
Wake Forest University Health Sciences
*Chest Pain Health Equity Assessment of Rural vs. Urban Treatment and Outcomes in the Emergency Department (CHART-ED)*
$4,984



## EMF/EMRA RESIDENT RESEARCH GRANT

**Benjamin T Hutchison, MD**
Wake Forest University School of Medicine
*ACE of SPADES: Assessment of Chest Pain in Patients with Known Coronary Artery Disease in the Emergency Department*
$9,999



## EMF/EMRA RESIDENT RESEARCH GRANT

**James O Jordano, MD**
Vanderbilt University Medical Center
*Use of a Large Language Model to Identify Inappropriate Antibiotic Prescriptions for Upper Respiratory Infections in the Emergency Department*
$10,000



## PILOT RESEARCH GRANT

**Utsha Khatri, MD, MSHP**
Icahn School of Medicine at Mount Sinai
*Emergency Department-Initiated Buprenorphine for Opioid Use Disorder: A National, Longitudinal Analysis of Addiction Treatment Outcomes and Acute Care Utilization*
$100,000



## EMF/SAEMF MEDICAL STUDENT RESEARCH

**Adam Kipust**
University of Miami Miller School of Medicine
*Exploring Emergency Care Experiences for Adults with Autism Spectrum Disorder: A Qualitative Analysis*
$5,000



## PILOT RESEARCH GRANT

**Deborah A Levine, MD**
Weill Cornell Medicine
*Salivary miRNA and Elevated Intracranial Pressure in Children with CSF Shunt Malfunction*
$100,000



## EMF/RESEARCH ACADEMY GRANT

**Holly McCarthy, DO**
IES Research Institute
*Effects of Early Addition of Acetazolamide to Loop Diuretic Therapy on Hospital Length of Stay in Scute Decompensated Heart Failure*
$10,000



## NIDA MENTOR-FACILITATED TRAINING AWARD

**Mark McMullen, MD**
HCA Tristar Skyline
*Addiction Treatment Newsletters in Middle Tennessee*
$12,000



## NIDA MENTOR-FACILITATED TRAINING AWARD

**Kristen Panthagani, MD, PhD**
Yale School of Medicine
*Accelerating the Dissemination of Knowledge through Video: Development of Explainer Videos for Medications for Opioid Use Disorder (MOUD) and Harm Reduction Strategies*
$12,000



## EMF/SAEMF MEDICAL STUDENT RESEARCH GRANT

**Owen Ramberg**
Stanford University School of Medicine
*Optimizing EMS-Physician Communication to Improve Transport Decisions for Low-Risk Trauma Patients*
$5,000



## EMF/SAEMF MEDICAL STUDENT RESEARCH GRANT

**Neil Rupani**
University of South Florida
*Impact Of Narcan Availability on Substance Use Behaviors Among Persons Who Use Drugs*
$5,000



## PILOT RESEARCH GRANT

**Anne Zepeski, PharmD, BCPS**
University of Iowa College of Medicine
*COMparison of Adenosine and Diltiazem FOR Supraventricular Tachycardia (COMFORT-ED)*
*Priority: Basic Science*
*Score: 3.43*
$99,993



## EMF/EMRA RESIDENT RESEARCH GRANT

**Gabrielle Zuniga, MD, PhD**
University of Texas Health San Antonio
*Assessing The Therapeutic Efficacy and Target Engagement Of 3TC In Mice After Severe Traumatic Brain Injury*
$10,000

## SEE THE MISSION IN ACTION AT ACEP25

### EMF RESEARCH SHOWCASE

**September 7, 3:30 PM MST**
**Research Forum, Room 1**
See how your donor dollars are spent on practice-changing research by EMF grant recipients.

### VIP RECEPTION

**September 7, 6:00 PM MST**
**Utah Museum of Contemporary Art (UMOCA)**
Donors who give $600 and above annually can unwind and celebrate EMF at the UMOCA—where contemporary art of the Beehive state meets the lifeline of emergency medicine research.

### MAJOR DONOR LOUNGE

**September 7 - September 9, 7:00 AM – 4:00 PM MST**
**Lower Concourse/Research Forum**
The donor lounge allows those who give $600 and above annually to relax and enjoy refreshments and breakfast each day.

### SILENT AUCTION

**September 7 - September 10**
**Lower Concourse**
One-of-a-kind experiences, sports, music, celebrity memorabilia, art, jewelry, and more. Bid, buy, and support EMF!

Council Members at the 2023 ACEP EMF Council Challenge



EMF and SAEMF Grantees at 2025 Grantee Workshop



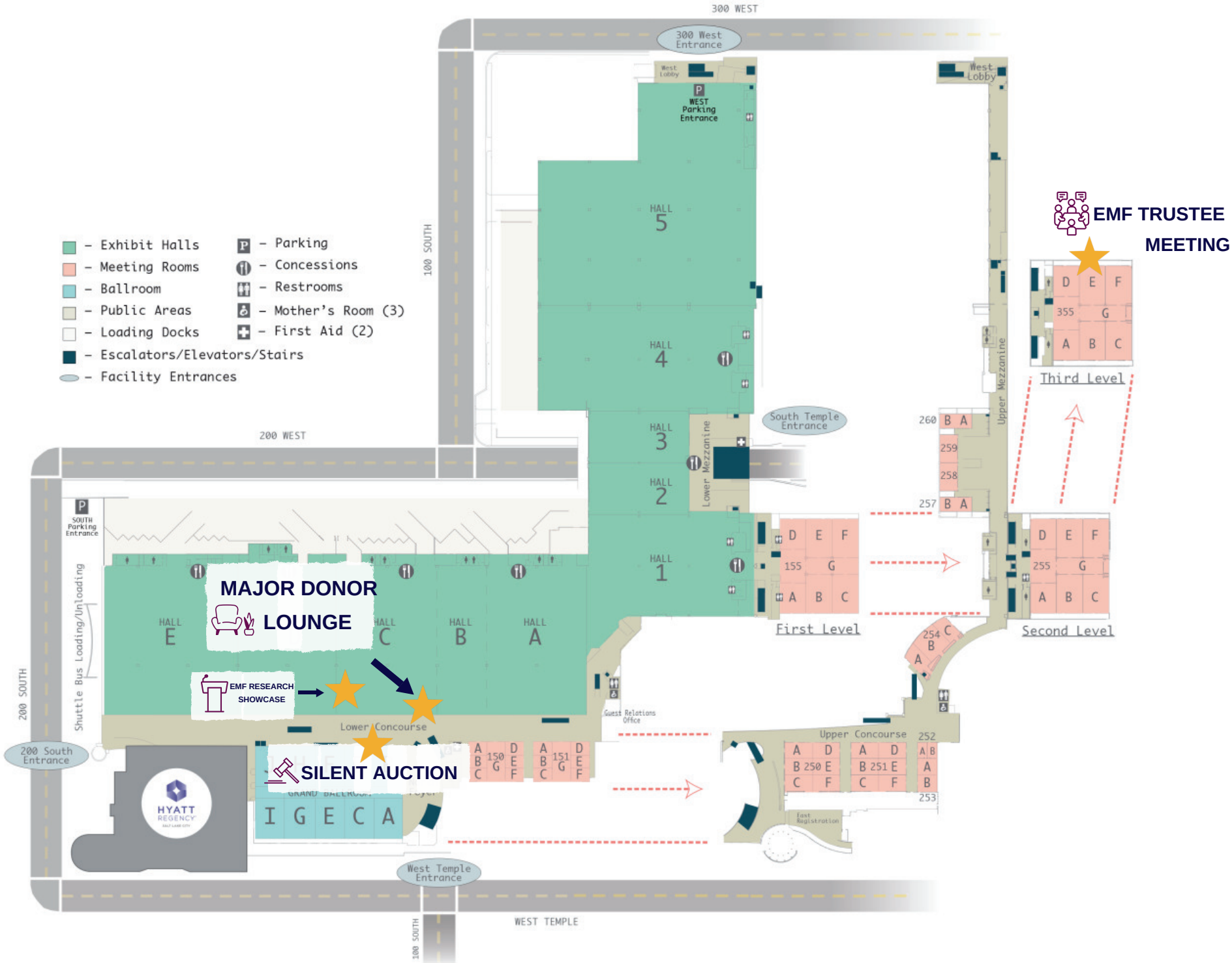
EMF and SAEMF Grantees at the 2025 EMF/SAEMF Grantee Workshop



2024 EMF Chair, Jim Williams, MD, FACEP, addressing the 2024 ACEP Council



# ACEP25 - SALT PALACE CONVENTION CENTER



# A SPECIAL THANKS TO OUR PARTNERS & SPONSORS AND LOCATIONS IN EXHIBIT HALL AT ACEP 25

## *CORNERSTONE PARTNERS*

Teleflex™
Empowering the future of healthcare

Abbott Point of Care

Visit at Booth #529

VAPOTHERM®

Visit at Booth #1736

vituity®
At the heart of better care.

Visit at Booth #1167

## *IMPACT PARTNERS*

ApolloMD™

Visit at Booth #1275

Cytovale

Visit at Booth #1641

Fisher & Paykel HEALTHCARE

Visit at Booth #1235

Pfizer

Visit at Booth #224

PointClickCare®

Visit at Booth #710

TEAMHealth®

Visit at Booth #1261

EMF Emergency Medicine Foundation®
research → education → patient care

# COUNCIL Challenge

# $3 MILLION



**ACEP Council has Contributed over $3 million over 29 Years**

**Help Us Reach our $200,000 Goal in 2025**

**START A CONVERSATION WITH EMF**

# Report to the ACEP Council

# The National Emergency Medicine Political Action Committee (NEMPAC)

# and

# ACEP Grassroots Advocacy

**September 2025**



# NEMPAC

**NEMPAC's mission is to educate and support federal candidates who will advocate for the highest quality of emergency care and the concerns of emergency physicians and our patients**.

NEMPAC celebrates 45 years of success in 2025. A small, forward-thinking group of ACEP members founded NEMPAC in 1980 to help ACEP promote our legislative goals and express the concerns of emergency medicine to members of Congress. Back then, the founders determined they would need to raise $10,000 to have influence on the issue of independent contractor status for emergency physicians. Today, due to the increased costs of running office and the many issues of importance to the specialty that ACEP can influence in Congress, our goal is to raise more than $1 million annually. For the past ten years, this goal has been closely met and, in some years, exceeded, despite challenges that continue to confront the specialty.

Just like the NEMPAC Board of Trustees today, NEMPAC's founders were from all parts of the country and were "party" blind when it came to selecting candidates worthy of NEMPAC support. And just like today, NEMPAC is the only national PAC solely dedicated to representing our bi-partisan interests in our nation's capital. Over the years, NEMPAC has steadfastly maintained our bipartisanship, trending toward supporting the party with majority control as noted in Attachment A, which details "NEMPAC Expenditures by Chamber and Party Trend."

NEMPAC serves a vital role in advancing ACEP's legislative agenda and in broadening emergency medicine's visibility with Congress. 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 45 years.

The Council Challenge has been in place for more than 25 years. Councilors collectively contribute an average of $250,000 annually to NEMPAC, which is more than one-quarter of our total raised annually. Each year during the Council Meeting, NEMPAC challenges all Councilors attending the meeting to support NEMPAC with the goal of reaching 100% participation.

**2024 Election Cycle**

In the 2024 election cycle, despite the challenges of national political unrest and divisiveness, and economic and professional concerns unique to emergency medicine, NEMPAC raised $1,645,523 and contributed more than $1.8 million to candidates, party committees, leadership PACs, and SuperPAC/independent expenditure campaigns. NEMPAC remains one of the top four medical specialty PACs and continues to play a critical role in ACEP's federal advocacy efforts.

Please see the link below to the NEMPAC 2024 Election Report.
https://www.acep.org/siteassets/new-pdfs/advocacy/nempac_2024electionreport.pdf

**2026 Election Cycle**

The NEMPAC federal candidate budget is developed and approved by the NEMPAC Board of Trustees with guidance of ACEP staff. It is subject to modifications as the election cycle progresses, and the congressional agenda takes shape, and we consider the resources available through NEMPAC's fundraising efforts.

In the 2026 election cycle, the NEMPAC Board of Trustees will pursue the following strategies to achieve NEMPAC's mission:

- Identify and assist candidates and incumbents who support ACEP's mission, vision, and values.
- Support candidates in both major political parties who will work to advance ACEP's issues or can influence positions important to the specialty of emergency medicine.
- Identify "Champions" of emergency medicine who would receive maximum funding for their re-election campaigns ($10,000) and for the Leadership PACs (if applicable) of $5000 per year, in addition to other benefits identified below.

- 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 enhances the contacts between these two Boards and their Congressional representatives by giving the Board members the opportunity to attend virtual and local events for their Members of Congress.
- Prioritize checking deliveries and attendance in person by ACEP members ACEP leaders, Chapter leaders, and NEMPAC VIP Donors.
- Prioritize contribution to members of key congressional committees (House Ways and Means, House Energy and Commerce, Senate Finance and Senate HELP) utilizing NEMPAC donations and interactions due to NEMPAC to educate committee members, particularly those new to the committees.
- Create a NEMPAC soft dollar fund including fundraising, disbursement, and recognition strategies.
- Sustain and strengthen partnerships with Leadership PACs and SuperPACs that support the election of qualified physicians to congress.

**Additional Evaluation Criteria**

2026 evaluation criteria will follow past NEMPAC practices of focusing on a candidate's support of ACEP's key legislative and regulatory initiatives, co-sponsorship of ACEP legislation, committee assignments (with an emphasis as noted above), leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions.

As we look at incumbents and new candidates for NEMPAC support, those that meet criteria in several categories would be eligible for more support.

Although a candidate may have an authorized budget amount, the candidate will not necessarily receive the full amount for which he or she is budgeted. A notable change in the legislative/political climate may dictate that we reach as many candidates as possible (rather than a targeted focus on candidates on a committee). Ongoing assessments will enable us to determine which overall approach is most compatible with ACEP's legislative and regulatory agenda.

Candidates and incumbents who receive NEMPAC support are expected to exhibit behavior and actions consistent with the mission, vision and values of the American College of Emergency Physicians and uphold the principles of our democratic process and orderly governance. NEMPAC supported candidates should affirm science, evidence and fact in their words and actions.

The integrity and character of the candidate will be assessed on an ongoing basis and NEMPAC may consider ceasing contributions to a candidate or committee if credible, specific, and serious allegations about the candidate's behavior arise.

NEMPAC will also continue our commitment to inclusiveness and respect for diversity.

The NEMPAC 2026 Election Cycle Guidelines and a complete list of candidates supported are available on the NEMPAC website and by request from ACEP staff.

**NEMPAC 2025 Fundraising and Candidate Contribution Highlights to Date:**

Amount Raised in 2025 as of August 7: $459,784
Donations to Candidates: $438,500 donated to candidates, leadership committees, party committees, and independent expenditures/SuperPACs as of August
Party Breakdown: 51.5% to Republicans and 48.5% to Democrats. (See Attachment B)
See the NEMPAC website for specifics.
Note: NEMPAC carried over $232,960 from the 2024 election cycle. (See Attachment C)

**Other Highlights:**

Co-host of the "House Call on the Mall" event with NRCC and multiple physician specialty organizations – donating $15K for access to party and committee leaders along with members of the GOP Doctors Caucus.

Lead physician specialty in support of the Healthcare Freedom SuperPAC organized in 2022 to help elect Republican physician candidates for Congress, run by former and current physician members of congress including Drs. Phil Roe, John Joyce, and Greg Murphy – NEMPAC is one of the inaugural donors.

Lead physician specialty groups in the creation, organization, and implementation of a SuperPac in 2024 to support Democrat physician candidates for Congress. We are currently in the process of raising and disbursing funds through this entity. The fund will also work in coordination with the newly formed Congressional Physicians Caucus (Democrat Doctors) currently comprised of co-chairs, Reps. Raul Ruiz, Kim Schrier, Herb Conaway, Kelly Morrison, Maxine Dexter, and Ami Bera.

Educating ACEP members about running for office and physicians and congressional champions currently in office through articles in ACEPNow, monthly NEMPAC Pulse newsletter and on the ACEP/NEMPAC website.

ACEP co- hosts annually and serves on the planning committee of the Physician Specialties PAC Forum and the Specialty Physician Candidate Forum.

In 2025 as of early August, DC staff and ACEP members attended **230 fundraisers and meet and greets** for incumbents and candidates running in the 2026 election cycle with nearly 15% attended in person by ACEP members back in their home districts or at LAC dine-arounds and other opportunities in DC. Twenty percent of these events were hosted or co-hosted by NEMPAC/ACEP. Each event is an opportunity to discuss the concerns of emergency medicine and legislative solutions.

2025 Dine-arounds at LAC: Reps. Brett Guthrie (R-KY), Kim Schrier, MD (D-WA), Lisa McClain (R-MI), Aaron Bean (R-FL), Brittany Pettersen (D-CO).

## The 911 Grassroots Legislative Network

Along with NEMPAC, the 911 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 tools and training to help 911 Legislative Network members effectively communicate with their legislators.

We have been kick starting our grassroots advocacy with ACEP members and federal legislators and staff both quantitatively and qualitatively in the past year. Over 6,000 ACEP members including Residents are actively engaged in our 911 Grassroots Advocacy and we continue to grow our "grasstops" program through our ACEP Advocacy Leaders Program. Advocacy Leaders receive specialized training and communications from our DC staff to help them develop long-term productive relationships with members of congress and their staff.

We have a robust ACEP Advocacy Action Center where you can find active action alerts, information about your legislators and access to the ACEP 911 Weekly Update.

ACEP's 2025 Leadership & Advocacy Conference allowed for opportunities to have productive conversations about the recently released Rand Report on the state of emergency medicine, reforms to the Medicaid and Medicare programs, ED patient boarding, physicians mental health and wellness resources and other issues of importance to the specialty and patients. 492 emergency physicians from 46 states participated in 297 meetings on Capitol Hill with federal legislators and their health care staff during LAC in 2025, 53 of which were Member Level. This was an increase of 105 attendees and 23 meetings from LAC24.

***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.

**2025 Member of the Year: Tom Sugarman, MD, FACEP**

Thomas J. Sugarman, MD, FACEP has been a dedicated advocate for emergency medicine throughout his career. A long-time member of the ACEP 911 Grassroots Network and a key participant in the newly formed Advocacy Leaders Program, Dr. Sugarman has consistently championed the specialty and the patients it serves. By building strong, productive relationships with federal and state legislators, he has become a trusted voice and go-to expert on health care policy. He served as Chair of the Emergency Medicine Policy Institute (EMPI) and led ACEP's State Legislative and Regulatory Committee. A two-term member of the NEMPAC Board of Trustees, he continues to play an active role in grassroots and political advocacy at both state and national levels. He is also a long-serving member of the ACEP Emergency Practice Committee and currently holds the position of Senior Director of Government Affairs at Vituity. Since 2006, Dr. Sugarman has been a valued member of the ACEP Council and served on the Council Steering Committee in 2022 - 23. His contributions were also recognized by California ACEP, where he served as Chapter President and received both the Walter T. Edwards Meritorious Service Award and the Chapter Service Award.

**ACEP ED Visit Program for Legislators**

We have revived our **Emergency Department Visit Program**, where ACEP Advocacy Leaders invite legislators and/or their staff to tour emergency departments in their communities. Most recently, we created the ACEP August Recess Toolkit that contains tips and tools for meeting with legislators back home to continue discussing issues from the LAC Hill visits, including the boarding crisis, and Medicaid and Medicare reforms and reimbursement. These visits allow ACEP members to provide an up-close look to legislators regarding the challenges faced every day in providing emergency care to their constituents. Showing elected officials and their staff the people, places, and health care delivery

system that their legislation impacts helps to build long-term meaningful relationships, distinguish our members, patients, and issues from other specialties, and establish emergency physicians as health care experts in their communities.

Our DC staff helps in setting up the visits, including scheduling, providing talking points and tips on coordinating the visit with hospital staff and administration, and pre-visit calls to prep the hosting physicians.

**You can join the 911 Network here: https://www.acep.org/federal-advocacy/federal-advocacy-overview/911grassrootsadvocacy/**

**NEMPAC and the 911 Legislative Network help promote the specialty of emergency medicine. We thank the Council for your past support and encourage all Councilors to contribute to NEMPAC and sign up for the 911 Legislative Network. Your participation will help ensure the future of our specialty and our patients.**

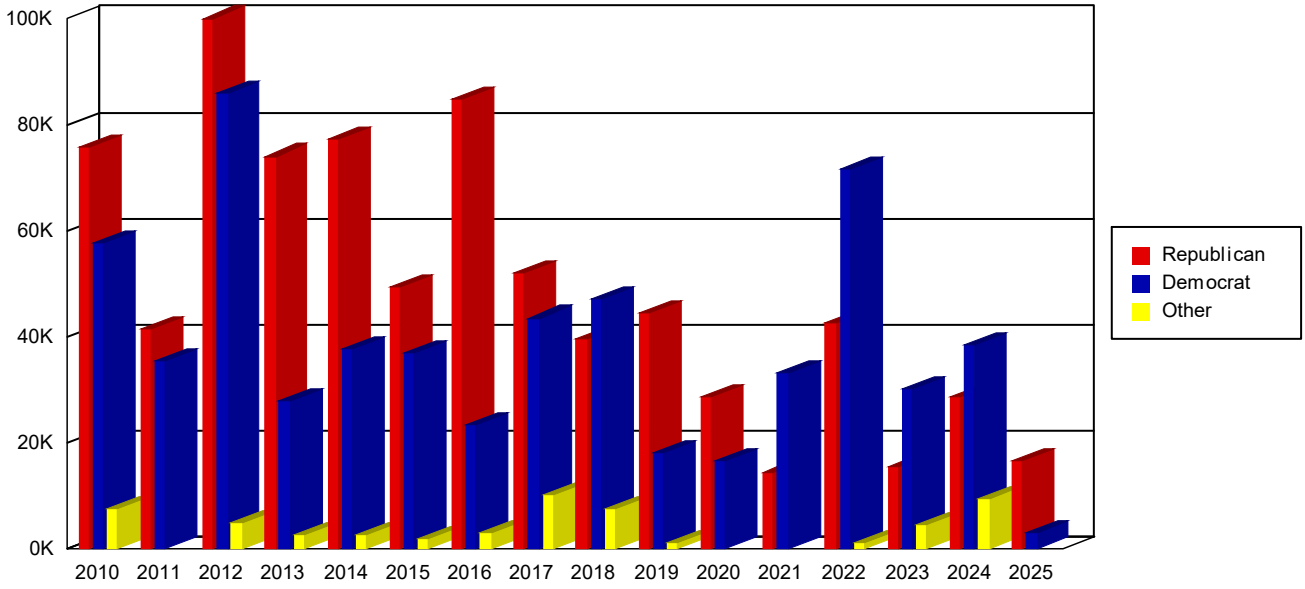
# *Expenditures by Chamber and Party -Trend*

Attachment A

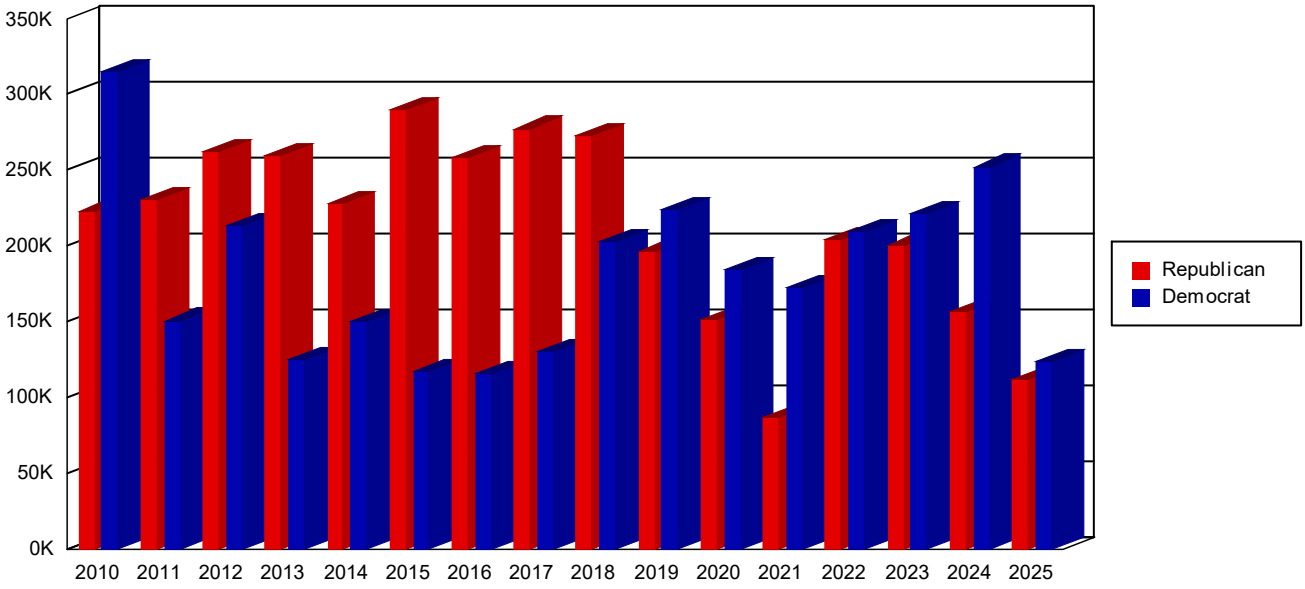
Date Range: 1/1/2010 to 8/7/2025

PAC: National Emergency Medicine Political Action Committee / American College of Emergency

## Federal Senate



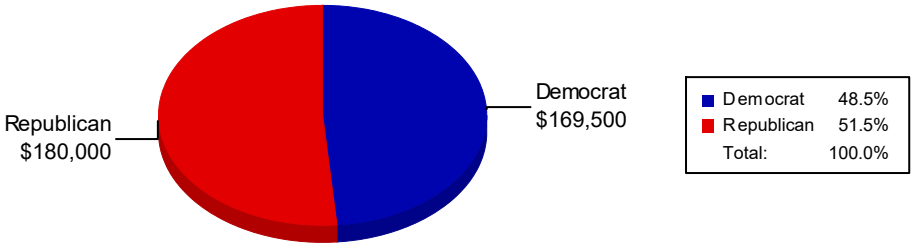

## Federal House



# Federal Expenditures by Election Year By Party

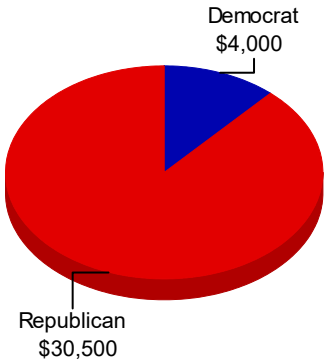
Leadership Committee Expenditures From 1/1/2025 to 8/7/2025
Candidate Committee Expenditures for election year: 2026
PAC: National Emergency Medicine Political Action Committee / American College of Emergency Physicians
Election Year: 2026

## Total Expenditures by Party



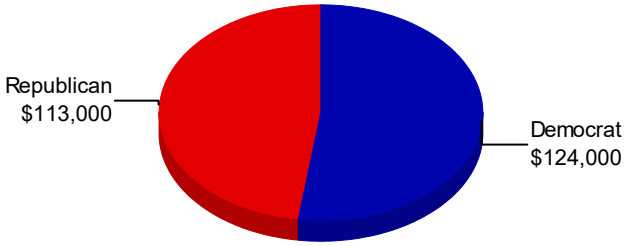

## Expenditures by Chamber and Party

### Federal Senate




| | |
|---|---|
| Democrat | 11.6% |
| Republican | 88.4% |
| Total: | 100.0% |

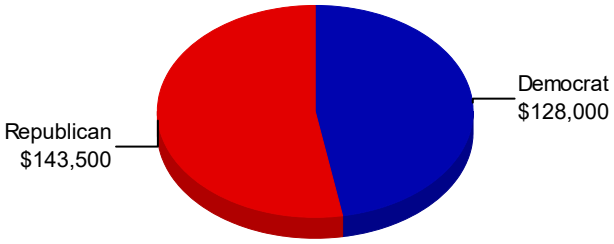
### Federal House




| | |
|---|---|
| Democrat | 52.3% |
| Republican | 47.7% |
| Total: | 100.0% |

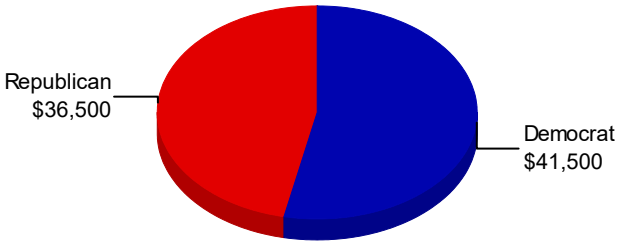
## Expenditures by Committee Type and Party

### Candidate Committees




| | |
|---|---|
| Democrat | 47.1% |
| Republican | 52.9% |
| Total: | 100.0% |

### Leadership Committees




| | |
|---|---|
| Democrat | 53.2% |
| Republican | 46.8% |
| Total: | 100.0% |

# National Emergency Medicine Political Action Committee / American College of Emergency Physicians Treasurer's Report

## I. Receipts

| | 2025 YTD | 2026 Election Cycle |
|---|---|---|
| Contributions | $459,783.99 | $459,783.99 |
| Interest Income | $4.82 | $4.82 |
| Reimbursed Operating Expenses | $0.00 | $0.00 |
| Refunds Paid to Contributors | $0.00 | $0.00 |
| Refund to PAC | $0.00 | $0.00 |
| **Total Receipts** | **$459,788.81** | **$459,788.81** |

## II. Expenditures

| | 2025 YTD | 2026 Election Cycle |
|---|---|---|
| Candidate Contributions | $255,000.00 | $255,000.00 |
| Committee Contributions | $173,500.00 | $173,500.00 |
| In-Kind Contributions | $0.00 | $0.00 |
| Operating Expenses | $5,371.15 | $5,371.15 |
| **Total Expenditures** | **$433,871.15** | **$433,871.15** |

## III. Cash Balance

| | |
|---|---|
| Beginning Balance - January 1, 2025 | $232,960.17 |
| Cash Receipts | $459,788.81 |
| Cash Disbursements | ($433,871.15) |
| **Ending Balance** | **$258,877.83** |

# COUNCIL CHALLENGE

*"Give-a-Shift" to the Future of Emergency Medicine*

## Did You Know?

- Councillors are the foundation of NEMPAC – and the decisions made at Council shape NEMPAC's advocacy priorities.
- NEMPAC supports champions for emergency medicine across the political spectrum.
- NEMPAC supports congressional candidates only - not Presidential races.
- NEMPAC is among the top five medical political action committees in fundraising and candidate support.
- Since NEMPAC's inception nearly five decades ago, the Council has been challenged to reach 100% participation in NEMPAC.

## The NEMPAC Triple "M"

2025 may not be a federal election year, but **the 2026 midterms are just 14 months away.** Legislators making decisions every day that affect the future of emergency medicine and your ability to take care of your patients - **it is more important than ever for NEMPAC to have the resources to fight for our specialty.**

NEMPAC provides the **Triple M** critical to our advocacy success:

**Money** – financial support for congressional candidates and incumbents so we can build a bench of champions and friends to work with on issues such as reimbursement, boarding, insurer bad behavior, and physician wellbeing.

**Mobility** – opportunities to attend hundreds of events in DC and across the country. Every contribution delivered to a candidate by ACEP members and staff is an opportunity to define and distinguish the specialty.

**Messaging** – unifying the voice of emergency medicine to maximize our impact.

***All Councillors from Sections and Chapters that reach 100% will be entered in a drawing for a custom North Face backpack.***

## NEMPAC VIP Donor Levels

$5,000 | CHAIRMAN'S CLUB
$2,500 | PLATINUM
$1,200 | GIVE-A-SHIFT
$365 | GIVE-A-SHIFT
(Retired.physicians.and.physicians.up.to.three.years.out.of.Residency).
$120 RESIDENT, FELLOW, AND MEDICAL STUDENT GIVE-A-SHIFT .
*Monthly and quarterly installment plans are available for all donor levels




## NEMPAC VIP Donor Reception: Welcome to the Rodeo!

Invitation-only. Open to NEMPAC donors at the $600 (attending physicians) and $60 (residents) levels.
**Come ready to line dance, eat barbecue, and enjoy some drinks! Cowboy boots encouraged!**
*Each Give-A-Shift donor ($1,200/attendings. $120/residents) is welcome to bring a non-member guest.*



**Saturday, 6:00 – 8:00 pm**
**Pierpont Place**
163 West Pierpont Ave #240
Salt Lake City, 84101
*Approximately ~5-minute walk from the SPCC.*



## NEMPAC Give-A-Shift Donor Lounge

*Open to Chairman's Club, Platinum, and "Give-a-Shift" donors*
**Sunday through Tuesday, 8:00 am – 4:00 pm**
**SPCC, Level 1, 150DEF**

Stop by the Give-A-Shift donor lounge to relax between events and connect with NEMPAC Board Members and staff! Complimentary beverages, **hot buffet lunch**, snacks, head and neck massage appointments, and business center amenities will be available.

## How Do I Support NEMPAC?

**NEW:** Visit the NEMPAC table in the SPCC to **give via Square** (physical cards and mobile wallets)!
OR
Scan the QR Code below and enter your ACEP ID# (on your name badge) to **give via the mobile site!**

*QR code links to **emergencyphysicianspac.org***

Contributions or gifts to NEMPAC are voluntary and are not tax deductible for federal income tax purposes. The amount given or refusal to donate will not benefit or disadvantage you. By law, we may only use your contribution to support federal candidates if your contribution is made using a personal credit card or personal check. We are required to provide your employer's name, your occupation, and to obtain an original signature of the ACEP member if contributing by credit card. NEMPAC encourages personal contributions. All non-personal contributions to NEMPAC will be used to defray costs of educational programs for NEMPAC and other activities permissible under federal law.

# FY25 Annual Report

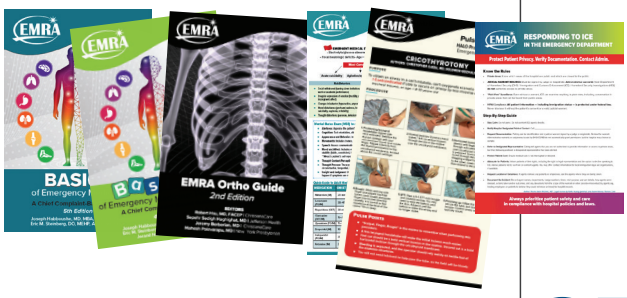
Membership: 20,075

**90%+**
EM residents are EMRA members

## BEST *DOCTOR*

**6** new/newly updated clinical resources

**36** *books, reference cards, digital, and mobile resources*




**260K+**
downloads of EMRA*Cast episodes

**18K+** *EM Resident* print distribution

EMRA Match

**85K+**
**monthly page visits to EMRA Match**

**$2.5M+**
Annually reinvested into EMRA members

## BEST *LEADER*

**22** committees, including NEW groups for Pain Management and Women's Health

**38** EMRA Leadership Academy students

**25** EMRA Medical Student Council members

**24** *representing medical schools from 24 states*

**6** EMRA Health Policy Academy fellows




**247**
EMRAfied residency programs

## BEST *SPECIALTY*

**75+** funded leader travel to ACEP Leadership & Advocacy Conference

**6** *Drop the Mic speakers at the EMRA & ACEP YPS Health Policy Primer*

**7K+**
**page visits to review proposed ACGME program requirements**

**14** resolutions and policy initiatives by the EMRA Representative Council

**10+**
ongoing collaborations to strengthen EM

*EMRA is the voice of emergency medicine physicians-in-training and the future of our specialty.*

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Memorandum

**To:** 2025 Council

**From**: Heidi C. Knowles, MS, MD, FACEP
Secretary-Treasurer

**Date:** August 8, 2025

**Subject**: Fiscal Year 2024-25 Financial Report (Unaudited)

These are preliminary FY25 year-end financials that are subject to change as year-end reconciliations are still in process for the FY25 audit.

## Key Take Aways

- Employee Retention Tax Credit (ERTC) – Half of the ERTRC funds totaling $1.27M, including $172,0000 in interest was received on July 17, 2025.
- The FY24 Audit & Form 990 have been approved. FY24 Single Audit began in June 2025.
- YTD bank balance is $819,000 better than June 2024. Managed organizations collected $1.2M, while chapter and PAC liabilities have been reduced by $1.1M, and accounts payable have decreased by $704,000 over the same period.
- As previously approved by the Board, $500,000 was transferred from the investments account in March, $500,000 in April, and a final $600,000 in May 2025.
- The Board approved the FY 2025-26 budget. The rolling cash forecast has been updated to incorporate the approved FY 2025-26 budget.
- In the FY26 rolling forecast, the only anticipated cash infusion is for the AMS system, which was previously approved to be funded through investment reserves. This forecast assumes timely receipt of member dues and early Scientific Assembly registrations, consistent with historical trends.
- YTD Net operating income is ($622,000), which is $1.5M better than the budget.

## Variance Comments

**Membership Dues –** Membership revenue is $538,000 above budget and $803,000 higher than FY24. This increase is attributed to a 3% dues increase, a slight rise in membership, and EMDI's contribution through its 100% Club discount initiative.

**Meetings and Events –** Meetings and events increased by $1.4M compared to FY24 but remains $343,000 below budget. Accelerate was $143,000, ACEP24 was $87,000, and Clinical Affairs was $79,000 below budget.

**Unidentified Contingency –** ACEP has historically maintained an internal contingency goal for additional revenue, though it was never a formal budget item. This was mistakenly included in the FY24–25 budget and has since been removed from the rolling cash forecast.

**Royalites and Advertising** – Of the $286,000 variance below budget, ACEP24 had a $391,000 budget and earned $109,000. The budget for ACEP24 advertising was more aggressive than anticipated.

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
Alison J. Haddock, MD, FACEP
*President*
L. Anthony Cirillo, MD, FACEP
*President-Elect*
Gabor D. Kelen, MD, FACEP
*Chair of the Board*
Jeffrey M. Goodloe, MD, FACEP
*Vice President – Communications*
Kristin B. McCabe-Kline, MD, FACEP
*Vice President – Membership*
Heidi C. Knowles, MS, MD, FACEP
*Secretary-Treasurer*
Aisha T. Terry, MD, MPH, FACEP
*Immediate Past President*
Jennifer J. Casaletto, MD, FACEP
C. Ryan Keay, MD, FACEP
Chadd K. Kraus, DO, DrPH, CPE, FACEP
Abhi Mehrotra, MD, MBA, FACEP
Diana B. Nordlund, DO, JD, FACEP
Henry Z. Pitzele, MD, FACEP
James L. Shoemaker, Jr., MD, FACEP
Ryan A. Stanton, MD, FACEP

COUNCIL OFFICERS
Melissa W. Costello, MD, FACEP
*Speaker*
Michael J. McCrea, MD, FACEP
*Vice Speaker*

INTERIM EXECUTIVE DIRECTOR
Sandra M. Schneider, MD, FACEP

**Emergency Medicine Data Institute (EMDI) Revenue –** EMDI revenue is $1.99M better than budgeted and $1.8M more than FY24. There were more customer dashboards and submissions implemented than budgeted. The team is reviewing the final 2024 calendar year invoice for any adjustments needed.

**Grants –** A detailed review of the FY25 budget revealed that some prior-year grants were mistakenly rolled over, overstating the budget by $351,000. This has been corrected in the FY26 budget. Adjusted for this error, grant revenue is $415,000 above budget.

**Association Management –** EMRA and CORD were updated to a monthly rate. Additionally, EMRA transferred financial services to EWALD as of January 31, 2025. These changes resulted in $166,000 being below budget.

**Accreditation Revenue –** The ED Accreditation Program, previously on hold, has resumed following Board approval.

**Temporary Services** – Temporary services expenses are $147,000 over budget due to the use of temporary staff in place of full-time salaried positions.

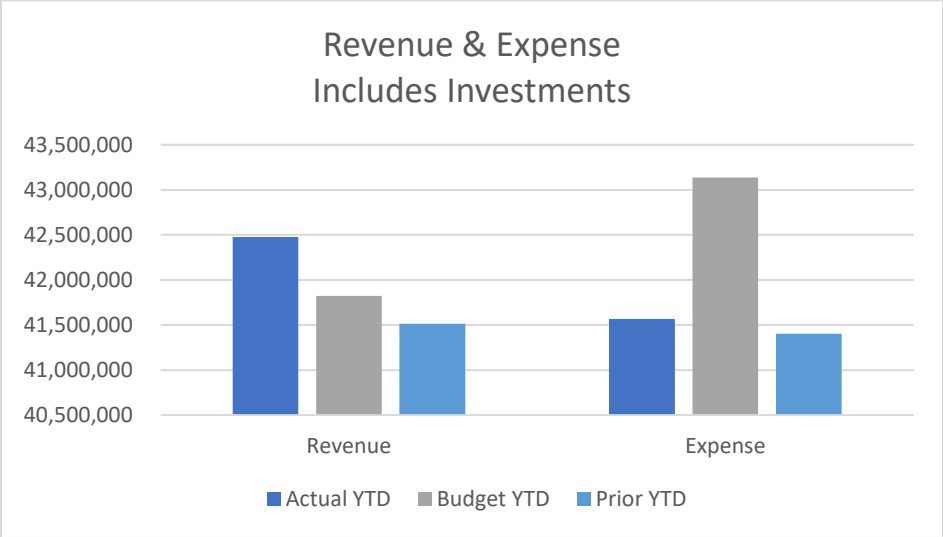
**Professional Fees –** Professional fees decreased by $571,000 from FY24 and over budget by $646,000 in FY25. Audit and tax fees are over budget by $151,000, which includes $69,000 in prior year audit fees paid in FY25. General professional fees are $475,000 over budget. This is due to finance costs of $529,000, EMPI $579,000, Leadership Management $168,000, Technology Services under budget by $272,000, EMDI $263,000 under budget, and grant expenses $269,000 under budget.

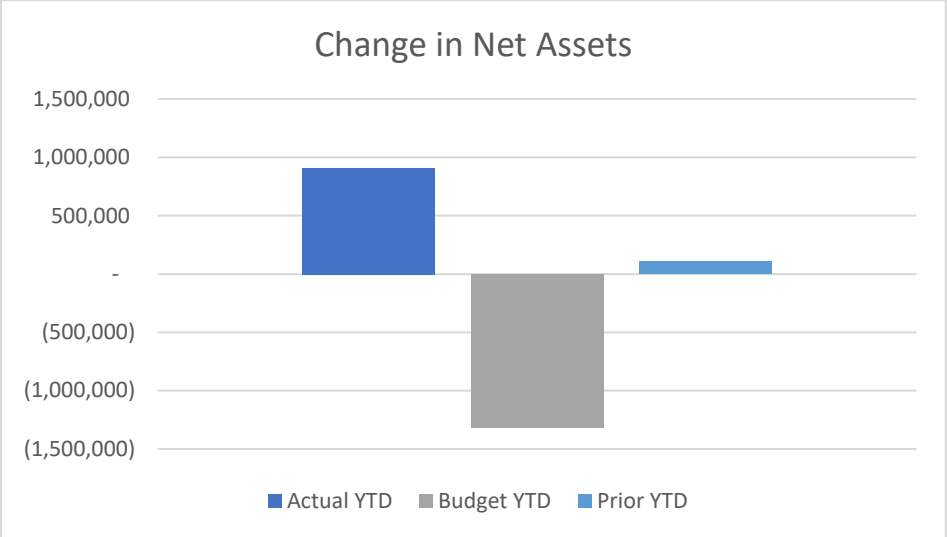
**Banking and Investment Fees –**Credit card fees were underbudgeted, resulting in $202,000 over budget.

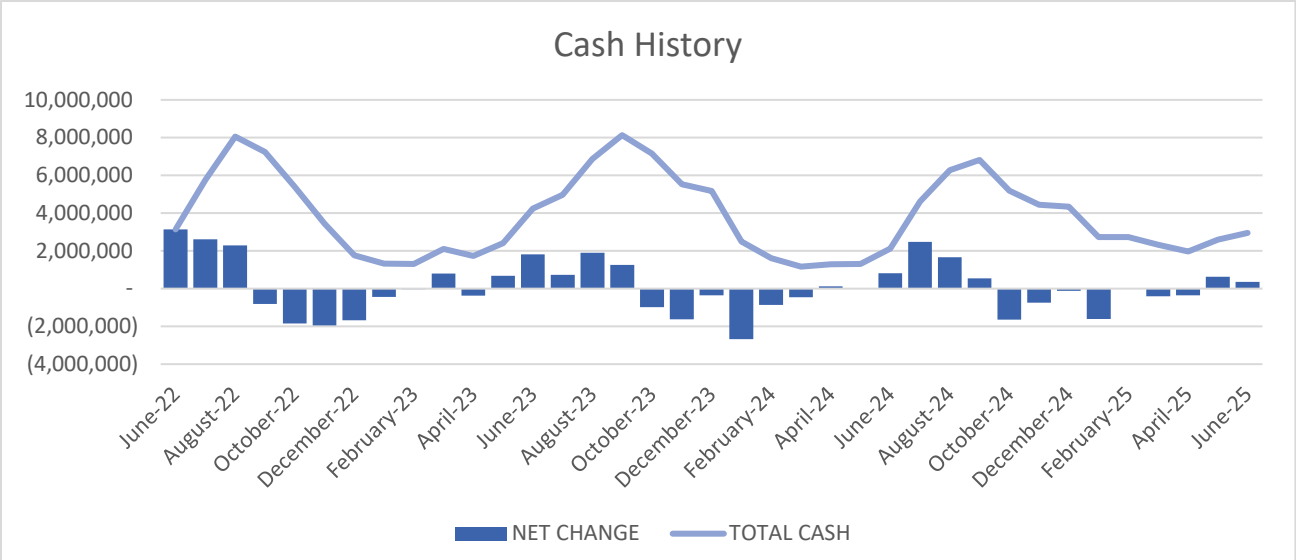
**Other Expense** – Expenses are $309,000 below budget. Grant related expenses are $173,000, membership marketing $87,000, and public relations with communications are $40,000 below budget.

See Attachment A for snapshot results with EMDI for the 12 months ending June 30, 2025 and 2024.

# ACEP Snapshot Results with EMDI
# for the Twelve Months Ended June 30, 2025, and 2024




Summer tends to experience strong cash increases followed by net decreases in late fall/early winter. Total cash typically peaks in August, drops to a low by January, and stays in a "valley" until upward momentum begins in May/June.